Missionaries, Radicals, Feminists: A History of North Yarra Community Health

The Free Medical Collingwood Mission Dispensary

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Photo: Courtesy of Collingwood Local History Photograph Collection
Introduction

‘A hospital is a complex of human relationships, a small stage upon which the wider dramas of life and society are enacted’ (Janet McCalman, 1998).

“Even more so a community health centre.” (Brian Stagoll, 2012).

The old building everyone called Singleton’s is still there at 162 Wellington Street, Collingwood, now part of Victoria’s heritage.¹ A classical two-storey brick building, it was built in 1889 with funds from public subscription as the Collingwood Free Medical Mission Dispensary ‘for the relief of the destitute sick of every creed and clime’. It was built on the site of the earlier Mission started by Dr. John Singleton in 1869. The building was active as a health facility until 1977 when, with a radically altered mission, it shifted to 365 Hoddle Street, as the new Collingwood Community Health Centre, later to become North Yarra Community Health (NYCH).

Symbolic of the changes in the neighbourhood, 162 Wellington Street, a former bastion of medical evangelism once renowned for its bathhouse out the back, (a public cleansing station dubbed the ‘Star Hotel’), is now WOW, ‘Wet on Wellington, Melbourne’s finest gay pool and sauna’.

This book is the story of what became of John Singleton’s Mission, an account of Community Health as practised over 140 years. Community Health has always been a chaotic, passionate and politically-charged project that insists on a social model of health. This model offers an alternative to the medically dominant, conventional models of health care in this country. Conventional medicine moves towards models of care that are private, individual, acute, hospital-based, hierarchical, and technology-focused. In contrast, the social model proposes an emphasis on the social influences and connections in peoples’ lives. It is sociable as well as social, and aims to be accessible, non-hierarchical, and directly accountable to the community it serves. It is usually low fee or free at the point of delivery and seeks options other than fee-for-service. Its catchwords are ‘public’, ‘population-based’, ‘participatory’ and ‘preventative’.

¹ Victorian Heritage Register[VHR]HO497
Of course, the reality of health care is more complicated than a simple division into ‘medical’ and ‘social’ would suggest. Effective health care requires both a biomedical and a social approach, a point some health policy makers now finally recognise.

The great triumphs of 20th century acute and hospital-based medicine (e.g., anaesthesia, surgery, antibiotics, diagnostic imagery, intensive care) have failed to come up with answers to the joint challenges of chronic illness and ageing, coordination of care, and effective strategies for prevention. This has brought the importance of the social model to the fore. It deals with problems that do not fit easily into the neat categories proposed by technology and biomedicine. As somebody quipped, ‘**Medicine is a very interesting intellectual and technologic discipline. Pity the patients mess it up**’. A social model is about clearing up the mess. Its institutional expression, Community Health, calls for a change in focus. Patients and their families living in their communities are placed at the centre of care. How can they participate actively and cooperate to improve their health, and that of their community? How are people affected by the powerlessness, marginalisation and lack of control that comes from poverty or social dislocation, prejudice or a toxic environment—the ‘social determinants of health’? What is to be done?

This book is an attempt to show how part of inner city Melbourne faced these challenges. It is not an exhaustive account of NYCH’s history since 1869. Writing it has been a messy process, just like the subject it tries to capture. In fact, at one point ‘**Messy Health**’ was put forward as a possible title! Several times the book threatened to be swept up in anecdotes of social movements and political struggles and the vivid personalities they spawned. They are good stories, but in the main the authors have tried to move on past them, to capture the challenges of health care in different eras, and how they were addressed. The particular focus is on two eras—the early Singleton Dispensary days, and the 1970s Whitlam reform era and its aftermath—because these were the times when the opportunity and need for reform was most evident.

It begins with the redoubtable Dr Singleton and his equally formidable wife, Isabella, whose portraits still overlook the Collingwood waiting room alongside a portrait of the recently retired Dr Chris O’Neill, a 20th century counterpart to Singleton.

The energetic fire first lit last century by this great Victorian doctor and evangelist has burnt in many directions, but has never been extinguished. Like other great institutions, Singleton’s and its successors have hosted missionaries, radicals and feminists along with charlatans, worthies and quiet heroes. All have been both provocateurs and victims of major social struggles.
in Melbourne. Most of all, they have been an ornament and an inspiration for the important idea of Community Health.

The roots of Community Health may be taken back to the idea of the Dispensary, an 18th Century response in Britain and colonial America to address the unattended health of the urban poor. The Dispensaries were to fade with the rise of hospitals, but there are still important lessons to be drawn from them. The history of the Dispensary Movement is recounted by the eminent medical historian, Charles Rosenberg (1974, 1992, 1997). He argues that this is a neglected history that can provide ‘would-be reformers with a potentially useable past’. This book is an attempt to redress the neglect outlined by Rosenberg.

Established in January 1869, Singleton’s was the first Dispensary in the Colony of Victoria. How it operated will be detailed in later pages. The ideas that infused the Dispensary remain the foundation stones of Community Health: recognition of the social determinants of health; community accountability and local involvement as an expression of democracy in health care; focus on primary care at the centre and not the margins of health; and, support for prevention, and health promotion and literacy.

These foundations of community health were reinforced in 1978 by the famous World Health Declaration of Alma Ata, ‘Health for All’. This was an historic assertion of health as a fundamental human right. Its resounding principles deserve repeating: equity, social justice and health for all; community participation; health promotion; appropriate use of resources; and intersectoral action.

More than thirty years on, these principles are still ‘relevant, revolutionary and revitalising’ (Lawn et al, 2008). Of course, the ‘Alma Ata Declaration’, like great works of literature, has more than one layer of meaning and has been interpreted in different ways by different people across the globe. This book is about one local interpretation of Alma Ata, played out in Carlton, Fitzroy and Collingwood.

The three small suburbs exist side-by-side on a gentle slope from the City of Melbourne down to the Yarra River. The descent reflects the fortunes and health of its residents. Carlton at the top of the hill is a unique suburb, home at different times to the centres of trade unionism, the nation’s parliament, and the city’s oldest and most prestigious university. Through its history, Carlton contained many areas of poor housing and poor health, but was largely a suburb of shopkeepers and the mobile working class. Fitzroy had a greater mix of middle class and poor with greater extremes of poverty, with the slums

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2 A Free Dispensary was also started in Richmond in March 1869. A Sydney Dispensary had been formed in 1826, later becoming subsumed into the Sydney Hospital (Korszniak, 2012).
at its southern end a particular focus for charities and missionaries. South Fitzroy was also an important centre of Aboriginal life. Both Fitzroy and Carlton would witness a rapid gentrifying process in the 70s and 80s, which coincided with slum clearances. This was an overt challenge to the traditional cultures of the suburb, cultures that had long engaged with those rejected by every other strata of society—Aborigines, the unemployed, single mothers, the homeless, drug addicts, and the ‘down and out’. The fight for a community health centre in Fitzroy would have these changes as its background.

As the hill slopes down to Collingwood another culture change occurs. Life here has always been harder, harsher, dirtier and more dangerous. This is where the NYCH story begins. Since its establishment in the 1840s Collingwood has been the end of the line for many and the start of a new life for many others. It was the poorest part of so-called ‘Marvellous Melbourne’ and a compelling place for Singleton to start his mission.

One hundred years later, Community Health exploded out of the reforming Whitlam government of the 1970s. Apart from a short period in Victoria, Community Health has never been taken seriously by governments and usually has been resisted by the medical community. Even in the Whitlam days it was something of an afterthought, a response by the Commonwealth Health Department, when national health insurance reforms were handed to the Social Security Department. It promised a preventative health system alongside Medibank, but financially separated from it. Health Department visionaries like Sidney Sax foresaw the ballooning cost to the taxpayer that a national health insurance system could create. When given a high quality medical service with little direct cost, people will tend to make proper and regular use of it. However like the proverbial iceberg the cost is mostly hidden. Unless that medical system aims to change the unhealthy behaviours, environments, neighbourhoods, and political structures of its citizens the system will come under increasing economic and logistical pressure. Community Health is a way to circumvent such an outcome. Unfortunately, it was never funded to fit into a fully integrated health system. NYCH’s funding has rarely gone beyond hand to mouth.

From the time of Dr Singleton to the present day battling the ills of the city has required confronting the fabric of the city. This is never a popular task and often seen as a threat to individual interests and property. Change occurs slowly. In the 1870s and 80s, the struggle was with poverty and homelessness, alcohol and drug abuse, mental illness, infectious disease, work injuries, poor hygiene, diet, and violence. And today? The struggle is still with poverty and homelessness, alcohol and drug abuse, mental illness, infectious disease (HIV/AIDS and Hepatitis C have replaced TB and polio), air pollution...and so on.
If Dr Singleton remained an outsider for challenging the medical profession and polite society, the Community Health worker of today is no closer to being an insider.

This book brings together the many personalities, cultures, ideas and politics that went into the creation of a small, but important, health service. For over 140 years, North Yarra Community Health and its predecessors have both reflected and challenged the medical and political values of their times. They have developed a distinct approach to health care and prevention in the inner north suburbs of Melbourne. They have literally ‘seen it all’ and ridden every wave and turn of time with their community. The fact that NYCH flourishes today is a great story that has never been written. Here is that story.

History Committee, North Yarra Community Health, 2008–2012

Brian Stagoll (Chair)
Harold Hamilton
Chris O’Neill
Brydie Quinn
Phillip Robinson
Jo Southwell
Dr. John Singleton 1808-1891
Chapter One

Singleton and Singleton’s

Dr. John Singleton was a great Victorian figure, now largely forgotten or only remembered as a leader of the unfairly derided Wowsers, the Temperance movement of 19th century Melbourne. He is buried in Melbourne General Cemetery. His grave is in a ruinous state.

The church pews and the stained glass window in Singleton’s waiting room in Wellington Street were outward signs of the moral passion that motivated the centre’s founder, and drove his extraordinary impact on medicine and society in Collingwood and beyond.

An evangelical Anglican, temperance advocate, and frenetic philanthropist, John Singleton founded the Royal Children’s Hospital and Melbourne City Mission, hosted and sponsored the Salvation Army on its arrival in Melbourne, championed the Aboriginal community of Framlingham, employed Australia’s first women doctors in Laura Morgan and Constance Stone, was known as the ‘prisoner’s friend’ for his support of penal reform, advocated for Melbourne’s homeless population, and in 1869 established the Dispensary that would become the Collingwood Community Health Centre.

Much of what is known about John Singleton’s early life is drawn from his 1891 memoir *A Narrative of Incidents in the Eventful Life of a Physician*. He was born in Dublin on 2nd of January, 1808, the third of nine children in a prosperous merchant class family. They were ‘strictly moral’ Anglicans in a time of ‘fox-hunting and dancing parsons’. He would remain Anglican for all his life, although he was drawn to the Methodist Society and its demands for a greater intimacy with God and more vigorous notions of modesty and sacrifice. Following a year of spiritual turmoil at age 19—‘I fasted so rigorously that I injured my health’—he experienced a spiritual rebirth through which he recast himself as an evangelistic crusader.

Singleton’s other calling was the medical profession. At the age of fourteen years, without his parents’ knowledge, he presented for and passed the qualifying exam to be articled as an apothecary. After a youthful and unpleasant experiment with whiskey, temperance was also to be an enduring passion. At nineteen years old, Singleton established his evangelistic working style when he took over a small practice in the poorest part of Dublin, and
began visiting the local hospitals and prisons with a view to comforting patients and inmates with bible readings; his autobiography is a litany of conversions of ‘infidels’ and run-ins with Catholic priests. At age twenty-eight, seeking to further his knowledge, he enrolled at the University of Glasgow, famous for its medical school.

In 1851, Singleton followed his clergyman brother, William, and migrated to Melbourne with his wife, Isabella, and their seven children. The Victorian gold rush had just begun. The population explosion of the gold rush, with its rivers of money and licentious entertainments to spend it on, brought on a public health crisis that shaped Singleton’s career from the start. It was his lifelong mission to fight disease, poverty, and drunkenness, and he was unflagging. With many doctors gone to the goldfields, he set up a practice while becoming deeply involved in civic life, especially in the reform of alcohol laws and prisons. He and Isabella would row out to convict hulks in Port Phillip Bay to provide spiritual and medical attention to the souls aboard. They would meet ships on arrival and guide vulnerable newcomers to safe accommodation.

Not robust of constitution, Singleton ‘had weak eyes and suffered from severe headaches’ (Morrissey, 1976). By the early 1860s he was exhausted and moved to country Victoria. In 1867 his daughter Frances died from TB. He collapsed from ‘brain congestion’ (a possible stroke). As he recuperated and brooded on a new venture, Singleton had a vision for a Dispensary ‘whose double object was the preaching of the gospel and the healing of the sick’ in ‘the poorest and most densely populated suburb in Melbourne’. It was among the first of its kind in Australia.

Dispensaries were a unique late 18th century response to the public crises brought by industrialisation and urbanisation. Prominent examples were developed in cities such as New York, Philadelphia and Boston, and London and Edinburgh.³ As a service to the neglected urban poor, they were much more than the pharmacies the name would suggest. Medications and therapeutics were part of what they offered, but additionally clinical care and ‘district visiting’, minor surgery and casual dentistry, and vaccinations. They were a forerunner of hospital outpatients, but with the notable difference of home and district visiting which made clear the importance of the environment in which a person lived. The home environment was regarded as central to a patient’s condition and recovery as any personal or moral ‘decay’. Rosenberg (1974) quotes a 19th century American Dispensary doctor: ‘No persons can more readily appreciate than we the utter uselessness of drugs if there is no possibility of nourishing and warming the patient’ (p. 40). Dispensaries were

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³ It was the Edinburgh Dispensary at Cowgate that inspired Singleton.
autonomous, free-standing institutions and could be designed around the dominant interests of those who founded them (Rosenberg, 1992). While other Dispensaries often centred on a medical specialisation (e.g., eye, ear, nose and throat), Singleton’s Collingwood Free Medical Mission Dispensary was a rather bold evangelical venture—a Protestant mission in a suburb of Catholics. For many Dispensary physicians, Singleton included, it was intemperance, the habit of excess and immoderation, especially concerning alcohol, that was the single most common cause of disease. However, the standard medical practice of the time was to prescribe vast quantities of brandy, wine and stout. Singleton set out in his Dispensary to prove the folly of this practice. He turned out to be right, if perhaps for the wrong reasons.

Chris O’Neill comments that “Singleton’s object was to bring temperance to Collingwood and he was singularly unsuccessful—there’s a pub on every corner”. But Singleton’s medical philosophy does have modern parallels. ‘We impress on the friends of the sick the necessity of judicious ventilation, cleanliness and quietness being observed…The patients while waiting have an opportunity of reading moral, sanitary or religious literature.’ Today we have relaxation, meditation and health promotion pamphlets, with warnings about alcohol, smoking and other ‘health vices’.

With the aid of the Melbourne City Mission and the Collingwood Council, a two-room stone cottage on Wellington Street was found and leased. It opened in January 1869, becoming only the second institution after the Melbourne Hospital to supply free medical treatment. The Dispensary would cover operating costs through the mission and subscriptions, and the Council was to pay the rent of the cottage. It was a fraught relationship. From its first days, Collingwood Council had represented industrial interests as well as those trading in property and liquor. The mostly Catholic Council also found more than it bargained for in Singleton’s religious fervour. Within a fortnight an inspection of the premises revealed religious tracts of seriously evangelical
Protestant nature and the Council ‘withdrew their support on the ground that the Society rested on a sectarian basis’ (Otzen, 2008, p. 25). After the ructions with Council it was decided Dr. Singleton also needed to distance the clinic from its other benefactor, the Melbourne City Mission—an establishment he had co-founded.

Dr Singleton was forced to rely on the subscription system, which had the dual purpose of raising money and ensuring patients were the ‘deserving’ poor. In this system people of means could purchase a subscription to recommend a patient or group of patients. The Ladies Benevolent Society, for example, could purchase subscriptions to refer the poor who had come to them for help. A factory could purchase a number of subscriptions for their workers. A £2 subscription also provided, in effect, moral cover for the purchaser. It also gave Singleton free rein to continue in his evangelistic medical practice where the demands he made of patients from such a ‘Romanist’ community could be onerous.

‘The waiting room had been hung round with texts of Scripture in large type and tracts were distributed among the patients…it was proposed to read a portion of scripture and offer a small prayer before the medical duties were begun. Patients would be given a tract and if they returned for a consultation, be asked to comment on it’ (Otzen, 2008, p. 25).

In 1886, Singleton was at the forefront of a major historical moment when he appointed Dr Laura Morgan as the first practicing woman doctor in Australia. The appointment was not without controversy. In 1865, The Australian Medical Journal referred to women doctors as ‘curiosities’, as novel as ‘dancing dogs, fat boys and bearded ladies’. Morgan faced fierce and prolonged opposition from the medical establishment in her efforts to have her American-issued qualification recognised (AMJ, 1865). Singleton championed her, as he ‘earnestly wished that women should be educated for the practice of the medical profession, so as to attend their own sex, especially in cases of midwifery’ (Singleton, 1891). Morgan began working at Singleton’s whilst the Victorian Medical Board dragged its feet over her registration. In 1886, the Burra Record saw fit to publish an ‘account’ of her practice:

‘We have it on the authority of a very respectable old church elder that when Dr. Laura puts her alabaster arm round the neck of a patient and caresses his jaw for the offending tooth, the sensation is something akin to that of going up to heaven between two rows of hot pancakes, while all the little angels stand on top and pour honey down your spine’ (p. 3).
Women had begun to be admitted to study medicine at Melbourne University since 1885, but even in medical school the going was tough for female students in Australia who were excluded routinely from essential classes deemed ‘unfit’ for women.

Despite Singleton’s appeal to the Victorian Premier on her behalf, Morgan’s career at Singleton’s was short-lived. Although three male doctors were practicing in Melbourne with the same qualification, the Victorian Medical Board refused to register Morgan and, for good measure, threatened to arrest her for practicing without a license. Chief Secretary Alfred Deakin intervened on her behalf, making the matter national news, and though Deakin managed to prevent a criminal conviction he could not win her job back. She left Singleton’s in 1888 and returned to North America.

In 1890, a short time later, (Emma) Constance Stone began work at Singleton’s. Hobart-born Stone had completed her medical training within the Commonwealth, in Canada, after going to the Women’s Medical College of Pennsylvania (the first medical school in the world for women). She was registered to practice in Victoria with apparently little fuss. On February 7, 1890, she became Australia’s first registered female doctor. The Women’s Christian Temperance Union held a reception for Stone at the Collins Street Baptist Church lecture hall, where John Singleton gave a speech in her honour. Singleton and Stone may have been a good match of personalities. Stone was described by a contemporary as ‘ultra conservative in her views, and thoroughly cautious and sensible as a counsellor’ (Wells, 1987, p. 151). She was also an early champion of womanhood suffrage, and would later found the Victorian Vigilance Society, which campaigned to make child prostitution illegal and successfully lobbied to raise the age of consent for girls. Stone soon began her local career at Singleton’s Dispensary, working on Tuesdays between 10am and 1pm ‘for Women and Children only’. Stone’s sister Clara, who graduated in the first female group at Melbourne University’s Medical
School, began work at Singleton’s in 1891. Clara attributed the poor reception to women from the male students at Melbourne University to jealousy—the women students in the cohort topped the final honours class, and won prizes and scholarships. The Stone sisters were also talented artists and supported themselves through medical school by selling their paintings. Their cousin, Mary, joined them a couple of years later.

The Doctors Stone worked together for some years as the women’s health team at the Dispensary. They averaged twenty-seven women patients per hour in 1894, more than the centre’s average daily attendance—and sometimes the patients topped 100 at a three-hour session. They realised quickly that the urgent need for women doctors amongst the female population was ‘as great as their strength could compass’ (Russell, 1990, p. 98). Constance Stone was keen to open her own dispensary. The high patient load led her to decide ‘that the time had come to start a women’s hospital officered by women’ (Wells, 1987, p. 110). The Doctors Stone would soon leave Singleton’s—under something of a cloud. They focused their energies on building what would become the Queen Victoria Women’s Hospital. Sadly, Constance was to die soon after in 1902 from tuberculosis, possibly contracted from her Collingwood years, but her work continued (Roberts, 1995).

Singleton was also associated with another famous moment in Australian history when he made an eleventh-hour attempt to convert bushranger Ned Kelly to Protestantism. Singleton visited the Pentridge Gaol hospital in 1880 while Kelly was recovering from wounds inflicted on him at the siege of Glenrowan. He passed along a copy of the New Testament and requested further visits to this hero of working class Irish Catholic Australians. They never met again, but it was Singleton’s belief that ‘Kelly sent his love to me on the morning of his execution’. Other sources confirm that as Kelly went to the scaffold he remembered the kindly old man who treated him ‘as if he had a soul to save’ (The War Cry, 11/2/1933, p. 2).

Through the 1870s and ‘80s Dr. Singleton would carry out his work attending to the needs of those crushed under the boot of the Colony’s booming economy. His bullish devotion to faith and the purity of body, soul and practice would earn him the disfavour of his medical peers. It would also see him link up with the Salvation Army who epitomised late Victorian evangelism. His beliefs in personal and social health were re-energised and he kept up a staggering pace of clinical and pastoral care, coupled with a constant stream of letters to The Argus newspaper, and epidemiologic reports on topics such as alcohol as a medicine, TB, child mortality, and cholera, which he posted to all doctors registered in Victoria.
The culmination of Singleton’s work was the opening of the new Dispensary in January, 1889. For Dr. John it was ‘a sermon in bricks and mortar’ with consulting rooms, a Mission Hall, a ‘large and commodious’ Dispensary, free reading room, and a drinking fountain outside ‘which has already cooled many a fevered tongue and saved cash from the hands of the publican’. Public subscription had raised £3773 and Singleton declared on opening, ‘We owed no man anything but love’ (Singleton, 1891).

Singleton manifestly had a ‘social view of health’ and was determined to put it into practice. He founded three establishments for women: The Home for Friendless and Fallen Women; The Widows’ Cottages; and an emergency refuge, The Night Shelter for Women and Children. All were located on land he bought in Islington Street, Collingwood. Similar shelters for homeless men were set up in West Melbourne. In the economic downturns of 1879 and 1889 he led a campaign to provide basic food to the unemployed, The Singleton Bread Fund. In 1889, he sponsored a Free Labour Exchange in the new building.

Singleton had found a new revenue stream in 1875 when the Dispensary was admitted to the Hospital Sunday Fund, an annual church-based funding drive for Melbourne’s hospitals. The Fund soon evolved into a battleground
of sectarian divisions, as Church groups demanded representation on the management committees of the hospitals that received their charity. The push for representation on management committees was argued forcefully by eastern suburbs Presbyterian churches, in particular after the establishment of the Catholic *St. Vincent’s Hospital* in Fitzroy in 1893. The *Toorak Church* took the step of dividing its collection amongst its members so they could get representation on the board as individuals. By 1883, the Fund’s contribution was almost half of the Dispensary’s budget, although Dr. Singleton began to call public attention to the inequitable distribution of the funds in letters to *The Argus* newspaper. Money was given out according to the number of subscribers to an institution. The 1900 Annual Report documents that only £85 pounds was granted, ‘a manifest injustice to our institution’. The Dispensary was in a poor suburb with few people able to afford a subscription. Money was forever tight at the Dispensary. Later, organisations such as the Victorian Football League, the Eight Hour Anniversary Fund, the Australian Native Association along with local factories and auxilaries became donors. Collingwood Football Club provided many Life Governors. The Collingwood Council, through the Mayor’s Fund, became the largest contributor, and the Mayor regularly chaired the AGM.

Singleton always argued that the savings generated by keeping people out of hospital, as his dispensary did, was not given enough significance in the allocation of funding. Indeed, the problem of quantifying the value of preventive medicine continues to this day.

Singleton made his son, William, director of the Dispensary in 1889, and put his other son, John Wesley (or J.W.), into a rather irregular medical ‘apprenticeship’ under himself. J.W. was to cause controversy at the Dispensary over the issue of qualification. He went by the title of ‘Psychopathist’, had no formal medical training, and was said to heal by spiritual magnetic force (*The Argus*, 1898). J.W. placed ads in country newspapers, asserting that he had: ‘...gone beyond the old method of treating diseases, [and] discovered means to cure.’

J.W. outlines his work in the 1893 Annual Report: ‘*The diseases of my department are mostly of a chronic form, including some that have defied all treatment; not only eye and ear diseases, but cancer, lupus, hip-disease, tumours etc. etc. have been dealt with, and it gives great satisfaction to be able to cure such afflictions.*’

In 1891, J.W. appeared in court for breaching the *Medical Act*. The Court was told John Wesley Singleton dipped his hands in water, instructed the witness to close his eye, then ‘*put a camel’s hair brush up the witness’s nostrils*’. J.W.
made ‘mesmeric passes to exorcise the demon out of the patient’s eyes’ then sold the patient a bottle of mixture and a box of pills. J.W. was found guilty (*The Argus*, 1891, p. 10).

Despite several more appearances in court for acting as a doctor without a licence, J.W. continued to practice alongside the Doctors Stone at the dispensary. Dr. John died around this time of pneumonia on 30 September, 1891. Otzen (2008) records that:

‘...as the news spread, the poor gathered outside his house and mourned for him, the Irish keening as only Irish can, knowing too well the significance of their loss’ (p.12).

His large funeral was attended by clergy, leading citizens and the poor, but apparently not by his medical colleagues. Crowds lined the streets as his cortege passed by, stopping briefly outside the new Dispensary.
Photo of the Singleton waiting room titled ‘Suffer Little Children’: 1948 Annual Report. The girl is attending for immunisation against Diptheria, a cause championed by Dr. Bradbury.
Chapter Two

Two world wars and two depressions

The great depression of the 1890s hit Melbourne hard after the boom years of the gold rush. The property boom had given way to a series of deep recessions fuelled by toxic debt and the removal of English capital to more exploitable markets. The people of Collingwood, Fitzroy and Carlton were very badly off. It was this decade that confirmed the ‘hard-bitten’ identity of these suburbs that would last well into the 1970s. Large terrace houses became boarding houses and tiny shanties were reinforced into semi-permanence. The middle-class moved across the Yarra. Heavy industry waxed and waned, but still kept the community dependent.

By 1893, the free medical care and baths provided by Singleton’s saw the patient load skyrocket by thirty per cent. In that year, a Mr. Parker, ‘late of the Bengal Medical Service’ (and also not a doctor), began working with J.W. and the pioneering Stone sisters.

Another doctor, J. Marmaduke Rose (later a member of the Legislative Assembly), in a report to the 1900 Annual General Meeting, gives an idea of the range of practice of the time:

‘120 patients in one afternoon consulting the doctor about influenza, pleurisy, nerve disorders or special diseases of women… also reported are large numbers of infants and children suffering from marasmus, and a few cases of typhoid. Also several cases of rapid and extensive glandular enlargements (which recklessly might have been designated the dreaded Bubonic Plague)’.

The notable, and supremely expensive, stained glass window featuring the Apostles Peter and John was also installed, as a tribute from J.W. to his father, while the centre was saddled with debt and nearly bankrupt. The dispensary’s financial position would remain tenuous over the coming years, and questions arose continually about the quality of management and of the service itself.
The Inspector of Charities, the Victorian Premier and the Charity Organisation Society soon expressed deep concern that unqualified people (J.W. and Mr Parker) were treating the sick. In particular, this was galling for Constance, Clara and Mary Stone, who had worked so hard for the right to practice. They resigned collectively in August 1896:

‘We have taken this step owing to constant irregularities, e.g., we find patients treated by unqualified men, and then when the cases are serious they are transferred to us; thus we are involuntarily made guilty of the offence of ‘covering’. We are also made responsible for the treatment of cases when the medicines dispensed are not those prescribed by us. Impelled by these, and the urging of influential friends outside the medical profession, we are compelled to relinquish a work in which we are deeply interested’ (The Argus, 1896, p. 6).

J.W. was called to account for the resignations, and suggested the women doctors had made a play to take over the dispensary:

‘Latterly, with her sister, another lady doctor who was her cousin, and a gentleman friend, it appeared… she had tried to get control of the institution. That could not be thought of, and Dr. Stone and her associates retired, ostensibly because there were unregistered practitioners practicing at the institution’ (The Age, 1896).

As for his own qualifications, The Age (June 3rd, 1892) reported:

‘Mr Singleton said he was not a registered practitioner, but he claimed that the had the requisite knowledge to do good, and he used his art because it was demanded of Christians to do good’ (p. 6).

“They were a medical mission”, Chris O’Neill said, “and the mission, in fact, was that you had to be holy before you got healed. But Singleton’s did some wonderful things: they ran a bread fund during the 1890s depression, fed thousands of people, and did the same thing in the Depression in the 1930s”. Still, the piety underlying the service meant for O’Neill, “that Singleton’s wasn’t of the community, owned by the community; there was no sense of ownership there”. Ownership was in fact very much vested in the Singleton family: they had written themselves into the constitution of the centre, which is what made the perceived ambitions of the Stones so unthinkable to J.W..

J.W., who in the intervening years had been obliged to file for personal bankruptcy and adopt the professional title of ‘Specialist’, died in 1924. In 1927, a District Nurse was appointed from the Melbourne District Nursing Society to attend Singleton’s. Placing a nurse in a community setting was an
innovation, and foreshadowed many successful collaborations over the years between the centre and other agencies (Annual Report, 1928).

Dr Ronald Bradbury joined the centre in 1931, and stayed on until the 1970s, by that time becoming something of an anachronism. “We actually had to change the by-laws to get rid of him”, Jim Goode, the centre manager, said. “He told me that he wanted to stay on until he did fifty years. By then he’d have been in his nineties.”

Still it must be recognised that Dr. Bradbury was a quiet hero of his era, part of the 1930s period of rejuvenation at the dispensary, under the leadership of Frank Singleton Howes, the founder’s grandson. Registering under the Charities Act and incorporating as a Dispensary and Welfare Centre in 1932, a new constitution saw the trustees who controlled the centre joined by an elected Board of Management in 1936. A Welfare Department was established to help deal with the chronic poverty in the area, and the medical focus expanded.

Dr. Ronald Bradbury. C 1950.
Though the Singleton family would stay an active part of the centre—Mary Singleton was secretary from 1927 to 1936—their formal control would dwindle over time.

Frank Singleton Howes, President of the Board of Management and the last family tie between the centre and its founder, died in 1956. He had been President since 1928. Howes wrote:

‘Looking back over the long years of the activities of this institution, one cannot but think of what a great spiritual influence has permeated the work so wonderfully initiated by the Founder, the late Dr. John Singleton… And were the dear old Doctor alive now he would undoubtedly rejoice in the consummation of those ideals he set out with when he started this work’ (Annual Report, 1956).

It would seem, however, that some of Singleton’s staff were distinguishing themselves incrementally and subtly from the philosophy of their founder. They were becoming as alert to the effects of social decay as they were to moral lapse, as conscious of the value of withholding judgement as of passing it. Dr. Bradbury slowly modified his views. He had proclaimed ‘moral cleanliness [as] another dire necessity… as much so in the growing child as in the adult, and alas is only too infrequent’ (Annual Report, 1944). But at the 1952 AGM he noted the link between ‘bad housing and the health of the
community’ and understood that, ‘the next generation of Australians, who are voiceless at present in shaping their futures, will be the sufferers’. The 1952 AGM also emphasised the effect of housing conditions in Collingwood: ‘1009 condemned houses… has much bearing on the medical and welfare work of the centre’ (Annual Report, 1952).

In the 1970s, Chris O’Neill recalls:

“When we joined the Centre we ran a cleansing station, a tin shed at the back of the building with rows of bathtubs. There was a sister there called Sister Kilfoyle who should’ve been sainted. She knew all these old guys who used to walk around Collingwood in these army surplus greatcoats and their Collingwood beanie with a flagon of sherry and a tranny in their Ansett bag tuned to the races on 3DB. Packet of Turf cork-tipped smokes. There were dozens of them. She’d get them in there, give them a bath and a shave and a haircut and a clean set of clothes, fix their sores. Without any judgement.”

Two World Wars and two depressions had come and gone, and the social, rather than moral, determinants of health were increasingly difficult to ignore.
In 1969 there was a Centenary Celebration at the fancy Southern Cross Hotel, with a toast proposed by the doyen of Australian medicine, Sir Albert Coates, and a response by Sir Henry Winneke, Chief Justice of The Supreme Court. A large photo of Sir Henry Bolte Premier (‘our patron’) decorated the program. The toast was ‘in Black and White Whisky, which also represents the colours of the Collingwood Football Club’. One might wonder what Dr. Singleton would have thought.
In truth Singleton’s, after 100 years as an institution, was sagging under the weight of its own history, neither truly irrelevant nor properly modern. It had both an X-Ray machine and pews in the waiting room. It was, as it turns out, The Rotary Club of Collingwood who created the conditions for change. The subscription system eventually delivered a group of reform-minded Rotarians to the board, Bill Ladner, Lyle Ellery, and Harry Earle. They, together with Collingwood Council’s board appointee, Dudley Cooke, began a process of review and reform, which included hiring a new manager.

In 1972, Harry Earle told the new manager, Jim Goode, to “fix [Singleton’s] or shut it down… And if you keep it going and you save it, as long as you’re right I’ll back you and keep out of your way”.

“He was the best boss I ever had”, said Goode.
Industrial Collingwood. Wellington Street around 1960.

‘The Singleton Medical-Welfare Centre had held a respected position within Collingwood for 100 years… Not a lot had changed in that time.’
Jim Goode was found eventually near the Gippsland town of Drouin. He had been the manager of Collingwood Community Health Centre for nine years, and his departure was painful and dramatic. He hadn’t answered calls or emails, and didn’t waste many words now, walking back and forth the length of his living room—stocky, bearded, serious, often with one arm behind his back, like a ship’s captain. Great windows overlooked his vineyard on one side and rolling farmland on the other. *“If you’re doing a lot of gentle anecdotes about patients Chris O’Neill remembers”,* he warned, *“or the time someone got dobbed into the medical board, or stuff like that, forget it—none of what I can say is of interest to you”.*

*“When I first took over Singleton’s it was dead”,* Goode explained. In 1972 *“it was a shambles, a ramshackle ruin”.* He recalls being told to *“fix it or shut it down”,* with the caveat, *“you make a mistake, you’re fired”*. The Singleton Medical-Welfare Centre had held a respected position within Collingwood for 100 years, alongside the Council, factories, schools, businesses and football club. Not a lot had changed in that time. The suburb of Collingwood since its founding in the 1840s remained a hard-bitten, hardworking, hard living and hard drinking neighbourhood—the industrial centre of Melbourne. Like other working-class suburbs, Collingwood contained a tight network of families, religions, institutions, and codes of behaviour.

Football mattered. Harry Collier, local boy and ‘Magpie’ great, proclaimed a Collingwood victory was *‘an elixir of life’*. The waiting room at Singleton’s was full on Monday if the team lost, and empty if they won. Homes were decked out in the Collingwood black and white: black and white lino, black and white dog, black and white cat. Breweries, fellmongeries, slaughter yards, wool scouring, rendering, tanneries, soap and candle making, glassworks and ‘night soil’ were the local industries, the foulest in a century that specialised in them. Little of the work in Collingwood (and neighbouring Fitzroy) factories was skilled and, until the late 1970s, most of it was dangerous. Industry featured at all levels in the ill-health of the community—whether related to
workplace injuries, industrial pollution, the effects of the work or the absence of it, or the gender of those involved.

For the most part, Singleton’s continued on as a quiet clinical service, non-political and non-threatening. While factory workers were Singleton’s patients, factory owners were its patrons. Revenue for Singleton’s was generated through a subscription model whereby employers bought tickets for their workers to visit the doctor. This dependence subdued the Centre’s voice against the factories that, while providing employment, were a main cause of ill-health and injury in the community (alongside the standard social determinants, poverty, poor housing, and poor air). Subscriptions were also bought by ‘respectable’ members such as councillors, lawyers, bakers, and the suburb’s poor could see a doctor by petitioning them for one of the dozen tickets that a £2 subscription would buy.

Services were focused on basic medical care, a pharmacy and, predictably, podiatry in a neighbourhood of boot factories. Social services included baths, breakfasts for kids, clothes and food vouchers. The heavy wooden desks and doors creaked of a pre-war quality; the pharmacy walls were lined with tiny cedar drawers each with labels in perfect Latin script.
Podiatry was an essential service in the centre of the Boot and Shoe district. C 1950.

Nursing a tattooed youth. C 1950.
The waiting room, furnished with church pews, was bathed of an afternoon with a light jewelled by a great stained-glass window, a reflection of its medical mission origins. The window depicted a scene from the Book of Acts, written by Luke, a physician. Apostles, Peter and John, have refused a disabled man money, and instead command him to walk in the name of Jesus. The man gets up and walks. The story, perhaps, is about a way of healing that calls on less tangible aspects of health—will, engagement, belief, empowerment. In other parts of the building, ivy crept through cracks in the walls and the foundations sagged.

Ronald Bradbury, a Methodist from Diamond Creek, was the presiding doctor when Goode arrived at Singleton’s. As a medical student during the depression, he had been influenced by the new Evangelical Mission, leading on to missionary work in the inner city. In later years, Bradbury took a daily nap on his examining table, and was woken for afternoon surgery by Sister Frances Fowler, who wore the starched, habit-like uniform common to her generation of nurses. In 1940, Bradbury’s sister, Miss D. E. Bradbury, took over as the manager and the siblings ran the clinic together from that time. A change in the by-laws eventually enforced retirement on Miss Bradbury. She was pushed out of Singleton’s and there is no record of what happened to her next. The Doctor followed her soon after the arrival of Jim Goode as manager.
Goode had come from managing the outpatient service at The Western Hospital in Footscray. He was an astute choice for manager: his ideas were aligned strongly to the new community-based models being breathed into life and the chronically cash-strapped centre was impressed by his vision of the health bureaucracy. “I regarded the Victorian Treasury as a piggy-bank”, Goode said, “and if I ever needed any money I went and shook it and money for what I wanted would fall out”. This was Goode’s ‘blunt instrument’ approach, his authoritative approach to management that would make him so effective, and eventually so divisive, at the centre. Goode was simultaneously autocrat and reformer, inventive but forthright and critical, fond of systems and adept at working them. Rebuilding wrecked organisations seemed to be the story of his professional life; he was destined to clean up after decline.

In 1972, as Goode joined Singleton’s, a long period of conservatism in Australia was coming to an end. Henry Bolte, Liberal Premier of Victoria since 1955 and Singleton’s patron, retired. The urbane and liberal Rupert Hamer won the battle to become leader over the Conservative rump of the Liberal Party. Health and social services, especially for the poor and disadvantaged, became a focus of the political changeover. Hamer (1972) gave a speech to the Legislative Assembly that year which disturbed many in his own party and seemed closer in spirit to his ALP opposition:

‘Economists gave us the concept of Gross National Product and interest has centred on the rate at which that grows. Is it time to think more about Gross National Wellbeing?’ (Parliament of Victoria, Legislative Assembly, September 12, p. 174).

Jim Goode was a pragmatic proponent of the concept of wellbeing. While his peers were implementing ‘empowerment models’ in the nearby North Richmond housing estate, Goode believed Singleton’s needed to respond to, rather than change, the attitudes of the Collingwood community to their own health.

“Your service has to reflect the community outside and that means it has to reflect their expectations. The customer is buying the service and you’ve got to meet that service, or they’ll go somewhere else—or usually nowhere. And that’s defeating the purpose. That’s why in Collingwood the model we adopted was essentially a clinical model, for that reason: the people we talked to had said, ‘I’ll go to a doctor but I won’t go to a nurse’ or ‘I won’t go to a social worker’.”

Though the new model at Collingwood may have been essentially clinical, it was a new model all the same—clinical practice and primary care were
becoming embedded in a much broader concept of what constituted health. Goode was also staffing the centre with a new breed of social workers, physiotherapists, podiatrists and nurses. The attitudes of these young professionals towards their role perhaps represented the greatest change at Singleton’s—the end of a mode of health service delivery centred on charity, and the beginning of one strongly influenced by social justice. Although the charity offered to Collingwood residents by Singleton’s had been much needed, it had come with mortifying traditions and categories of ‘deserving’ and ‘undeserving’. The new practitioners took instead a social view of their patient’s health, a perspective with an emphasis on prevention and education—and politics.

For a man so interested in managing, Goode took a very laissez-faire approach to hiring. “That there was a job at Collingwood almost never got advertised. People would arrive and say, ‘We hear you’ve got a vacancy’ ”.

Chris O’Neill got his job at Singleton’s in this way through Cas Everil (later, Chris and Cas would marry). Cas had just graduated from Melbourne University as a social worker, and had heard of Singleton’s: “You could just walk in and be offered a job on the spot”.

Ruth Borenstein, Marion Oke, Austin Paterson, Yvonne Turner, Nick Crofts, Lyn McKenzie, Ross Lazarus and Peter Sago all joined Singleton’s in the mid-1970s, and their personalities, motivations, and allegiances would deeply influence the service in these years. But Goode, in his preference for the structural view of things, was not overly concerned with the more subtle aspects of human resource management. “[Singleton’s] pretty much ran itself, with a little bit of blunt instrument over some rugged people”, he said. Within a few years, staff would come to feel quite differently—that they could and should make decisions about the Centre’s management and direction—and would unite to make Goode’s position untenable. In those early days, though, his particular management style and this self-selecting recruitment process created an extraordinarily cohesive team. “There was a sympathy and a likingness amongst them”, Goode recalled, “and there was a great degree of respect for each other’s skills. One of their favourite sayings was ‘Conflict escalates power upwards’. So if you don’t want Jim to have to decide, work it out yourselves. And they did”.

Many of the staff were young, educated and active, belonging to the new inner city residents inspired by a range of social justice movements around the anti-Vietnam War demonstrations. Women’s rights, Aboriginal rights, gay rights, anti-racism, anti-uranium mining and pro-environment campaigns spilled into local campaigns against public housing developments
and freeways. A growing number of people were also linking social justice with health. One of the first of this new breed at Singleton’s was Dr. Ruth Borenstein. Arriving in the wake of Dr. Bradbury, she, like the others, was beginning to see health, especially women’s health, in a broader way. The daughter of European communists, ‘brilliant’ in Goode’s estimation, Borenstein went from her medical internship to the Women’s Health Collective, based around the corner from Singleton’s in Johnston Street. “To work at the Women’s Health Collective you must have been a bit radical”, Borenstein said, “because you were working for women, for nothing”.

The early 1970s were a watershed period for women’s health and social issues. The ‘Menhennit Ruling’ of 1969 made abortion ‘not illegal’ under certain circumstances (but police were known to seize files in raids on doctors’ practices). The Pill had become more freely available. The Single Parent Benefit allowed some women to step out from abusive relationships, but rape was still legal within marriage and would remain so until 1981.
The Women’s Health Collective was new, radical, and suspect in the eyes of a conservative state government and the medical establishment. Victorian health bureaucrats had investigated the Collective over suggestions terminations were being given, and stories of a perceived lack of sanitation. The aim of the Collective was to provide a space and service in which women would feel empowered to control their health needs—a place where they were free to express themselves, to talk about, explore, and gain knowledge of their own bodies without a male presence. It was staffed only by volunteer female health workers and saw only women patients. It included Victoria’s first Rape Crisis Centre among its services. Borenstein and the Collective saw the personal as very political, and nothing was more personal than a woman’s body and health. “We were trying to treat women in a much more fair, less patronising sort of way”, she said. “And we’d have sessions about contraception and helping women in a way that really hadn’t been done before”.

Following several locum jobs at Singleton’s, Goode invited Borenstein to stay. “I loved it straight away. I loved the community work, I liked the preventive side, I liked the theoretical side, I liked the political stuff.”

Borenstein soon gained an ally at Singleton’s when Marion Oke joined the staff. Oke was a nurse with a degree in psychology, and had worked at the community health centre in King’s Cross, Sydney, “back in the days when everybody was very idealistic and had this philosophy of no hierarchy at all”.

Together, Borenstein and Oke wanted to transform Singleton’s medical and social services through a left wing feminist philosophy. Borenstein established a women’s health clinic and Oke started the first women’s group at the centre from the template of feminist consciousness raising. Borenstein and Oke jokingly described the women’s group discussions as “raving on, trying to give everyone a say, but in truth they were exciting and transformative”.

Oke recalls eyes rolling at her suggestions of a women’s group for the local community: “I remember there were a couple of comments like ‘you’ll never get the women around here. The women at the Housing Commission flats, do you think they’d come to something like that? Oh God, they’d never be able to understand the ideas’. Like they’d never be able to understand any sort of intellectual ideas that you might have”. But the sessions were always full.

Oke began by leaving handmade fliers around the Collingwood Housing Estate. Soon a dozen women were turning up every week: some of the regulars were people from the flats, some single parents from Clifton Hill, a couple of Greek women, and an Aboriginal woman. “I used to have people ringing me up from the media wanting to come and look at it”, said Oke.
“Although people were having these women’s groups in their houses this was the first one in a public setting.”

Domestic violence didn’t have a name at that stage, but it was a powerful concern. “There were a lot of issues of domestic violence that were coming up in the group”, said Oke, “coming and staying at each other’s places for safety”. Oke recalls Dr Lyn McKenzie, who had been enlisted from the Women’s Health Collective by Borenstein, being “absolutely amazed” by the group.

This pioneering work breaking new ground for the empowerment of women had strong precedents at Singleton’s. The ghosts of Laura Morgan and the Stone sisters were surely hovering. Even then doctoring would remain a difficult profession for women. By the 1970s, just ten per cent of medical graduates were women. It would take another twenty years before women would be over fifty per cent of new graduates, and a final vindication for these pioneering women.

For the times they were a’changing. Singleton’s was becoming a place of innovative, intense and often improvised activity, both clinical and non-clinical, around a variety of issues. For Singleton’s new staff, this was the most compelling aspect of their work: the possibilities, the relevance and the optimism for change.

Gough Whitlam’s Labor Party was elected in December 1972, after twenty-three years of conservative coalition governments. “The conservatives had hung on for so bloody long that change just had to happen”, Chris O’Neill recalled. “It was the aftermath of the Vietnam War period and we were all radicalised.”

The effect of Whitlam’s election on O’Neill’s generation, and on those individuals who would go on to play significant roles in community health in Yarra and beyond, is difficult to overstate. Of significance for Singleton’s, ‘A Community Health Program for Australia’ (colloquially known as the ‘Little Green Book’) was published within months of Whitlam taking office. The Little Green Book was part policy document and part manifesto for a potentially radical structural change to health service delivery across Australia. It was a serious attempt to address systematic and social causes of ill-health, and was the policy instrument by which centres like Singleton’s—along with services such as women’s refuges, halfway houses, geriatric services, drop-in centres and mental health teams—could be federally funded through the newly-created Community Health Program (CHP). The Little Green Book, with its outline of a community-focused approach, was a vigorous expression of the social view of health, affirming
that many of the factors that shape the health of people are outside the health system and require social intervention. Included in this is the need to level out some of the inequalities that exist in society, and the democratic notion that people should have some say in the decisions that affect their lives. It was a new direction for Australian health policy.

The Community Health Program was, in fact, something of a compromise. The Whitlam government, in search of a feasible form of universal health care, was debating the merits of a national health service with salaried doctors versus a national health insurance scheme for private practitioners. One of the keenest advocates for a salaried national health service (like the United Kingdom) was Dr. Moss Cass who became Minister for the Environment. Cass described the night in 1967 when he invited Whitlam, members of the ALP’s health caucus and two health economists to discuss health policy at his Kew home. Cass recounts when he tried to discuss a national health service, “Gough looked bored, he didn’t take a note and yawned a bit. As the discussion on services fell away, the economists explained that a small levy on taxpayers could pay for all GP medical expenses in the country. Gough took out a piece of paper and wrote a little note”, said Cass. “That was the last shot I had, the evening ended.”

Thus Medibank was born, Australia’s first national health insurance scheme, and the first generation of the Medicare system that exists today. It became a powerful campaign tool for Gough Whitlam. But Cass was dissatisfied, saying Medibank “was how you pay for it; we were interested in talking about how you might provide the service”. Cass and the Health Caucus continued to advocate heartily for the national health service model after Whitlam’s election; the Community Health Program was offered as a mollifying, compromised, scaled-down version to a health committee dubious about Medibank: “All it does is pay the doctors bills, it doesn’t change the way doctors treat patients, it doesn’t give people access to hospitals—it just pays their bills and stops any further development.” Cass had left his position as the first Medical Director at the pathbreaking Trade Union Clinic in Footscray (now Western Region Health Centre) to become a member of parliament (Bartak & Deery, 2004). Universal health care and health care as a right rather than a commodity were fundamental to his vision (DeVoe, 2003).

There were antecedents to this view, of course—some more distant than others. By the time the Little Green Book was published, the idea that there are social determinants to physical health was well-established. The foundational story for social medicine takes place in 19th Century Prussia. Rudolf Virchow, the famous scientist known as the ‘father of modern pathology’, compiled a report on the 1848 typhus epidemic in Silesia for
'The Iron Chancellor’, Otto Von Bismarck. Virchow listed remedies with a structural focus, like ‘full and unlimited Democracy’ and ‘separation of Church and State’ rather than ‘mere palliatives’ (Krieger & Birn, 1998). As the story goes, Bismarck was not at all pleased and eventually challenged Virchow to a duel. Given the choice of weapons, Virchow decided on two pork sausages: one cooked and the other infested with a deadly parasite. Bismarck withdrew the challenge—a triumph for Virchow and social medicine (Schultz, 2008).

Despite this earlier awareness, science rather than sociology remained the dominant influence on medicine until circumstances of near-apocalypse in the form of world wars, depression, and revolutions across the globe created the conditions for social determinants to be integrated into medical practice. Social medicine was sensitive to its surrounds; it flourished here, withered there. It was the asphyxiation of community health in 1940s South Africa that drove Dr. Sidney Sax to Australia. Sax, author of the Little Green Book, would soon play a key role at a critical juncture for Singleton’s.

Jim Goode remembers Sax as “a little bit like Poirot without the moustache... neat, pedantic”. Sax had arrived unannounced one day at Singleton’s while writing the Little Green Book. He was a gerontologist who had been part of a community-oriented primary health care demonstration centre in a remote South African Zulu community (Geiger, 1993). The approach involved diagnosis of the community, as well as the individual; malnutrition, for example, could be ‘treated’ by establishing farmers’ associations and local markets. The program was set to provide the architecture for a national health service, but was quashed by the rise of apartheid under the National Party in 1948. Sax and many of his colleagues left South Africa soon after. Sax seemed to have liked Goode’s style, and the feeling was mutual: “Sax and Doug Everingham [Health Minister] ran the best health department ever.” High praise from a man who thought most bureaucrats should be taken out behind the woodshed. Sax returned to Canberra to write his policy and a great volume of communication between them followed. Yvonne Turner was Goode’s assistant: “People would be on the phone from Canberra almost every week. It was someone’s baby up there.” Turner typed up Goode’s correspondence: “Jim produced an awful lot of stuff.”

Later that year, Goode called up Sax and asked for a lot of money. Singleton’s had been offered new premises—an old factory on Hoddle Street. The projected cost of the building was equal to the annual budget of the centre, and they had only weeks to make the purchase.
“So, we rang Sid Sax and said, ‘What’ll we do?’ and Sid said, ‘I’ll send you a cheque’. And he stuck the cheque in the mail. This is all in May and heading up to the end of the financial year. We were all panicky and the post office went on strike. And the cheque got stuck in the mail exchange in Canberra. So, we had a famous finance committee meeting, it started at about five o’clock on a Tuesday night, went till about midnight, stopped, everybody went home, and started again on Thursday. In the meantime, I went off and consulted our solicitors and said, ‘Look, if we write a cheque for this—because we have to pay it by the 30th of June or we don’t get the block of land, and this is Collingwood, we’re not going to get another one—what can go wrong?’ ”

Risking the possibility of a fraud charge if Sax’s cheque didn’t make it in time, Singleton’s management committee went down to the Country Roads Board and signed for the land.

It would take four more years before the centre could relocate to Hoddle Street, but the purchase was of enormous significance. The Community Health Program (CHP) was funded by a miniscule four per cent of the total federal health budget—a capital investment such as the Hoddle Street building was no small thing. The support of Canberra for Singleton’s ambitions was made evident, and the die was cast for a total break with the remnant traditions—medical, social and philosophical—represented by the Wellington Street building.

Austin Paterson joined Singleton’s in 1975 as a welfare officer. A Newly minted youth worker, it was his first job—he earned $5000 a year and turned up nearly every day in the same blue denim jacket. Paterson had lived in Richmond for several years and had been involved in community development projects in and around the North Richmond housing estate. For Paterson, Singleton’s Wellington Street building was a big problem.

“I could see that the community health centre was really entrenched in its building. There was a real power issue in terms of people having to come to the centre, come up those stairs, come to your office. It was very much an institution, a place you had to come to.”

While plans for the new premises promised a single-level, accessible centre, Paterson’s point was more that coming into the centre for welfare at all was a humiliating tradition—and that community health could do better. Cas O’Neill (nee Everil) had a similar perspective.
“Singleton’s was still a welfare agency in a very poor suburb with a hundred years of community expectations that that’s where you go to get food vouchers. People would come in knowing the food vouchers were going to run out at the end of the month, and they knew they had to have better and better stories as the month was coming to an end. That was awful. It was demeaning for them—demeaning for us too, in a way.”

Welfare clients, Paterson recalls, would:

“…take their vouchers down to the Coles checkout and the checkout person would raise it in the air and say, ‘Food voucher!’ And then the manager would come over and sign it. It was dreadful. The health centre at that stage wouldn’t shift to giving out cash. There were still these overtones that they might spend it on whatever they thought they needed.”

Before O’Neill and Paterson joined Singleton’s, the voluntary charity organisation, the Ladies Benevolent Society, provided members for the Singleton’s Ladies Welfare Committee and was largely responsible for the local distribution of material aid. The active and dedicated Mary Lescun joined the Welfare committee in 1945, later becoming the President, and would be a key figure on the committee and at the centre for decades. Interviewed by the Herald in 1952 she observed:

“When I see all those deprived children from broken homes [at Singleton’s], deserted wives, the aged unable to make ends meet, I cannot help but count my blessings and feel a tug at my heart.”

To Austin Paterson, though, Welfare Committee methods were sentimental and reinforced a disempowering tradition. “They would go with good intentions, and it was a lot of work—but the story was that they would check the fridge, or check how many shoes were there.” Welfare recipients had to provide proof of virtue, as well as of hardship. In this, the welfare tradition was something of a joint enterprise, albeit barely conscious, between the giver and the receiver, with rewards on either side for those who felt their position: a credible performance of shame ‘deserved’ a charitable deed.

What community health proposed was a disassembling of this relationship. The Annual Report, 1974, recorded that:

“…little in the area of social justice and power for those who have become passive victims of an unjust society has been tackled by welfare agencies in the past, and the staff feel committed to involving themselves in this area.”

This meant providing more than just the satisfaction of immediate need, and, of particular interest to Paterson, it meant challenging the very notion of position through organisation and self-representation. This became the purpose of the Community Flat, a kind of Singleton’s outstation in the Collingwood housing estate. The estate at that time consisted of three twenty-storey towers and 300 walk-up flats. It was home to thousands of people. Since the 1940s, the Victorian Housing Commission had designated swathes of Collingwood as ‘slums’, and compulsorily acquired and cleared land for public housing.

Much of the housing in the area was bad—Singleton’s treated people for scabies, lice, gastrointestinal and respiratory conditions because of dark, damp, crowded, unheated and dirt-floored housing. There was also a good supply of houses that were simply cheap, ripe for renovation. An increasing number of young middle-class people were drawn to the area by these cheap houses and the working-class and ethnic community traditions of the established residents. Migrants had been settling in the area since the 1950s and by the time of the Community Flat they made up a third of Collingwood’s population.

Collingwood had never been a bastion of tolerant pluralism. Its daily and often violent racism was legendary, but could be overcome by personal connection and common experience. People, too, were making modest improvements to their lives, establishing local businesses or fixing up their homes. Houses and businesses—fruiterer, butcher, confectioner, hairdresser, dairy, tobacconist, wood yard, hotel—would all be razed to make room for the housing estate. Many locals, and especially the gentrifiers, were passionately opposed to the clearances. Melbourne’s newspapers often featured battles between residents and bailiffs over forced removals. Some of those who became active in their opposition would go on to play important roles in the evolution of Singleton’s, or become powerful local figures. The residents of the towers themselves would become, for the most part, isolated from each other and the local community. For Singleton’s social workers, the towers were concentrations of needs, simple and complex alike. The Annual Report, 1971, recorded the stories of some of the clients of that year:

‘A couple who met while receiving treatment at a mental hospital. The girl had a baby and now the couple are married and expecting a child. The mother had another mental breakdown and was re-admitted to hospital.’
‘A Turkish family referred from the Immigration Department. There were four dependent children, but no one in the family was able to speak English. The father was awaiting a hospital bed.’

The Community Flat was a neighbourhood house of sorts. Austin Paterson set himself up with an office, and residents came to see him and, perhaps more importantly, each other. Paterson took inspiration for the Flat from the Family Centre Project, a Brotherhood of St Laurence (BSL) program in which sixty families from the Atherton Gardens housing estate in Brunswick Street were trained in advocacy and representation. The Family Centre Project was a direct response to the rapid demographic change in the area. The movement of middle-class professionals into the area has had a dramatic effect on community organisations. In no time, a local Residents’ Association, a new Education Centre, a Council for Social Services, and a Co-operative Day Nursery were formed.

‘Energetic, young and dedicated professionals are also slowly taking over the local council and displacing the lesser-educated members of the Labor Party who, although they had many faults, were at least representative of the local working-class people. Although all these moves are well-intentioned and the goal is to speak for and represent all the local residents, the voice of poor people in the area is still not heard’ (BSL, 1972).

The families in the Project were provided with an income, rather than aid; the Project did not distribute welfare, but power over resources, relationships, information and decision-making. Some interviewees speculated that the abiding politically-aware culture of the Atherton Gardens estate may stem from the influence of the Family Centre Project. The Project ran for three years, when management was handed over to the residents. The newly named Action Resource Centre went on to foster the Fitzroy and Carlton Community Credit Co-operative.

Austin Paterson’s Community Flat had more social aims. Paterson found that “for the first time there was a vehicle to facilitate some good relationships, some good friendships, some real infrastructure on the estate. I was quite energised by that; it was much more fun than giving out food vouchers”. (Marion Oke went there once a week to have lunch). It is unclear whether the more sociable Community Flat has had a lasting influence on the culture of the Collingwood Estate.

Paterson soon came to learn that issues around unemployment benefits were a major concern for residents. He mobilised colleagues from the local area—including Edith Morgan, Collingwood Council’s radical social worker—and became an energetic advocate for legislative reform, staging a
series of actions at courts and welfare offices that saw him arrested, bailed and bonded. Paterson remembers having to convince Goode of the value of such action:

“We had a very … heated is probably too strong a word…we had a very dynamic discussion. [Singleton’s] was quite panicked about this because they were right in the centre of it, and this was something they weren’t used to at all.”

Goode’s recollection is somewhat cooler: “Austin convinced me of something?” There was friction enough between Paterson and Goode. At a Singleton’s staff meeting about the community flat, Goode expressed concern that its users were ‘emotionally dependent;’ others pointed out the problems of socialising between citizens and professionals. For his part, Paterson suspected Goode of being too conservative:

“I remember we had some big fights. He was very passionate. Conservative is a good way to describe it, but willing to have a fierce debate. Thump the table. We used to have long discussions up in his office over a bottle of Chivas Regal.”

What appeared as conservatism to Paterson was likely Goode’s determination to prioritise the delivery of health services. He told a story about a politician’s visit to a community health centre:

“...[the visitor] found everybody sitting around on the floor cross-legged chanting ‘ohm’ and there were two salaried social workers leading this group to do it. And this was the main service that health centre was running for that day. Now, outside there are people who can’t get medical services, they can’t get dentists, they can’t get things from the pharmacy, they can’t afford health insurance, and these guys were wasting their time.”

Edith Morgan was the Collingwood Council’s first social worker, and she took a largely dim view of Singleton’s:

“People had romantic views of Singleton’s, but in many respects they let people down. It was funded through the Health Department of Victoria, with a Board made up of people who did not represent the community and did not live in the area—not appointed by the community and not accountable to the community. I think they looked on the people who came as the unworthy poor. I always argue that if you give a service for ‘poor’ people, you’ll give a poor service. You’ve got to be saying ‘This service will be for all people, including the poor’. They had a
very judgmental attitude. I was invited to address the AGM at the Singleton’s Centre in 1973. At the AGM, people were (virtually) saying things like ‘the people have to pull themselves up by their bootstraps’ ” (Lindsay, 1994, p. 21).

Austin Paterson encouraged Collingwood housing estate residents to stand for Singleton’s Committee of Management (COM). This was consistent with the community health model, which required community participation in management, but Chris O’Neill recalls that it was seen as a bit of internal jostling, a challenge to the legitimacy of the longstanding Committee, who were giving Goode enough grief as it was. As instructed, Goode had ‘fixed’ Singleton’s. By 1975, there were over ten thousand patient contacts a year, staff numbers had increased by 100 per cent, and a new building had been bought courtesy of Canberra. But the place was almost unrecognisable to the Committee of Management, most of whom Goode had inherited from the days of Dr. Bradbury. Much of what went on—the women’s groups run by Ruth Borenstein and Marion Oke, the appearances of Austin Paterson on Channel Nine being dragged by police off the steps of the welfare office—was difficult for the Committee to grasp. Goode said, by way of explanation, “They were from Heidelberg…”

The minutes from the Committee of Management recorded that: ‘

The role of the Social Work Department was discussed at very great length by the Committee and it was obvious that there is not only a lack of unanimity amongst the Committee as to the function of the Social Work Department, but there are many members of the Committee without concrete ideas as to the role of that Department. It is, in fact, apparent that the Committee is in this identical situation as regard the Centre itself. The Manager [Goode] pointed out that it is imperative that the Committee have some unanimity of opinion and some consensus of philosophy and function of the Centre in order to provide the staff of the Centre with a framework within which to work. If this cannot be done it is unrealistic to expect anything other than continuous conflict between the staff’s function and the Committee of Management. In making this comment, the Manager expressed the belief that many members of the Committee are, in fact, in conflict with the original submission, made to Canberra for funding of the Community Health Centre’ (23 November, 1976).

If the Committee lacked ‘concrete ideas’ about the centre, to their credit they understood that in just a few short years the ground had shifted beneath
them. Sister Fowler had abandoned her nurses’ uniform, women were doctors and wore pants and smoked, health care was free and you didn’t need to be sick to get it. The centre had changed and management needed to change with it; long-serving Board members steadily fell away. The question of who could properly represent the Collingwood community in their place was much more complicated than it might appear. ‘Old’ Collingwood—industrial Collingwood, Collingwood Football Club, John Wren’s Collingwood—still existed at the suburb’s core, but everything around it was changing.

“When I started [at Singleton’s] we had Serbs and Croats and Italians [in the area]”, Goode said. “By the time I finished we had Turkish, Lebanese, Spanish, South American, heaps of South Americans. So the whole population rolled over. And all the Italians had gone north or out east and people like Vietnamese were coming in.”

Middle-class Australians had moved in too, and their numbers and influence were growing. Solange Shapiro, a teacher, joined Singleton’s board as a community representative in 1974. Shapiro had moved to Clifton Hill in 1972, had become active in local organisations, and was soon encouraged into civic life by Edith Morgan. Shapiro started immediately to scout more local talent for the COM:

“When people came up for re-election I would just quietly ask them ‘Are you standing for re-election? Because if you’re not I’ve got a terrific person who lives in this local area and who wants to come on the board’. So there was no reason to be crass about it, but we did change the board… Austin said ‘Solange, you live in Clifton Hill, you shouldn’t be on this board. And other people who live in Clifton Hill shouldn’t be on the board’. I think that was a wrong view, and I told him so. The community health centre was there for everybody who lived in the municipality. It was not a community health centre just for the flats, right?”

Frankie Thompson joined Singleton’s COM as a Collingwood Council representative in 1975. Thompson, who merits a book of his own, was awarded a Medal of the Order of Australia in 2007. He was born in Carlton and spent his early childhood in Sale before landing in Collingwood, eleven years old, in the midst of World War II:

“I remember going to Singleton’s in our younger days, because our baths and showers and old tin things were rusted through and the landlord wouldn’t fix them, so we used to go up to Singleton’s every
Thompson worked in local boot factories, and on the Melbourne wharves for most of his life. He was elected to a seat on Collingwood Council in 1972 and met Solange Shapiro when she was elected as one of the first ALP progressives to Council in 1975.

“Solangé said to me, ‘Would you be interested in coming on the Singleton’s committee?’ I said, ‘Why?’ She said, ‘Oh, it’s a hodge podge’. When I got down there I understood exactly what she meant. There were people on that committee, and what I’m telling you is the exact truth, there was a bloke called Sleep and that’s all he did.”

Jim Goode remembered Thompson as “a pretty good board member, and a lot cleverer than he likes to let you think”. Thompson was also a great advocate for Singleton’s. He “knew everyone, and knew how to speak to them”, and understood better than most how much good a decent health centre could do for local people. “[The community] could go somewhere where they could trust people. And talk about their complaints without being ridiculed, without being spoken down to by the doctor.”

Even so, in 1976 Singleton’s could not muster a community nomination to its Committee of Management. In 1977, departing COM member, J. Fairbairn, expressed her dismay in a letter:

‘It is in my opinion a sad and serious state of affairs that a community like Collingwood so willingly accepts so much from the wider society, but is apparently unwilling to accept the responsibility involved.’

This was perhaps a more conscious permutation of the old notion of ‘deserving’—a needy community has some obligation to represent itself. There was also some kind of exchange at play—community ‘representativeness’ was the means by which a health service could legitimately be a community health service and distinguish itself from other kinds of health care, other ways of thinking and operating. Without the cooperation of the community, Singleton’s was just another clinic. ‘Representativeness’ would also soon become a useful political tool in an inner-city stoush over funding arrangements. Sidney Sax’s Little Green Book described in detail the health benefits of community control of services—an ideal of participatory democracy—on the assumption that the community was autonomous, rational, and in agreement with the structural view posed
by community health. The conundrum for a health service directed by the community is that, most often, the community (quite sensibly) prioritises its immediate clinical needs. The trick for those working within the community health model was to figure out how to run clinical care in tandem with advocacy or development—the process of allowing citizens to direct services demanded citizenship from the services themselves.

The enormous changes at Singleton’s between 1972 and 1976, when the place became almost unrecognisable to parts of itself, are perhaps best encapsulated by this shift in philosophy. From the moment Jim Goode rearranged the waiting room pews to a more secular configuration, the health centre was reconfiguring its status, redistributing its power and redesigning its services around new conceptions of its purpose and function. It was travelling from ‘museum to laboratory’, from a 19th century relic to a 21st century prototype.

By the end of 1976, Singleton’s was fully transformed. What this meant in practice was highly dependent on the personalities and priorities of management and staff, who were not always in accordance on the finer points. What did unite them, and make them so effective at Singleton’s for years to come, were things perhaps outside of health or medicine: a mutual perspective on life, a shared view of larger relationships and responsibilities, and a common political perspective.

“Somebody did a survey of the staff”, Goode said, “…and asked what were the things that influenced them and why they chose their careers. It wasn’t true of the women, but amongst the men it was Holden Caulfield’s dream. From Catcher in the Rye, do you remember the dream? He’s on the edge of a cliff and there is a field of rye. It’s so high that people can’t see through it and the children are playing in the rye and he’s on the edge of the cliff. And every so often a child bursts out of the rye and is about to fall off the cliff but he grabs them and puts them back. And they go on playing and nobody ever even notices he’s there… But people were all younger and much less disillusioned then. We all were.”
Chapter Four

Territorial jostling

In January of 1976 another Community Health Centre had opened its doors at 28 Nicholson Street, Fitzroy. The Depaul Centre was managed by St Vincent’s Hospital, a redoubtably Catholic institution. St Vincent’s had, like Singleton’s, received funding from the Community Health Program (CHP). To a group of community activists and local politicians this was one of the few things the two services had in common. The Depaul Centre was seen as a Community Health Centre in name only, unrepresentative of the community, beholden to St Vincent’s, and a hindrance to the prospect of a truly community-managed centre in the suburb of Fitzroy. The campaign to wrest funding from St Vincent’s to create the Fitzroy Community Health Centre (CHC) brought community health decisively into the political sphere, and coincided with an intense period of formal and informal political activity at Collingwood CHC. Changes in state and federal governments also changed the terrain, for better as well as for worse. Between 1976–1982, these political connections at every level, from interpersonal to parliamentary, cemented health as a common issue for a new generation of activists and political aspirants, and played a defining role in the development of NYCH as it exists today.

St Vincent’s had a long history as a public institution. The Hospital was founded in Fitzroy in 1893 by the Sisters of Charity, an Irish Catholic religious order. Much of the block dominated by St Vincent’s Hospital had been boarding houses until the 1950s and 60s. By the 1960s, while the role of the Sisters had waned, St Vincent’s had expanded greatly in size and significance, with a nursing school and a clinical school, and was integral to Melbourne’s public hospital system. Its expansion swallowed up some of Fitzroy’s most historic buildings, including the first to be built in the suburb and the area’s first pub (Egan, 1993).

The Hospital was, in many ways, Fitzroy’s most stable institution. Apart from the MacRobertson confectionary factory off Johnston Street, most local business was small and economically vulnerable. Historian, Renate Howe, describes the suburb as ‘provincial’, with the dominant business model being

A growing Aboriginal population formed tight-knit cells in the face of general exclusion. Fitzroy was the urban home of the strong Koorie community. Gertrude Street, the ‘Black Mile’, was a place of meeting and social action where a number of significant advances began, including legal aid, and health services (Hindsight, Radio National, 2010). But without permanent industry to sustain it, much of the population of Fitzroy was heavily dependent on welfare and on the charity supplied by a cluster of churches—Anglican, Wesleyan, Catholic, Missionaries of Charity, Sisters of Mercy, Sisters of Charity. Such a ‘much-charitied acre’ was, quite logically, attractive to those in need of aid—the boarding houses serviced the homeless, the itinerant, the newly arrived, the addicts and the ill (O’Brien, 1989).

The demolition or re-purposing of boarding houses and other historic buildings by St Vincent’s had long attracted the ire of campaigners who had cut their teeth on protests over inner city ‘slum’ clearances. As in Collingwood, swathes of Fitzroy were acquired compulsorily for housing estates and freeways. An entire block of housing between Gertrude, Moor, Napier and Brunswick Streets—comprising 180 homes, 50 shops, and a beautiful bluestone church—was levelled from the mid-1960s, and by 1971 four twenty-storey towers were erected.

Mary Lescun at Fitzroy Council 1969, looking over the Housing Commission plans for the Atherton Gardens Estate on Brunswick Street.
Barry Pullen, who had campaigned for a seat on Fitzroy Council in support of the protests, saw St Vincent’s as “not so much the enemy, but something that imposed good works on the city, controlled by management committees—remote people…who walked in and demolished houses that the poor Italians and Greeks had renovated but were then getting pushed away and paid a pittance for”.

Pullen now grants a certain narrowness to that view “it probably wasn’t appreciated that St Vincent’s had a marvellous outpatient service and looked after skid row people and actually had a real heart in what they did”. But at that time, Pullen associated St Vincent’s with the rending of the heart of the community, and the opening of the Depaul Centre under the aegis of the Community Health Program provided a focus for ire: “You [St Vincent’s] don’t run a Community Health Centre because you don’t know anything about community.”

In 1972, Brian Howe, the minister of the demolished bluestone church, backed a young, progressive ALP faction into power on the Fitzroy Council. Howe had spent 1967–68 in Chicago, witnessing first hand the US Civil Rights movement, and seeing the extraordinary organising power of activist Saul Alinsky in action. His book, Rules for Radicals, advised activists that: “To organize a community you must understand that in a highly mobile, urbanized society the word ‘community’ means community of interests, not physical community” (Alinsky, 1971, p. 120).

Howe used funds from the State Government for the compulsory acquisition of his church to replicate its purpose in non-physical forms. He established a research and action organisation, CURA (the Centre for Urban Research and Action), and became aligned closely with Barry Pullen and the newly-formed Fitzroy Residents Association. Soon both men moved onto higher levels of politics, Howe eventually becoming Deputy Prime Minister of Australia, and Pullen serving in several Victorian ministries.

The ALP had maintained firm control of Fitzroy Council since the end of the Second World War, but was inert and remote in the face of local opposition to the ‘slum’ clearances. The arrival of the young progressives displaced the ‘old guard’ of Labor party members—career councillors, ‘outdoor workers’ and working-class residents concerned primarily with the traditional tasks of Council: rubbish, roads. Pullen recalls that “the old guard told the outdoor workers that a pack of communists were taking over and if they didn’t do anything they’d lose their jobs”, but a kind of class war of attrition tipped the balance. “It was too hard to get the outdoor workers to turn up to meetings. Middle-class people love meetings!” This, to Pullen, was “a revolution, but
not dramatic”, at least not to him. Energised and assured, the new Council also had money for welfare services with direct Commonwealth funding through Whitlam’s Australian Assistance Plan. In 1974, Council appointed a Social Planner, Jenny Wills. Wills tapped further streams of funding, and Council began to provide a range of new services through the Social Planning Office (SPO)—including aged care, housing and multicultural services—“an empire” according to Pullen. Wills, however, took lesser interest in the distribution of material aid. In Collingwood, Jim Goode’s material aid budget was $2000 per year “and all of a sudden [there were] all these people turning up from Fitzroy and I rang Jenny up and said, ‘What the hell’s going on?’ ”

The role of Social Planner was an innovation of the Fitzroy Council—the first office of Jenny Wills was a ‘cupboard’ before a large old shopfront was established in Brunswick Street. Her first task was to define her role. Wills had studied at Melbourne University’s School of Social Work with a (‘very conservative’) focus on individual casework. She came to Fitzroy from a family counselling job in North Melbourne. Also influenced by Saul Alinsky as well as Melbourne social work academic, Leonard Tierney, Wills had the issue of power at the forefront of her thinking: “A lot of the decisions of our lives are taken by other people and we freely allow that to happen, there’s a lack of challenging that right.” Wills saw traditional welfare work as complicit in maintaining the status quo—not long before she joined the Council the names of welfare recipients were read out at meetings, each one representing a budget line item for approval. The ‘planning approach’ had instead a goal ‘to change the socio-economic system by social development’. On a much broader scale, the 1970s were marked by the social effects of a worldwide economic crisis. Inflation, oil price ‘shocks’, and the collapse of the Bretton Woods system of fixed currency exchange rates signalled the end of the post-war ‘long-boom’ and the beginning of an increasingly monolithic, integrated and competitive international economy. Social planning described its ‘basic orientation to power structure[s]’ as one of ‘conflict’. In practice, this meant local responsibility for services managed more commonly by the state, such as health, and long-term, integrated social development strategies. “And by planning the future of the services they would fix everything”, was the sceptical view of Jim Goode. “It was about that stage, we decided Collingwood was for people who worked, lived or went to school there and nobody else”. The Fitzroy SPO worked closely with Edith Morgan and Collingwood on expanding new organisations such as the Fitzroy-Collingwood Accommodation Service, and a range of campaigns, but a joint office, often mooted, was never finalised: ‘the politics of the situation meant it never happened’.
Chapter Four: Territorial jostling

The situation is perhaps best described as ‘territorial jostling’, which was also occurring between services and governments at every level. Community Health Program funding put CHCs in the midst of tensions between the radical Whitlam federal government and Hamer’s conservative Victorian government. Whitlam’s MPs, for example, were encouraged to cultivate connections with small groups, perhaps aligned already with the ALP, to apply for community health grants as a method of developing constituencies—Singleton’s board was working closely with Moss Cass, for instance. This direct contact with federal powers was becoming an issue with state government officials, who were already feeling maligned: the Australian Assistance Plan of the Whitlam government had sidestepped State governments and funded local councils to deliver welfare services.

Territorial issues continued when Sidney Sax introduced a caveat to the CHP funding: geographically proximate organisations were to act collectively to decide on service provision in their area. At an uneasy meeting between St Vincent’s, Singleton’s and the North Richmond and Richmond CHP applicants, the Victorian Hospitals and Charities Commission Chairman—perhaps saw the caveat as an encroachment of his own territory—shepherded the services into agreeing to a liaison committee rather than any amalgamated service.

Ironically, through a series of painful territorial shifts that form the crux of later chapters, North Yarra Community Health is now roughly the same size as the community health service envisioned originally by Sax. ‘Territory’ might also apply not just to physical location, or notions of control, but to the very character of services. Community Health Centres were established via the Victorian Hospitals and Charities Act. This meant CHCs were accorded the privileges and respect due to other hospitals by the bureaucracy, but also required that the management structure of CHCs conform to the Act. This was unproblematic for institutions like St Vincent’s and Singleton’s—already constituted soundly in accordance with the Act, with traditions of management by committees populated by the well-to-do—but diabolical for organisations like the Women’s Health Collective, whose rejection of orthodox hierarchy of any kind was one of its reasons for being. The Collective chose not to conform to the Act and, unable to secure ongoing funding, soon closed its doors. The fate of the Collective was an instructive one for CHCs: ‘knowing about community’ barely figured in the legal definition of a CHC. Elsewhere, to the State government’s dismay, what they perceived as ‘radical’ groups in Brunswick, Broadmeadows and East Preston were shaping applications to receive large Commonwealth government grants to establish health services.
St Vincent’s was the exception amongst this first round of CHCs with its advisory board structure and traditional values, which (combined with the perception that it had won Fitzroy’s allocation of CHP funds over the Women’s Health Collective) made the hospital vulnerable in the local political situation.

In May 1975, before Depaul had even opened its doors, Jenny Wills had called a public meeting of community health stakeholders, ostensibly to discuss the mechanics of working together under the Community Health Program. The meeting soon focused on the Depaul Centre, and on two issues in particular: the weakness of provision for community management at Depaul, and the limitations on women’s reproductive health services imposed by St Vincent’s Catholicism—anti-contraception and abortion. Some time later, when the campaign against Depaul made national news on the ABC’s Nationwide program, much would be made of Depaul’s position on abortion. This issue certainly made better news than issues perhaps more intrinsic to the conflict—the difference between community advocacy and representation, and the ‘rightness’ of a large institution delving into community health. Nevertheless, abortion as an issue, with its weighty political and moral dimensions, inevitably would draw the focus of everyone involved.

The May meeting was informed that Dr Joe Santamaria was to be the inaugural chair of Depaul’s Advisory Board. Santamaria was brother to Bob Santamaria, tacit leader of the Democratic Labor Party and prominent media identity—a powerful ideologue, organiser and leader for conservative Catholics across Australia. Joe Santamaria was a milder man, a long-time doctor at St Vincent’s. In the 1950s and 60s, he had ‘worked away quietly’ in the alcoholism unit (an initiative of the University of Melbourne, based at the hospital) before, in 1966, getting a vivid introduction to multidisciplinary care in wartime Vietnam. St Vincent’s, like other Australian public hospitals, sent civilian surgical teams. Santamaria recalls that:

“[It was] to help fill the vacancies in the public hospital system serving the civilian population in South Vietnam. Most of the South Vietnamese doctors were serving in the armed forces. I could see how the hospitals in Vietnam serviced the local civilian community. I noticed the way we were structured as a team: we had physicians, surgeons, radiologists, radiographers, nurses, quite a few other allied health professionals, as part and parcel of each team”.

In the way of such things, once Santamaria had become aware of this multidisciplinary approach, he began to notice it everywhere—at the Royal Children’s Hospital under Dr. John Colebatch, where he worked for a time
on his return from Vietnam, and later at St Vincent’s itself. “It was one that we actually employed in the alcoholism unit. Very often we’d have counsellors and social workers, nurses, one of the nuns from St Vincent’s Hospital. We had AA and Al-Anon and those organisations involved. We all worked together as a team.” In 1970, the alcoholism unit evolved into the Department of Community Medicine, and Santamaria became its Director the following year.

Santamaria acted quickly on his interest in multidisciplinary care. He was a supporter of Singleton’s plans to become a Community Health Centre, and early meetings explored the idea of a St Vincent’s auspice; meetings with Fitzroy Council discussed the idea of a Community Health Centre on the Atherton Gardens housing estate. Santamaria, alongside social worker Margaret Hamilton and assistant physician Pat Wilkinson, also initiated a study of St Vincent’s emergency patients. ‘We found one-third of patients genuinely required the services of the emergency department of a major public hospital, one-third of the patients required a general practitioner attending to their care, and one-third didn’t need medical officers but other allied professionals such as nurses or social workers, counsellors or occupational therapists’ (Hamilton, Wilkinson, & Santamaria, 1972). This finding formed the basis of St Vincent’s submission to the Community Health Program, and Depaul came into being. “In our application for Community Health funding we made it clear that we would be unable to provide abortion and contraception services—no St Vincent’s service ever has or will”. The service was established, with the support of Fitzroy Council, at the far south-west corner of Fitzroy, nestled amongst the rooming houses facing Exhibition Gardens.

Sister Maria Cunningham was the first coordinator of the Depaul centre. She had trained at St Vincent’s Hospital in Sydney, which had been established by the Sisters of Charity in 1857. As a student nurse she was deeply impressed by the “respect for the dignity of the individual” shown by the Sisters of Charity. Returning to Melbourne as a member of the Order, she worked in St Vincent’s maternity and children’s wards before becoming involved with the Department of Community Medicine. She was one of the first in Australia to be trained in the new role of community health nurse in a course designed to support the new Community Health Program. The course introduced nurses to Aboriginal health, public health, health education, and statistics. At Depaul, “we didn’t offer contraception or the pill, but…I don’t think there was any tension caused by [that] either. I don’t think there was”. In the daily life of Depaul, “the abortion issue never came up” for nurse Maria Wright. “Officially, we weren’t supposed to recommend [abortion]. We just did what
we thought was appropriate. So, unofficially, we probably went against the hospital’s principles. But I didn’t feel that I was being curtailed”. Helen Barlow, a podiatrist who loved working at Depaul (and still attends to the Sister’s feet), recalls that abortion was an absolute ‘no no’, but contraception could be prescribed.

That staff might have varying recollections of the implementation of Depaul’s policies reflects that, from the first, things didn’t run smoothly at the Centre.

“Somebody had got the job [there] and she loathed it”, Maria Wright said. “I arranged for a swap. I didn’t have to apply. When I started I thought it was fantastic. I could go out into the community and go to the high-rise flats. But it didn’t have a great deal of direction... We were floundering around wondering what was appropriate, what to do.”

Sister Maria also saw a mismatch between the structures of the hospital and the centre: “I think [St Vincent’s] expected that we would be similarly hierarchical and this sense of us all being a team was a bit strange to them”.

This notion of hierarchy was no small thing. A school of thought in medical sociology holds that doctors as a profession produce and protect their specialised knowledge through an elite education system that reproduces class inequalities, which are again reproduced to some degree between doctors and patients. Even further, amongst the medical professions, doctors can dominate through subordination (as with nurses), limiting other occupations to a part of the body (dentists) or a specific method (pharmacists), and by delegitimising other medical practices such as chiropractics (Turner, 1995). Doctors are able to do this because, generally speaking, they have social status and are well-organised. An early criticism of Depaul was that only members of the Australian Medical Association (AMA) would be employed there as doctors. In contrast, community health insisted on, at the least, an analysis of the power of doctors, and at its most radical overthrew the position of the doctor altogether. Some Community Health Centres had no doctors at all. Unsurprisingly then, Joe Santamaria saw that “the vast majority of people who worked at St Vincent’s Hospital really didn’t understand community health—and they might have been against the idea anyhow”.

Depaul, as required by the Community Health Program, had its own Advisory Board, which was presumably in favour of the Centre, but more or less toothless by design. The May 1975 meeting held by Jenny Wills, with its criticisms from ‘local interests’ of the Depaul proposal, had prompted St Vincent’s CEO, Radcliffe Grace, to seek clarification from the authorities:
‘[The meeting indicated] support for some policies that were unacceptable in the philosophy of care given by the Depaul Centre. In view of our plans to provide places on the Advisory Board of the Centre for local interests the end result might be an impossible conflict within such a Board.’

Hospital and Charities Commission Secretary, J. N. Touzel, assured Grace that St Vincent’s had ‘no obligation to include representatives of all groups…or the most vocal, extreme, or socially dissident members of such groups’. Touzel then placed the Commission at a certain distance from the matter by stating its concern was not how the Advisory Board was run, only that it exist. The details were a matter for the hospital and the community to figure out. In Jim Goode’s opinion, Depaul was “the absolute antithesis of what your Community Health Centre ought to be. The idea of attaching a Community Health Centre to a public hospital is just grotesque”. At Collingwood, despite Joe Santamaria’s early involvement, Goode refused to have anything to do with St Vincent’s, preferring to have a representative from the Austin Hospital in Heidelberg on the board. Ron Westlake, a vocal Fitzroy personality, held the sole ‘community representative’ position on the Advisory Board, but struggled to make an impact. Talented Depaul staff struggled to communicate their successes to the Board and Hospital management, and were demoralised by the constant criticism from Depaul’s opponents. Gradually some left their jobs. Depaul went on in this way, troubled, moored in a far corner of the Hospital grounds.

In January of 1979, after an incident with a violent patient, the front door was locked. “You had to ring the doorbell to be allowed in”, Jim Goode recalled, “which is about as bad for a health centre as you can get”. It marked the beginning of the end for Depaul.

In September 1977, not long after Depaul opened its doors, Singleton’s had finally moved to its new premises on Hoddle Street, acquiring a new name: Collingwood Community Health Centre. Staff numbers had almost doubled (from 26 in 1975 to 48) and annual client contacts increased from 10,276 to 29,639—the Centre was in good health. In Canberra, however, interest in community health was rapidly cooling under the Fraser government, with funding arrangements soon to change significantly. Despite this weakening of political will at the federal level, over the following years Collingwood CHC would nurture a strong local constituency, both for the Centre and for an expansive concept of health itself. Food was health, work was health, the family, childcare, roads and libraries were health; society, and therefore the politics that organised it, was fundamental to health. The practice of community health at Collingwood became more explicitly political, with
official and unofficial forays into the public sphere to argue the case for a social view of health and an increasing alignment with a wave of progressive local politicians, eager to make their mark.

The move to Hoddle Street put Collingwood Community Health Centre literally in the midst of a spectacular confrontation over the construction of Freeway F19 (now known as the Eastern Freeway), the ten-lane freeway that runs from Collingwood to Ringwood. Opposition to the Freeway had been growing since the Country Roads Board first proposed it in 1969. Despite overwhelming local objection, construction had begun in 1970. By 1977 opposition was at a fever pitch with construction crews requiring a police presence. Resident and neighbourhood associations, students, hippies, health, heritage and political groups united to obstruct the project. On one occasion, Fitzroy mayor, Bill Peterson, was arrested in full mayoral robes. On another, a public meeting resolved to barricade the road with whatever people could carry: rubble, corrugated iron, fridges, cars. Fitzroy Council authorised a road narrowing of Alexandra Parade, still classified as a Council road. Philip Bull, a Fitzroy Council member at the time, explained that “our engineer insisted we table a motion saying that he disagreed with the decision we made, but that he’d carry it out”.

The Freeway campaign galvanised the local community, and reinforced important links between the Collingwood CHC and local politics. Anne Horrigan-Dixon, who would later be President of the Fitzroy Community Health Centre, recalled that, “the freeway struggle was when we really became involved in the local community. We met people down at the demonstrations and that’s when we joined the ALP… It was through that that we became involved in all sorts of things through the community. There
was a group in the ALP, the Brian Stagolls of the world, who were involved in improving community health… They had a real bottom-up approach to community organising”.

Horrigan-Dixon was typical of the new residents: baby boomer generation, eastern suburbs, young, professional, new family. An ex-Catholic, Horrigan-Dixon said the inner-city ALP replaced church, if not religion, through the networks and community feeling it fostered. This strong local support was of enormous significance. With both state and federal government under conservative control, the ‘grass roots’ was the only friendly political terrain available.
The lack of interest by the new Fraser Government in progressive approaches to health saw the end of Sid Sax’s National Hospitals and Health Services Commission (NHHSC), Medibank’s transformation into a private insurance scheme, and the absorption of Community Health Program funds into the general state allocation. Expenditure on community health was now at the discretion of the State Government, not a tied grant.

This was particularly dispiriting for community health as it was just as its philosophy and practice was finding global expression. In 1978, at the International Conference on Primary Health Care of the World Health Organisation in Alma-Ata, USSR, a resounding call was made for a ‘New International Economic Order’ to achieve the goal of ‘Health For All By 2000’ (WHO, 1978). The Alma-Ata Declaration was signed by all countries, rich and poor. This was a watershed moment in global health (Banerji, 2003). It put the ‘public’ into public health, highlighting the control by communities and families of their own health, and emphasising the social determinants of health and health care. Primary care must be rooted in communities, for communities, and with communities.

Yet the message at home was nothing if not reductive. The tide was going in the opposite direction. Ralph Hunt, Minister for Health in the Fraser Government, published an article in the Community Health Bulletin locating the responsibility for health decisively with the individual: ‘You can help yourself to health by personal knowledge, by personal decision and personal effort’ (Hunt, 1979). This emphasis on the individual pointed to a narrowed policy focus, and a lack of interest in other determinants.

Sid Sax, on his departure from Canberra, published On Paying for Health Care, a somber analysis of his reform efforts. For Sax, the focus on individual health policy and medical expenditure as the primary contributors to physical wellbeing gave ‘comparatively small marginal benefits’ (NHHSC, 1978). By ignoring ‘better food, improved housing, expanded recreation, and a cleaner environment’, Sax wrote, ‘society deprives itself’. It could have been John Singleton speaking. Sax continued in the public service until 1982, when he became an academic and health policy advisor. He died in 2001 at the age of 81 years. A medal in his honour is given annually by the Australian Healthcare and Hospitals Association for leadership in health policy and services.

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Even as the long-term prospects of a properly funded, viable community health approach seemed to fade, Collingwood continued to attract practitioners deeply committed to a social view of health. Chris O’Neill
joined the centre just before it moved to Hoddle Street, and GPs Nick Crofts
and Peter Sago arrived soon after, in 1978. O’Neill, Crofts and Sago were all
tall, bearded men. O’Neill recalls, “People would say they wanted to see ‘the
big hairy doctor’ and the reception staff would ask which one?”

Nick Crofts (who preferred Catch-22 to Catcher in the Rye) describes
himself as a “terrible student”. He had “hated medicine, I hated doing it.
And I hated, really, the medical students and all that sense of private school
privilege. Having said that, I went to Scotch College on a scholarship and
hated that too”.

Dr. Chris O’Neill worked at NYCH from 1977 to 2010.

Dr. Nick Crofts
He graduated from medicine, completed his residency at the Austin Hospital, then drifted, barely knowing what to do with himself. He dabbled at being a country doctor, did a sociology degree, looked for “some kind of socially conscious medicine to make a living and do something meaningful, in a way”. At the Austin, he had met David Legge: “He was the first to show there was a different way of being a doctor”. Crofts was doing locums at North Richmond Family Care Centre and West Heidelberg Community Health Centre when a position came up at Collingwood. “You had the sense that we could try anything because we were creating something new. The future was open.” It was Crofts who documented the relationship between Collingwood Football Club and the health centre waiting room. “If Collingwood lost on the Saturday, the waiting room was full on the Monday morning...”

Brian Stagoll, a social psychiatrist working at the Melville Clinic (a Commonwealth funded community mental health centre in Brunswick) began his long association with Collingwood and Fitzroy around this time. Stagoll, like Brian Howe, had spent time in the United States, and witnessed the blossoming of the community mental health practice established during the Presidency of John F. Kennedy. Stagoll was influenced by antipsychiatry, a movement from the late 1960s that questioned the categories and motivations for diagnosis and treatment. He became involved in Family Therapy, a practice he describes as “arising from a reaction to models of psychotherapy that focused on the individual”.

On a practical level, he explained that Family Therapy meant, “If you see a kid who is anxious, don’t just talk to the kid, meet with the whole family. But Family Therapy is not only about families or therapy. The unit of attention and intervention in Family Therapy expands out from the individual to larger groups, particularly the family, and then to the larger context of the social network, and beyond to the community within which it’s embedded”. Stagoll ran training sessions for Collingwood staff, and many attended weekend sessions. For Marion Oke, it fitted with her picture of things so well that she would eventually complete a Ph.D. in Family Therapy. “It was terrific... People’s problems arise within a context”, she explained. “A person’s problems have as much to do with the system as the individual. And in fact, you can’t really separate the individual totally from the system.” Nick Crofts had tried other forms of psychotherapy. “I hated them all because it was all concentrated on your problems and making you feel worse. And family therapy didn’t do that, it concentrated on your strengths and that intuitively appealed to me.”

Family Therapy, for Chris O’Neill, also fostered unity amongst staff:
“We had several training sessions where we had all staff looking at the principles of family therapy and how they would be applied… The sense of being part of the team was almost like being in a family. There was a sense of belonging, a sense of purpose, and everyone played their part [at the Centre]. The reception team was part of it and fired up with the same sort of passion for change and progress that the doctors were.”

This passion for change extended beyond doctoring, and well beyond the walls of the centre. In 1978, a Sydney meeting formed a public health advocacy group called Movement Opposed to the Promotion of Unhealthy Products (MOP UP). MOP UP proposed a letter-writing campaign in service of preventative health measures, and immediately began a splinter group led by Sydney environmentalist Bill Snow and artist Rick Bolzan. Billboard Utilising Graffitists Against Unhealthy Promotions (BUGA UP) proposed a more radical approach: ‘refacing’ billboards that advertised unhealthy products. In its simplest form, BUGA UP would take to the streets and reface billboards for cigarette and alcohol advertising, turning ‘Marlboro Country’ into ‘Cancer Country’, and ‘Anyhow, have a Winfield’ into ‘Anyhow, have a Wank—it’s healthier’. In BUGA UP jargon, this was ‘refacing’, not ‘defacing’: a healthy message replacing an unhealthy one. Nick Crofts and other ‘health radicals’ (some of them dedicated smokers) decided to get a Melbourne arm of BUGA UP happening.

“The best refacing was at the intersection between the Queens Parade [High St.] Railway Bridge and a couple of paddocks. There were two billboards on either side and they were always tobacco ads. [David Legge and I] were in the Collingwood Community Health Centre car. We parked and I did one billboard and he went across the other side and did the other one. Suddenly we’re surrounded by these plain clothes coppers from the Vice Squad. They’d seen us walking out of this paddock and thought we were doing naughty things in there. When they found out we were both doctors, and they saw the spray cans, they killed themselves laughing. And they said, ‘Look, we’ll have to tell our sergeant about this, but nothing’s going to happen.’ Somehow they got into conversation with David about tobacco advertising. One of them must’ve said something a little bit sneery, like, ‘Do you reckon this stuff works?’ And off David went and they copped this fifteen minute lecture on the evils of cigarette advertising. And in the end the two coppers are shuffling off trying to get away from David Legge.”
BUGA UP found sympathy in the courts, too. While handing down a $275 fine and a good behaviour bond on two BUGA UP members for ‘maliciously injuring’ a Marlboro billboard, Judge Loveday of the NSW district court complimented the pair:

‘I have great sympathy for anyone who is crusading against cigarette smoking. As a person who believes that smoking has a deleterious effect on our community, I admire any person who does what he can to eradicate this problem. The commission of this crime is of the highest idealistic nature’ (Daily Telegraph, February 26, 1982).

Clandestine as it was, it is impossible to say who else was ‘in’ BUGA UP, or how many people were involved. “It was never an organisation”, Nick Crofts recalls. “It was a social movement. People would see the sign BUGA-ed UP and start to do it themselves. That was the best part about it.” BUGA UP’s targets soon expanded from tobacco advertising to include products marketed with ‘excessive consumerist’ hooks, and began its own splinter groups: Graffitists Against Sexism (GAS) attacked industry-promoted sexism, SUGA UP attacked sweetened food and drinks. A pro-smoking activist group calling itself Smokers Against BUGA UP (SABU) graffitied a BUGA UP member’s home and car with pro-smoking slogans, cement-glued his doors and threw stink bombs into his house. Undeterred, BUGA UP published a Do-It-Yourself Graffiti Guide to rally the like-minded:

‘Even if you paint only one billboard per week you’ll be costing the corporate pushers between $500 and $5000 per year, depending on your thoroughness… Nothing will get those ads down faster than if their profits are reduced by escalating maintenance costs.'
But even more important than this financial factor is the effect that the refaced ad will have on those who read it. At the very least you’ll be Speaking Up for Community Health, something none of our governments seem to care much about’ (BUGA UP Spring Catalogue, 1981).

It was not only governments that needed to be convinced to take a broader view of health. Sid Sax’s ‘On Paying For Health Care’ had identified the medical profession in Australia as a significant obstacle to reform: ‘the lesson of Australian history is that major changes in the organisation and financing of health services are not likely to succeed in the face of concerted opposition from the doctors. They are at the heart of the system’ (NHHSC, 1978). The Australian Medical Association was the preeminent doctors organisation, more than 15,000 members strong, and had thoroughly demonstrated its attitude to reform in its blanket opposition to Gough Whitlam’s health policies, such as the Community Health Program and Medibank. The Australian Medical Association (AMA) was a priori opposed to universality in health care—national insurance, salaried doctors—as the thin edge of a socialised medicine wedge. Chris O’Neill recalls when he completed his medical residency in Canberra: “People would blank you in the corridor if you said community health was a good idea.” The AMA took out a permanent advertisement in its Medical Journal of Australia warning doctors to contact the AMA before applying for any salaried position under the Community Health Program (Siedlecky, 2005). For his part, Whitlam saw the AMA as the country’s ‘most militant trade union’, a ‘self-serving bureaucracy’, primarily interested in protecting its traditional ‘cottage industry’ economic model (Whitlam, 1985).

Initially formed to counter the AMA’s position on Medibank, the Doctors Reform Society (DRS) was a small network of doctors, mostly with community health connections. David Legge, then Nick Crofts was Secretary of the Victorian branch. Most significantly, the DRS challenged the AMA’s claim to speak for all doctors, and championed a reformist approach not just to health care, but to the very culture of medicine. Brian Stagoll recalls that the DRS “was actually a small group but we had very good media advisors... We had [the AMA] spooked because whenever they’d come up with something, the DRS would chip in with an alternative response. The fact that it was only a few dozen of us around Australia doing it drove them spare, but the public didn’t know this”.

Natalie Savin, a local teacher who would later become closely involved with community health in North Yarra, recalled: “I’m driving along the street and there’s a big billboard up in the north of Fitzroy, it’s still there today, the same
In 1978 the DRS defied the AMA’s position on numbers of practicing doctors, fees and salaries, excessive diagnostic investigations, rising health costs, uranium, bulk billing, private health insurance, home birthing, midwifery and pathology lab kickbacks. The DRS told the press that entrepreneurial doctors were getting paid by pathologists for referrals, and encouraged the government to employ salaried pathologists in public hospitals: ‘Taxpayers money is being used to subsidise the affluent lifestyles of a sizable number of pathologists, many of whom have consistently found it difficult to exercise proper ethical standards and restraint’ (McIlraith, 1978, p. 2). Private medical practitioners were the highest paid group in Australia in 1978—$68,894 per annum on average, up from $21,291 just ten years before. At Collingwood Community Health Centre in 1978, doctors earned less than $40,000.

Progressive practice at Collingwood, along with formal and informal forays into the public sphere by its workers and associates, strengthened the Centre’s connections to the local left-wing political scene and the Committee of Management (COM) became something of a proving ground for rising talent. In 1978, Solange Shapiro became president of the Collingwood COM, a position she would hold until 1984 when she became a ministerial advisor. Similarly to Brian Howe and Barry Pullen in Fitzroy, Shapiro (and fellow Singleton’s client Caroline Hogg) had been instrumental in transforming the character of Collingwood Council since joining it in 1975. Her reforming drive is well-illustrated by Shapiro’s achievement, together with three other female councillors, in convincing Collingwood Football Club to grant them membership, just as they traditionally did to all male councillors. Shapiro recalls that, at the Centre, “We had the political networks. … Frankie [Thompson], Jim [Goode] and I—we were absolutely unbeatable. I don’t mean that in terms of we would necessarily win every argument, we wouldn’t, but the big things that mattered, we would win”.

This context—the growing relationship between community health and local power—provides a useful explanation for the vigour, and tenor, of the ongoing debate over the Depaul Centre. The traditional distribution of power in the suburb was being challenged by a new wave of residents, activists and politicians: health care was one ‘front’ and a good, galvanising one at that. The attachment of Depaul to St Vincent’s Hospital was seen at best as a reinforcement of the status quo—health as the province of institutions, and institutions as guardians of representation—and at worst, a significant step backwards, a hindrance to a truly community-managed centre in Fitzroy.
Fitzroy Council appointed Philip Bull to the Depaul Centre’s Advisory Board in October 1978. Bull, an academic who had been active in the anti-Freeway campaign, was uncomfortable with Depaul’s position on reproductive health. “Services to which the hospital was ethically opposed were talked about under euphemisms. And on [these services] Dr. Joe Santamaria and I had opposite positions.” He recalls “pushing for another member of the board who could be seen as representing the community in a general way”. Yet the issue of representation was less about demographics than philosophy—a community of attitudes, in this case towards reproductive health. Despite Catholicism being a majority faith in the Fitzroy area, the campaign against Depaul gathered strength from its position that St Vincent’s policy on reproductive health was not representative of the attitudes of a new constituency—which was, in turn, largely made up of those who were campaigning against Depaul.

After the rejection of his suggestion that the Depaul Advisory Board be restructured to include Jenny Wills from the Fitzroy Social Planning Office, representatives from local voluntary organisations, an elected Depaul staff member and four resident representatives, Bull decided that, “the thing to do was to resign [from the Advisory Board] and to make clear publicly why I was resigning”.

He quit the Board in June 1979, eight months after he joined. A week later Natalie Halstead, a health educator at Depaul and wife of one of Bull’s fellow Fitzroy councillors quit the staff.

Their resignations caught the attention of the local Melbourne Times, which began to cover the situation in earnest. In July 1979, the ABC’s Nationwide program picked up the abortion angle in the story, interviewing Collingwood CHC’s Peter Sago on the issue:

Peter Sago: “A large proportion of our patients are single-parent families, social service dependent families and the stresses put upon people in those situations by increasing number of children is obvious to anyone who works in this environment.”

Reporter: “Obviously you’re not an abortion clinic, you don’t do abortions, but presumably you’d be a little more sympathetic than in other places to women who wanted a termination of their pregnancy.”

Peter Sago: “Every day I see the problems of unwanted children and I am very conscious of the need for women to
have full contraceptive advice, especially women in inner urban environments” (ABC, 1979).

Sister Maria Cunningham remembers “angst in the community about the Catholic nature of the facility not being representative of the community. But I think that often came from people who didn’t really see the work or the way that our staff worked, who put labels on them ... [but] there were politics at the crossroads too”. She left Depaul shortly after. At a July 1979 public meeting 400 attendees passed a motion “that a Fitzroy Community Health Centre be established as soon as possible” with salaried medical staff. In attendance at the meeting was Moss Cass and, according to the Fitzroy Voice: ‘Are we being realistic in asking for this funding [for the centre]?’ a local resident asked. Dr Cass replied, ‘It’s not our job to work that out. It’s our job to demand our rights and kick up a fuss if we don’t get it’ (Rea, 1983).

The Australian Council of Social Services (ACOSS) later released a report on the campaign against Depaul. The report noted that the campaign was ‘very heavily dominated by articulate professionals who are quite politically sophisticated’, and went on to pose a series of prickly questions:

‘... is a philosophy of community control of any point, if the community which ends up in control is essentially the professional middle-class. Is this not consumer advocacy rather than consumer control, or is it just representation of the interests of the more advantaged with a belief that it is for the good of the disadvantaged? This is not to say that others have not been involved; only that they have been less influential, and unable to secure control. Here we have a great problem. Perhaps it requires this sort of leadership to be in control when a project has such a highly political component to it. Or else perhaps it really does not matter because the real question is philosophical accountability and not community accountability because the second follows from the first anyway’ (Crowley, 1985).

Several Depaul staff, and both St Vincent’s and the new Fitzroy Community Health Centre’s Committee of Management wrote a joint letter of objection to this assessment of the changeover by ACOSS. The report was too limited in scope, they argued, over-simple and of dubious standard; the high rhetorical tone was also unwelcome. Yet the questions the report posed were as applicable (and familiar) to that situation as they are to any endeavour that claims to be representative. ‘None of this is intended to be a slight against those who have been involved in the campaign for the Fitzroy Centre’, said the report, ‘The dilemma is no doubt as real for them as it is for all other
community activists’. If, as the report suggests, distinctions can’t be drawn between types of representation, authority, control, or accountability — what is the value of the distinction?

It would take another three years, and many, many iterations of advisory committees, planning groups and associations, research reports and reviews before any further progress was made. The hospital was also wavering in its commitment to Depaul. The publicity was undesirable and in any case, the patients the hospital had hoped would divert to Depaul were still presenting at Casualty, and in even greater numbers than before.
Community Health — riding off in all directions?
Chapter Five

A crisis in health care

The anti-freeway campaign, BUGA UP, the Doctors Reform Society, and the campaign to create the Fitzroy Community Health Centre were all political forays into the public sphere that expanded community health’s constituency at a local level, and made vital links to a new wave of political actors. By plugging in to politics, activists could address the social determinants of health directly and engage fully with the community: the ideal community health model in full flight. “It was working in Collingwood,” Nick Crofts said, “one of the few places I’ve ever had anything to do with where it really was working”.

This period, from 1977 to 1982, was for many the ‘golden era’ of community health in the inner city, of intense personal, political and professional significance—but impermanent after all. This level of politicisation and sensitive relationship to external conditions was as much a strength of community health as it was a weakness. Major state and federal policy changes in the early 1980s affected greatly the spirit and viability of community health in Yarra and beyond. “I was young”, Crofts reflects, “I wish I’d been a bit more conscious of the politics that were going on... how fragile what we were doing really was”.

The ‘fragility’ of the community health model had much to do with its original conception, as laid out in Sidney Sax’s Little Green Book. The model Sax described was comprehensive in its scope, but employed indefinite language and avoided prescription. It argued that services should be shaped around what individual communities needed (or believed they needed). In particular, the Book shrouded the notion of ‘success’ in ambiguity. Sax listed a broad set of unprioritised goals that may be contradictory when enacted. For example, the goal of better integration of health and welfare systems may collide, at least initially, with the goal of lowering costs. The ‘extent of community participation in management’, another of the program’s benchmarks, ran constantly into the problem of who the community was at any given time. The focus on fostering and maintaining wellness, and on addressing issues normally outside of the domain of the health services sector, meant, too, that established methods to evaluate the achievements of a program did not easily apply. When Collingwood undertook an internal
evaluation of the Community Flat, for example, the relationship of the Flat to the physical health of its users was nowhere on the agenda. Instead, the activities hosted by the Flat—playgroup, food co-op, leatherwork classes, op-shop, trips to the market, craft groups and literacy classes—were related to the degree to which ‘people can gain more control over their own lives’. The outcomes from such labour-intensive, qualitative, longitudinal development work are notoriously difficult to evaluate; a particular picture of human society, and a deal of imagination, is necessary to interpret and communicate its significance. “The business ethic has become part of the way all organisations operate [now]”, Chris O’Neill commented. “We have to pay our way, we have to be seen to be cost-effective. One of the long-term struggles of the health centre has been to show that what we do makes a difference. The big programs we’ve been involved in… haven’t fitted very well into the existing models of measuring health outcomes.”

An enormous strength, however, of the Community Health Program was its emphasis on prevention which, in turn, motivated research that informed education and health promotion. Practitioners at Collingwood undertook unique, ‘hyper-local’ research that provided highly detailed pictures of its client population, often with consequences for the wider community.

Occupational health had been a focus for Collingwood since Singleton’s days, when the medical mission had canvassed local manufacturers for the business created by unsafe workplaces.

“My big thing at Collingwood was injured migrant workers”, Nick Crofts said: “We had hundreds of Greek men and women who had been injured at work in one way or another, had been through the workers compensation mill and come out the other side with a lump sum payment—that’s the way the old workers comp used to work—and then they were totally invalidated for everything. They were invalids socially, to family, to work, crippled, absolutely crippled emotionally, mentally, socially, in every way, invalidated.”

Brian Stagoll remembers being invited to talk at Collingwood CHC about his ideas on occupational health documented in Lloyd and Stagoll, 1979:

“At Melville Clinic we also saw many injured workers referred for psychiatric problems. With John Lloyd we developed a social model trying to show how the system was compounding the stresses around injuries and then blaming the victims as ‘malingers’ with ‘Greek Back/Mediterranean Spine’. Collingwood applied the model to reduce invalidism and disability, and was influential in changing practices around Australia.”
A dedicated Occupational Health program started at Collingwood in late 1975, with a multidisciplinary team of GP, Ross Lazarus, ergonomist, Ken May and physiotherapist, Izzy Shaw. The team made routine visits to local factories, treating injuries, demonstrating good posture and lifting techniques, and making safety recommendations to management.

The Occupational Health team’s analysis of work-related injuries presenting at the centre found that the majority of its patients were underrepresented in national statistics. Most presenting injuries resulted in less than five days absence from work, excluding them from the national count, which, in any case, collected data from insurers. The team found that many of these minor injuries never reached the notice of insurers because they were either covered by employers, or went unreported as workplace injury. Their research suggested that the extent of workplace injury in Australia was poorly understood.

The team was also well positioned to monitor closely changes in work conditions and related health issues. Over the course of the 1970s, almost half of all factory jobs in Fitzroy and Collingwood were lost; Broadmeadows, Knox, Cranbourne and Altona were the new industrial centres. Whitlam’s reduction of tariffs (especially in textiles) hit the area hard; factories were undercapitalised and unable to compete. By 1981, there were few large factories employing over 500 people, and an increasing number of factories and small businesses that employed less than twenty people in piecework. This shift to outsourced process work, as well as the introduction of new technology, brought with it its own ‘industrial epidemic’: tenosynovitis, widely known as Repetitive Strain Injury, or RSI. The centre’s outreach and research gave its staff the authority on the issue; an Age article explaining the ‘epidemic’ used Nick Crofts and fellow doctor, Lyn McKenzie, as its sources. “I have patients who can’t dress themselves”, Crofts told the reporter, noting that women and migrants mostly suffered the condition—the population most employed in low-paid unskilled jobs. Lyn McKenzie added that “the cost to the community will… be enormous; social welfare and emergency relief will be needed to cope with family breakdowns when people are permanently invalided” (Kissane, The Age, 10 February, 1982, p. 14.).

Research in Collingwood also made a significant contribution to the introduction of lead-free petrol in Australia. The construction of the Eastern Freeway had caused a massive increase in traffic in the local area: an estimated 118 per cent increase on Hoddle Street, and 370 per cent on Alexandra Parade between 1973 and 1979, raising concerns about the public health consequences of increased emissions, in particular, airborne lead. Many of those who had been active in the campaign against the freeway were
connected to the centre. “I was asked by the Committee of Management to look into the matter”, Dr Peter Sago said. “In my view it was a great example of community health work.” With the support of Collingwood Council, Sago designed a study that combined air pollution data with a comparative study of lead levels in the teeth of children. (Teeth are a good indicator of lead levels, as lead displaces calcium and does not metabolise, providing a reliable indicator of accumulated lead levels.) Sago compared the deciduous milk teeth of 29 Collingwood children with those of 29 children from Sherbrooke, an outer suburb. “The kids would have a party and then we’d collect teeth”, Sago said, “it was what’s called a moving cohort with a non-standard starting point”.

Sago’s research revealed compelling results. Collingwood children’s teeth exhibited an average of 30 per cent more lead in their teeth than Sherbrooke children. Sago concluded that, “this indicates airborne lead pollution, 95 per cent of which originates from motor vehicles, is a significant contributor to body lead burdens”. Collingwood CHC’s report was submitted to the EPA and formed part of the body of research that helped apply pressure on the federal government to remove lead from petrol.

Chris O’Neill notes that it was a rare moment when all three levels of government were aligned and responsive to progressive health reforms. The new laws went through without complication. From 1987, all new cars were mandated to be powered by unleaded petrol, and by 2002 Australia began to phase out leaded petrol altogether.

Dental Health Education programs (which found that local school students had twice the incidence of tooth disease than the wider population), podiatry (‘ministering to the feet of Collingwood in true Singleton style—saving souls’), Vietnamese ante-natal programs, self-help health care groups, English classes, swimming clubs, and family camps all formed their own bodies of evidence that were fed back into daily practice. Evaluation was a constant preoccupation. The true marker of the work, though, was only becoming evident now. “We’ve always provided services for newly arrived communities”, Chris O’Neill said. “The Vietnamese…always knew they could come to the health centre and they would be seen, or their children would be seen, and they had equal rights…We’ve had some of those kids back [working] as registrars”. Where Collingwood succeeded quantitatively was in lowering the cost per visit of primary health care, especially for complex or long-term care. In 1981, a visit to a private doctor, physiotherapist or other medical service provider cost approximately $15 per visit, per service. Therefore, a condition that required a visit to both a doctor and physiotherapist would cost $30.
Collingwood calculated that, in the same year, a visit to the Centre cost under $18 per visit, with as many services provided as necessary. The pharmacy report found the average cost of prescribed drugs at the Centre was $1.18, showing that doctors used a relatively small number of low-cost medicines to treat the majority of patients; 37,770 prescriptions were dispensed in 1981.

Nevertheless, these local successes were deeply vulnerable to policy changes at the state and federal levels. In the same year, the Federal government decided to absorb hospital, dental and community health grants into its general allocation to the states—a return to pre-1973 arrangements when, as Collingwood’s 110th annual report noted, ‘Community Health was the poor second cousin of the health service’. (The limited extent of state government commitment to community health was revealed when it was reported that, the previous year, Victoria had returned millions of dollars to the Commonwealth, which had been allocated to CHCs on a cost sharing arrangement, because it was not prepared to match the money). Collingwood’s participation in the Pharmaceutical Benefits Scheme was also cancelled, after thirty years of the Scheme subsidising medicines on the basis that the Centre’s prescriptions contributed to reducing costs at hospitals. The cancellation left a horrific hole in the Centre’s budget—nine per cent of its total revenue. There has been an unending struggle for the pharmacy ever since. In May 1981, Collingwood hosted an aptly named seminar: ‘A Crisis in Health Care’. The ‘crisis’ consisted not only of budget shortfalls; the Fraser Liberal government was literally turning back the clock on health care in Australia.

Fraser had been elected on a platform of rationalising government services. Government was to take a smaller role, reduce inefficiencies, and withdraw its services wherever they overlapped with the private sector—including health insurance and medical services. The Fraser government had successively dismantled Whitlam’s health program, with five policy changes between 1975 and 1981. The general trend was toward a gradual dismantling of the universal health insurance scheme and a dispersal of responsibility for community health funding. Free hospital in-patient and out-patient treatment was abolished except for pensioners and the disadvantaged, Commonwealth benefits were paid only to the privately insured, subsidies for private care increased, and uptake of private health insurance was encouraged through tax incentives. The approach of the Fraser government was focused largely on how to pay for services, not what the services were, or how they were delivered.

Consistent with the conservative concept of ‘individual responsibility’ (or ‘mutual obligation’ in the contemporary policy environment), the Fraser
government set out to introduce a user-pays system in health care—a return to 1950s Liberal Party policy. The user-pays principle is not only that those who use services should pay for them, but that there is a moral benefit in paying for them, in that it preserves the dignity of the service user; free services, in this conception, create dependency and diminished responsibility. The theoretical net effect is supposed to be that something, such as visit to the doctor, has greater value if it comes at a personal cost, therefore people take more care of their health if they have to pay for it directly. Fundamental to this is the shift from thinking about health care users as citizens, to considering them to be consumers. While community health increasingly had adopted the term ‘consumer’ instead of ‘patient’—the better to imply autonomy and equality—it strongly rejected the notion (or expectation) that consumers of health care behave the same way as consumers of any other product or service.

Stephen Duckett, a health economist from the University of New South Wales, addressed the Crisis in Health Care seminar: ‘They think that if people have to meet the cost themselves it will reduce the use of health services. I don’t believe this is so, because the most powerful deciders are the doctors. Once you have decided to go to the doctor’s surgery, the rest of the costs are determined by the doctor’ (McIntosh, 1981, p. 3).

In her address to the seminar, Solange Shapiro, President of Collingwood’s COM, pointed to the fundamental social implications of the changes:

“In the role of government funding, it seems one major question has not been addressed today. I believe it is the sign of a humane and civilized society that it cares for its sick, its young, its aged, and its disadvantaged. Such care is given, not because of plusses or minuses on the economic analysis, but because humane and civilized people care about the humanity of others. If this is so, then such a society expresses its concern and its caring through the collective support provided for its members who need such help. An important role of government is as the legitimiser of that collective support, and as of the agency of expression of the society’s concern…”

The perspective of community health was that services should be organised around need, rather than ability to pay: a user-pays system has a tendency to cluster services around those with greater income, rather than those with greater need. Whilst ‘need’ had been accounted for in the Liberal government’s new scheme, it was not a self-determined or relative concept. Rather, the Health Care Card was introduced—a rigorous, means-tested
form of identification for those in ‘need’. “I thought we had reached the stage in Australia when people didn’t have to do that anymore”, Duckett said, lamenting a return to the charity model that Collingwood, in its long metamorphosis from Singleton’s, had worked so hard to shed. The Australian Council of Social Services estimated that 430,000 people who could not afford health insurance were also not eligible to be ‘card-carrying poor people’, and were obliged to choose between ‘consuming’ health care and other, perhaps more immediate, needs such as food or rent (Sax, 1984, p. 172). “The losers in the new system are the poor, the unemployed and all those looking for a rational system of health care”, Duckett told the seminar. “The winners are the rich, especially that subset of the rich with medical degrees”.

Things were no rosier, for the moment, at the state level. States were obliged to accept a complicated set of Federal funding regulations that obscured the locus of responsibility for community health. Victorian Health Minister, Bill Borthwick, announced a plan to scrap salaried doctors and adopt a user-pays system in the six Community Health Centres that employed them, including Collingwood Community Health Centre. He gave the ostensible reason as the need to raise money to meet the cost-sharing agreement between the State and Commonwealth governments. ALP Health spokesman, Tom Roper, believed the switch would ‘change the very philosophy of Community Health Centres’ (Metherell, The Age, 3 October, 1981). The protests by health centres in response to the announcement were particularly strong in Bendigo at Eaglehawk and Golden Square Community Health Centres—the only centres in a Liberal Party electorate. The 700-strong protest was greater than the margin by which the sitting member held his seat. The plan was soon dropped, but only for the moment.

The Health Commission of Victoria was also setting staff numbers and classifications for Collingwood, freezing staff numbers while nearly forty thousand client contacts were made each year. The 1980 Annual Report clearly records the painful consequences of this circumstance:

‘This past financial year has been one of the most difficult the Centre has ever encountered. There is little point... attempting to disguise the fact that the workload falling on the Centre is increasing and the resources available... are [unchanged]. These facts, combined with the deepening financial recession which is falling more severely on the City of Collingwood than on other municipalities, have ensured that this extra workload is of a more complex and difficult nature. ...this burden is taking increasing toll on the people who work at the Centre.’
Marion Oke remembers that “there were people burning out all over the place…what we took on was enormous. I remember Nick Crofts saying one day, Why don’t we just lock the doors and put a sign on the outside saying ‘We’ve had enough, it’s your turn to come in and look after us’. When you went into the women’s toilets you never knew who you’d find in tears in there”.

Discontent with Jim Goode’s management was also brewing: a petition went around Collingwood Community Health Centre calling for his resignation. “We were all very concerned and up in arms, and it was about something that he’d done. I think it was something quite serious”, Marion Oke said. “And I’ve totally forgotten what it was.” Chris O’Neill remembers ‘it’ as being that “one of the physiotherapists saw her own job advertised when she was on holidays”. It wasn’t an isolated incident, according to O’Neill. “Jim would ignore people’s rights of employment if it suited him”, he said, “if anyone was an anarchist, Jim was”.

This push against Goode was perhaps in any case something of an inevitability. Goode himself had disassembled the traditional medical hierarchy at Collingwood, giving podiatrists and receptionists equal authority with nurses and doctors. “There was a stage”, Ruth Borenstein said, “when everybody had an equal vote [at meetings], including the cleaner”. Goode’s interpretation of this flat structure was that “the Centre pretty much ran itself…with a little bit of blunt stick over some rugged people”. Staff considered that nurses, doctors, podiatrists and receptionists had parity with managers too; they had their own ideas about what work to do and how to do it. “We were always battling Jim or the Committee of Management or those Labor Party members caught in a conflict between government policy and local needs”, Borenstein said. For Brian Stagoll, “one of the strengths of community health is that it didn’t accept the categories as given…it is conscious of the problems of disciplines and the way they’re used for setting up hierarchies”.

Goode’s structure had allowed staff to distribute authority amongst themselves; the emphasis of community health on structural change made action inevitable. “We sent him a letter and ended up having a meeting where we told him he should go”, Nick Crofts said. “But we never said he wasn’t good or didn’t work hard”.

“Oh no, they really didn’t want me running it any more”, Goode said, “[but] I’d been there probably as long as I should have”. He had done his job of salvaging the wreck of Singleton’s, and could see that staff, the committee,
the political and social community that surrounded the centre wanted to “do things their own way”. He left in June 1981.

Jim Goode went on to manage the Aftercare Hospital in Collingwood (another work of salvage) and eventually ended his career at the Victorian Health Department. He saw, now, the community health program as an incredible, but mostly unrealised, opportunity.

“If, instead of Malcolm Fraser, the next prime minister [after Gough Whitlam] had been Don Chipp, the whole of Australia would be different… Chipp said, ‘We can change the face of Australia with this if we go about it the right way’. That was Chipp. The whole Community Health Program in Australia could have been run for a fraction of the money [John] Howard put into the private health insurance subsidy.”

He was critical, too, of those most directly responsible for community health—political actors, managers, boards—for being distracted, during this crisis period, with efforts to find an economic solution to an essentially organisational problem.

“When the chips were down and… [community health] had to fight for [its] own place in the world, they didn’t do it. And I think that is very sad and they badly let down their communities in the process. And I don’t think we’ll get another chance like that for perhaps another fifty years, I don’t expect to see it in my lifetime. It’s a great pity.”

Goode was more conscious than ever of the importance of high quality, integrated health care.

“When you saw a patient you didn’t see the isolated components. I had a serious infection in my heart a few years ago and all sorts of bullshit went on. I got referred to people and from people and up and down gum trees. I haven’t had that sort of garbage for years. I think the next time I’d rather die than go through all that again.”
Fitzroy Community Health Centre

1992 ANNUAL REPORT

"Fitzroy - You own this health centre!"
Chapter Six

‘I own a health centre’

A shot in the arm for community health in Yarra came with the end of twenty-seven years of conservative rule in Victoria, when John Cain led the Labor Party to government in April 1982. Tom Roper became the Victorian Minister for Health. He was considered by many to be a ‘community health man’. He had been shadow Minister for Health since 1976, as well as President of the Brunswick Community Health Centre. “One of the commitments we’d made prior to our election in ‘82”, Roper said, “was to expand the Community Health Program to do two things: to increase and make more viable centres that already existed, and to expand the number of centres, because really it had been frozen largely where it had been when Whitlam lost in ‘75.”

The federal election of March 1983 delivered Bob Hawke, former president of the Australian Council of Trade Unions, to the office of Prime Minister and Neal Blewett to the Health Ministry. The changes to government saw the graduation of a host of local talent to federal and state politics, including committed community health advocates. Roper soon established a Ministerial Review of Community Health that included Collingwood CHC President, Solange Shapiro, former Whitlam Minister, Moss Cass, and Brian Stagoll. Significantly, Stagoll and Collingwood CHC Chief Pharmacist, Phil Robinson, were on Roper’s policy advisory committee, and David Legge advised Roper on community health from within the Department. “We were blocked at the next level [on a decision on the Depaul Centre]”, Brian Stagoll recalls, “until John Cain got in. There might have been some sympathetic advisors in the health department, but basically the minister [before Roper] didn’t even know about community health and St Vincent’s was very powerful”.

Stagoll identified another consequence of this graduation of local talent to higher political rungs: “By ’85 or ’86 everyone had gone off to work for either the Cain or the Hawke Government and so there was no-one left at the local level...Fitzroy council went independent or conservative for the first time in fifty years.”

Federal Health Minister, Neal Blewett, a former University professor, made clear his personal support for community health, and his recognition of the role of the Doctors Reform Society:
‘[My election] was a victory for which I believe you in the Doctors Reform Society can rightfully claim a share… It was tacit approval for the kinds of priorities in health care that we both advocate: community health over private health, preventive health over the emphasis on curative health, a patient perspective over a higher technology perspective; for a national effort in occupational health and safety; for a real recognition that in one of the wealthiest of affluent societies we have a group of people in our society with a health profile comparable with the worst of underdeveloped societies’ (Blewett, 1985).

The concentration of political support for community health at state and federal levels made for an inevitable outcome when a 1982 report from the Community Health Unit of the Victorian Health Commission advised a separation between St Vincent’s and Depaul. The report recommended, in effect, the de-funding of Depaul and the establishment of a community-controlled service—Fitzroy Community Health Centre. Those advocates inclined to optimism saw this, albeit cautiously, as a potential ‘second wave’ of much-needed political commitment to community health. The question for those who had worked so hard to establish Fitzroy Community Health Centre then became how to capitalise on the change? How to begin?

“We go through various public meetings”, Brian Stagoll said, “all attended by large numbers of people, until May ’83 a committee is formed and that’s the interim committee for Fitzroy Community Health Centre…I was elected because I go to the footy with Tommy Marino who was the Fitzroy mayor of the time. I sat next to him at the meeting because I want to talk about the footy. I don’t know how committed I still was to continuing in community health. Time comes for nominations and Tommy picks up my hand and puts it up, so I’m in. Still there!”

Also on the interim committee were Jon Faine from the Fitzroy Legal Service (later of ABC Radio fame), Fitzroy ALP Councillor, Deirdre Mason, and Natalie Savin from Fitzroy’s Social Planning Office. Collingwood Community Health Centre provided its expertise and support through an auspice agreement and a Board member, Alan Hokin.

“A few weeks later we have a meeting in the Infant Welfare Centre to discuss this and that…How do we get some money? How do we get premises? When we do that we’re going to have to get a manager. I think at a certain point later in the afternoon”, Stagoll continues, “out of frustration, I said, ‘Listen, why don’t we just announce that we’ve opened? Why not? We’ll say that we’re Fitzroy Community Health Centre and we’ll open’. ” To his fellow committee member’s objections that Fitzroy had no service, money or
manager, Stagoll insisted that “community health is an idea”. With some fast thinking, the committee decided to claim an already SPO-sponsored existing dental program running out of the Infant Welfare Centre as ‘the first program of Fitzroy Community Health Centre’.

“So we wrote a letter to Mr Roper saying that we were opening. In between there was a bit of fancy footwork. I went and talked to Barry Pullen, the local member. ‘You can’t do that!’ he said. ‘We just have Barry,’ I said ‘You’ve got to go through a process.’ ‘Stuff the process.’ I think we told Roper then. He wasn’t amused. Then I was at some occasion at Parliament House and met up with Caroline Hogg who was secretary of the health caucus and a great supporter... a big mover at Collingwood. She said [to Roper], ‘All those terrific people in Fitzroy, we’ve got to support them.’ Tom said yes. So we opened. How do you get these things started? Well, you just start.”

The *Melbourne Times* got into the spirit of the ‘opening’ of the idea of the Fitzroy Community Health Centre, dryly advising its readers not to attend the centre if they were sick. *There are no doctors, nurses or medicine cabinets inside, just bare rooms*, and anticipating ‘another official ceremony for the internal fittings later on’ (*TMT*, 1983). Roper was photographed, smiling: ‘I am not at an opening, but a process of development’. Within a
matter of months, though, Fitzroy had enough money from the state Health Department to employ its first manager, Terri Jackson.

Jackson was a USA-born health economist and academic, who came to Fitzroy from running women’s health programs in New South Wales. Jackson had found that community health in NSW “was much more centralised. There were no committees of management. Lots of really good people doing good work, but it didn’t have the same community accountability that Victoria developed. That fitted very well with my own philosophy of how services should be delivered”. Given that the Fitzroy Community Health Centre had been ‘born’ out of a philosophical dispute over community accountability, Jackson’s attitude made her the ideal inaugural manager.

Jackson became the manager of the existing Depaul Centre staff initially from a remote location. They continued their work from St Vincent’s premises, while Jackson had her office in the Infant Welfare Centre in Moor Street. Depaul staff were to be given the opportunity to transfer physically and philosophically to Fitzroy once it had somewhere to operate from. These were the challenges facing Jackson and the new board. Maria Wright remembered that some Depaul staff “could see benefits to getting out of St Vincent’s hospital, but Terri might have still had to convince us. And I guess it was Terri’s presence [that was convincing]... I felt she was somebody who knew about community health [and] I was going to learn more and do more interesting work”. By December 1984, Jackson had secured temporary premises in a converted architect’s office factory in Brunswick Place, a narrow, dog-legged lane tucked behind Brunswick Street. Just across the road was the Atherton Gardens housing estate.

Sally Mitchell joined Fitzroy as a community health worker in 1985: “It was an interesting place to work in because it was very open plan... There was a big open space out the back there.”

“That was a conversation pit”, Maria Wright said. “It had been someone’s architecture firm...I think that conversation pit led to a lot of discussion. At lunchtime people would sit there and have their lunch. I often thought it generated something that if we were all in separate offices wouldn’t have happened.”

“It helped with the multidisciplinary teamwork”, Mitchell recalled, “but it also helped with the melding of the Depaul [staff] and the new staff that were coming in as Fitzroy Community Health Centre workers”.

This multidisciplinary meld was precisely what Terri Jackson had in mind. For Jackson, all her staff were, first and foremost, ‘community health
workers’, and some took this as their job title. But others resisted. They worried about the idea that this meant that “we don’t care if you come from a social work background, a nursing background or a physiotherapy background, we want you to work holistically with people apply what skills you have, and appropriately refer... I found that one of the most challenging things that we did”, Jackson said. “It was at a time when training of all these different disciplines, particularly nursing, was moving into universities rather than these sort of free-standing health colleges. And what came with that was a real rigidity about professional roles. Physiotherapists just wanted to be physiotherapists. Or, they wanted to perform a professional role rather than being what was needed in the community. And sometimes that’s physiotherapy and sometimes it’s not.” Podiatrist Helen Barlow, who transferred to Fitzroy from Depaul, recalls initially telling Jackson, “I’m a podiatrist, not a social worker... But [Jackson] worked with me on how to look at what I was doing in a more structured way”. Barlow came to recognise that her elderly clients had needs for support and care beyond podiatry, but “older people don’t go to see social workers, it’s not in their culture”. Barlow gained post-graduate qualifications to provide pastoral care in situations of grief and loss.

Theresa Swanborough, a community health nurse, joined Fitzroy on secondment from the Council to Homeless Persons, the first time CHP had placed a staff member in a community setting. Swanborough wondered if she had contributed to the ‘challenge’ Jackson had described. “I was confrontational, opinionated. It wasn’t until I became the coordinator of a team and I was on the receiving end that I realised how chat, chat, chat I was.” But she could clearly see that some nurses “felt that they were being deskilled and reconfigured into what was basically a social work model. It wasn’t that the nurses struggled with the concept of community development... they got that, but they wanted more control about the interaction with individual clients”. There was a risk, Swanborough could see, in nurses trying to be all things to all people.

Swanborough had also arrived at Fitzroy in the midst of the strongly political atmosphere of the nurses’ 1985–86 industrial battle—gruelling months of work bans and negotiations in pursuit of wage and career structure reforms. In October 1986, Victorian nurses began the longest strike by Australian women since the nineteenth-century Tailoresses’ strike; the Royal Australian Nurses Federation (RANF) led thousands of nurses into a fifty day strike in response to state government attempts to reduce the classification and pay of almost half of the nursing workforce. A parallel issue was the desire of nurses for professionalisation, or ‘career structure’ reforms; the end of
‘traditional’ notions of hospital nursing as a vocation — task-oriented, moral and subservient to medical authority — rather than a profession, with its own body of knowledge and standards. With professional status so high on the agenda, the danger of potential ‘de-professionalisation’ represented by the community development model at Fitzroy was clear.

The strike, though, had lesser resonance in community health settings than in hospitals. Clusters of nurses such as the Royal District Nursing Service (RDNS), and Homeless Persons Program nurses, went out, perhaps largely in support of the spirit of the strike. “While community health nurses felt it wasn’t relevant to their current employment they felt it was important to support hospital-based nurses”, Theresa Swanborough said. “Many felt loyalty from their hospital training, and while we didn’t want to work in that sector we admired and supported those who did. We recognised their fundamental contribution to health care provision.” Yet in the RANF’s eventual negotiations with the state government, community health nurses were not included in pay rises and had, in fact, lost an increment. “We never found out why. We might have just got lost. Those deals are figured out line by line and it seems no one was there to look out for us…HPP went to negotiate our increment back. It took us ten years…and it still didn’t flow on to community health nurses more generally.”

Despite the gains made by the RANF, and the discrepancy in pay rates, community health nursing continued to be an attractive alternative to hospital nursing. A 1987 survey of community health nursing found that ‘21% entered community nursing because of ‘dissatisfaction with hospital nursing’ with a further 32% and 33% because of the ‘independence’ and ‘working conditions’ offered by community nursing’ (Temple-Smith, Johnson, & Dunt, 1989). The more extensive patient contact, family friendly hours, and lack of hierarchy was attractive to many nurses looking for options beyond the institutional walls. The survey still found very low levels of expectation as far as career and remunerative development but, in a result that perhaps few other industries could match, 87 per cent of community health nurses were happy in their jobs.

Despite this, the integration of staff in the face of external pressures, and the inevitable internal difficulties, was an ongoing and high-maintenance endeavour. Maureen Schleiger joined Fitzroy as a medical records clerk in 1986 (becoming the Manager of Corporate Services at NYCH in 2011):

“The whole centre got together and talked about everything. Everyone knew what was going on…Every Wednesday the centre would be closed [for a staff meeting] from 9am to 12 noon. I nearly died at the first
meeting I went to. The physio burst into tears because she didn’t know what she was supposed to be doing. Terri called us all ‘fuckwits’ because we didn’t know how to fill in our timesheets...she asked the receptionist to come in on time and she burst into tears. There was a lot of high drama….”

But Sally Mitchell also notes it was a time of excitement and achievement with a sense of doing ground breaking work.

Together with staff and the Committee of Management, Jackson developed a “definition of good health... for our Centre”, a supremely inter-disciplinary manifesto. Fitzroy’s View of Health, which would form a key part of the centre’s philosophy for years to come, included:

‘Having people who you love and who love you; Believing there is some kind of future and being able to plan for it; Being able to find out what is wrong in ways that you can understand and use; When things get out of control, being able to get back control by being able to be a part of the best treatment.’

Given many of Fitzroy’s clients’ needs were as basic, or as complex, as ever, these were in effect ambitious statements about Fitzroy’s long-term vision of its purpose. In practice, “you were going into rooming houses that were dirty, unkempt, they were like rabbit warrens”, Theresa Swanborough remembered. “You would walk your way out the back and you would knock on what looked like a shed door and some old boy would be living in there. Or you would go up the back stairs and you would find a burnt out room, and in the midst of this burnt out room you could see two white eyes and there was a woman sitting there, obviously really mentally unwell... [but] the struggle to get such a person into psych services was amazing really.” Much of Swanborough’s work was deeply pragmatic; getting a wheelchair for ‘frail old alcoholics’ (for whom she had a longstanding empathy, a ‘soft spot’) and pushing them up to the hospital, or back to Fitzroy to have their feet looked at; arranging for a shower, or for the soup van to dole out comfort and a few extra calories in the form of a brandy eggnog. Maria Wright, who worked a great deal in the Atherton Gardens estate recalls that she “worked a lot at Exhibition High, which was a girls’ school, and my sense was that if they got pregnant at sixteen instead of fourteen then we had been successful. That was all we could aim for...we started off with very highfalutin’ ideas, but you had to temper it back to reality”.

Terri Jackson also introduced a process that involved the Committee of Management more in the work carried out at Fitzroy. She established a Programs and Services sub-committee on the COM:
“Its role was, on an annual basis, to review all the services that were offered...and do some evaluation—or, rather, encourage the workers to do self-evaluation—so that the committee of management had a real understanding of some of the difficulties for the workers at the coalface, and the workers felt some sense of responsibility back to the committee of management.”

The communication between workers and the sub-committee was via the ‘pink planner’, a six-page project-management document, literally pink to distinguish it from other bits of paper on a messy desk. The pink planner could also be used to forward-plan proposed programs, taking account of costs, limitations and potential obstacles. Theresa Swanborough remembered that “in those days, which would never happen now, I had a two-month orientation period [when I started in Fitzroy] where I could go out and talk to everybody and then come back and document a program planner”. (In 2011, Swanborough was managing the RDNS Homeless Persons Program, which has 34 nurses doing outreach across Melbourne in partnership with a wide range of community organisations. She received an Order of Australia Medal for this work in 2002. More than twenty-five years later, she still has her first Fitzroy pink planner).

Jackson’s planner was an innovation in that it facilitated communication between Fitzroy and other agencies, as well as ensuring a program was not dependent on an individual making themselves indispensable (and, as a consequence, creating dependencies), but was structured into the centre. Most significantly, the planner introduced a level of formal documentation rare in the rapidly evolving practice of community health. Bill Newton, the manager of West Heidelberg Community Health Centre, said “our mistake...was not to realise how significant what we were doing was, and we completely failed to write it up...and consequently there’s no bloody record of the thing at all”. As Maria Wright recalled, because of the very nature of community health work with its heavy emphasis on qualitative change: “It was very difficult to claim successes. So you had to write it up. The pink planner pushed us towards documenting these things.” Effectively, the planner provided the practical means to plan, implement, and evaluate the vision articulated in the View of Health.

“Conceptually, Terri Jackson was the one who gave us the vision [for Fitzroy],” Brian Stagoll said, “and then she implemented it. She was a strong advocate of community health as a vision and she was able to put it into practice”. Fitzroy’s early and effective protagonism was given a galvanising boost by the local appearance of Australian healthcare’s latest challenge, entrepreneurial medicine.
In 1986, the Victorian Health Issues Centre (HIC) published a description of an entrepreneurial medical clinic:

‘1. The general practitioners working in an entrepreneurial medical clinic are employed (often paid on a commission basis) by one or more people who also have ownership interests in other medical services to which the general practitioner refers patients. These include: medical specialists, diagnostic facilities (e.g. pathology, radiology), day surgery, and sometimes private hospitals. Often these other non-GP medical services are located in the same building as the entrepreneurial medical clinic, but not always.

2. Funds for the clinics often come from commercial investors not primarily involved in health care, but with reaping a return on their investment’ (HIC, 1986, p. 1).

The 1984 reinstatement of a national health insurance scheme by the Hawke government, this time under the name ‘Medicare’, had created an opportunity for medical businesses. Medicare formed a central part of the Prices and Income Accord, a landmark agreement with Australian Trade Unions, whereby real wage increases were kept low in return for increases in the ‘social wage’. Medicare would be a universal health scheme, funded through general revenue and a one per cent levy on taxable income, with exemptions for low-income earners. Medicare provided access to some treatments at medical centres and public hospitals, but unlike national health services in other countries, did not assert influence over the cost of services. Medicare did not offer any cover at all on services such as dental, podiatry, and physiotherapy; people who needed this kind of care had to either pay the full cost themselves, or join a public hospital waiting list.

The 1986 Annual Report of the Health Department of Victoria (HDV) advised that average hospital waiting time in Victoria was two months and sixteen days. The integration of private service provision into a publicly funded industry opened up a significant business opportunity for GPs, as well as making healthcare a potentially lucrative third-party investment. The Australian Medical Association had objected powerfully to aspects of Medicare. A year of ferocious wrangling, including mass resignations of specialists in NSW, obliged Hawke to make considerable concessions to the AMA, many of which effectively guaranteed the future expansion of the private system. Attempts by private businesses to establish for-profit medical clinics in Fitzroy provided a rallying point for local advocates; if they sometimes had difficulties explaining the value of their ideals, Eighties-style entrepreneurial medicine provided an opposite example to counter
what Community health represented. Community health was everything entrepreneurial medicine was not.

Entrepreneurial medicine’s best-known practitioner was Dr Geoffrey Edelsten. Edelsten’s numerous ‘superclinics’ were enormous one-stop-medical-shops, with their owner’s flamboyant personality stamped all over them—his Frankston clinic featured a grand piano and chandeliers in the foyer.

In 1985, Edelsten claimed that half a million Sydney residents, 10 per cent of the city’s population, used his clinics; his Blacktown centre was seeing 1700 patients a week (HIC, 1986, p. 4). Edelsten also owned Omniman, a pathology company to which his clinics referred virtually all their business. The profitability of the enterprise was suggested powerfully when, in the same year, Edelsten bought the Sydney Swans Football Club for $6.3 million.

The Doctors Reform Society was one of many organisations alarmed that the proliferation of for-profit medical centres represented ‘a serious threat to the quality of patient care... and has the potential to distort the allocation of Commonwealth Medicare benefits’ (HIC, 1986, p. 16). In 1985, a parliamentary joint committee reported on ‘Medical Fraud and Overservicing – Pathology’, using, as an example, the pathology records and Medicare claims of ‘a ‘medical entrepreneur’ whose corporate medical marketing operations, general practice style and professional ethics were of serious concern to both the profession and the Government’. The individual was referred to in the report as ‘Dr X’, who was also the owner and operator of pathology company ‘Y Pty Ltd’. The committee found that:

Medicare benefits payments to Y Pty Ltd during May 1984 resulting from Dr X’s request totalled $86,363.87 for 5723 services, this averages $130.26 per patient and 8.63 services per patient.

The balance of pathology services performed by Y Pty Ltd for which Medicare claims were processed in May 1984 were requested by 16 other practitioners, of which 13 were practice partners of Dr X (HIC, 1986, p. 17).

The Health Issues Centre made a general comparison of average annual pathology statistics of medical entrepreneurs with those of Collingwood Community Health Centre. To Collingwood’s 1.66 tests per patient, at a cost to Medicare of $32.76 per patient, the superclinics were billing the Commonwealth $109.80 per patient for 7.77 tests. The Health Issues Centre also reported that, in one of Dr Edelsten’s clinics, ‘the average GP was seeing 60–80 patients for a 10–12 hour day—six patients an hour, almost three times the number of patients seen by a GP in a standard practice’ (HIC, 1986, p. 9).
The numbers prompted concerns that patients were being over-serviced and under-examined, and that curative, rather than preventative, services were being prioritised. The potential for patients to be ‘sold’ unnecessary or ineffective treatments in such a high-turnover, profit-driven environment was alarming to many. If all GPs provided billable services at the rate of ‘Dr X’, the cost to Medicare was projected to quadruple. The AMA’s Victorian President branded it the ‘McDonaldisation’ of medicine amid concerns that the private sector’s primary concern is to make money, rather than make people healthy (The Age, 26 September, 1985).

Supporters of entrepreneurial medicine claimed the clinics made medical care more efficient and convenient, and were a sensible response to pressures on the public system. Objections from groups such as the Doctors Reform Society were labelled, in the Journal of the Institute of Public Affairs (IPA) (‘Australia’s journal of free enterprise opinion’), as a ‘threat’ to Australia’s health system:

‘Many of these groups are politicised. Their reform agenda are often more ideological than pragmatic, seeking to advance minority rather than mainstream interests...Generally these groups attack the old health system on the grounds that it failed to serve the public interest, but predominantly served the special interests of the private professions and the pharmaceutical and other health-related industries. It appears, however, that the new model [they propose], even more so, will serve the special interests of organized social workers, social engineers, minority political activists and others drawing their salaries mainly from the public purse’ (Browning, 1987, p. 14).

The IPA Journal urged the cutting ‘of the umbilical cord of taxpayer finance...[to] those utilising health issues to advance types of social change ranging from the self-serving to socialist.’ In reality, though, groups such as the DRS could have only minimal effect on what was essentially one aspect of a worldwide shift in the relationship between governments, citizens, and markets.

Broadly speaking, the 1980s were characterised by processes of deregulation and privatisation. The economic crisis of the 1970s had laid the foundations for a fundamental shift to neo-liberal conceptions of society and state, transforming the fabric of political and economic structures worldwide. Governments increasingly were reluctant to accept responsibility for social welfare, and increasingly eager to accept market outcomes in sectors, such as health and education, that were previously well outside the market ambit. In general, developed capitalist nations saw the end of the concept of ‘full
employment’ and the acceptance of joblessness (and its related consequences) as structural, rather than cyclical. ‘De-industrialisation’ saw manufacturing shift offshore in search of cheap labour; the disappearance of relatively less-skilled, lower-paid jobs hit residents in suburbs such as Collingwood and Fitzroy hard. Across Australia, unemployment rose from 1.6 per cent in 1970 to 9.9 per cent in 1983.

British Prime Minister Margaret Thatcher’s infamous statement that ‘there is no such thing as society’ is representative of dominant attitudes towards community in this decade:

‘I think we have gone through a period when too many children and people have been given to understand “I have a problem, it is the Government’s job to cope with it!” or “I have a problem, I will go and get a grant to cope with it!” “I am homeless, the Government must house me!” and so they are casting their problems on society and who is society? There is no such thing! There are individual men and women and there are families and no government can do anything except through people and people look to themselves first. It is our duty to look after ourselves and then also to help look after our neighbour … people have got the entitlements too much in mind without the obligations… If children have a problem, it is society that is at fault. There is no such thing as society’ (Thatcher, 1987).

Where many post-war social and economic reforms ameliorated the worst effects of capitalism, such as redistributing income and sheltering essential services, like health, from market forces, the 1980s saw a rapid stripping-away of government protections, and a retreat from collectivism to a particular form of individualism. The ‘post-welfare’ state privileged market competitiveness over social policy, the global over the local, and re-commodified the citizen into the consumer, society into the market. In contrast, community health proposed co-operative, local and democratic power relations.

In Australia, the Hawke government staged significant reforms towards economic deregulation, privatisation, inflation control, tariff reduction and ‘internationalisation’ of trade, and a reduced, but highly ‘managerial’, role for the public sector. For the health system, the focus was on cost containment, such as shifting costs to individuals, increasing private service provision, and incentives to take up private health insurance. Entrepreneurial medicine in the Edelsten mode was unusual only in its ostentation; for-profit health services were simply a manifestation of irreversible political and cultural change.
In September 1985, *The Age* reported the intentions of Viscount Holdings Ltd, a dry cleaning, linen hire and laundry business controlled by Hecron Ltd, a property developer and investment company, to open a 24-hour private medical clinic in Fitzroy. ‘*In its announcement to the stock exchange yesterday, Viscount said it saw the provision of 24-hour-a-day health care as “a direct response to the needs and desires of the Australian public...”*. The centres also were planned to provide some relief from the current pressures on the public health system’ (*The Age*, 26 September, 1985).

The announcement mobilised Fitzroy and Collingwood Community Health Centres to launch a ‘Campaign Against Entrepreneurial Medicine’, together with the Aboriginal Health Service, the Health Issues Centre, and numerous other Community Health Centres around Melbourne. A public meeting at the Fitzroy Town Hall was attended by the proposed head of Viscount’s clinic, Dr Sergei Alexeyeff, who made valiant attempts to defend his enterprise against critics. ‘*What they are looking at is the Edelsten model which I am rejecting and certainly they are rejecting and which, I think, speakers at the meeting will reject*,’ he told *The Age*.’*[But] there is a need for medicine which is geared to the community and is available at all times and is tuned to the private market*’ (Birnbauer, 1985a). Alexeyeff explained that his clinic would relieve pressure on local emergency wards, and also gave a guarantee that ‘*he would have no financial involvement with pathology or radiology services*’ (Birnbauer, 1985c).

The Campaign Against Entrepreneurial Medicine focused on concerns about overservicing, conflict of interest and public accountability, but beneath it all was a fundamental conceptual clash. ‘*Part of the idea of the superclinic is that [it is] convenient for people whose problems are purely medical,*’ Terri Jackson said, ‘*and I doubt that anyone’s problems are purely medical... particularly in areas like Fitzroy where ill-health is so tied up with so many other things...The concern was that [entrepreneurial medicine] was...one of the worst aspects of fee-for-service medicine and that, in a sense, it would medicalise what were essentially family and social and financial problems*’.

On a purely pragmatic level, Fitzroy was already well-covered by existing health services, and the Viscount clinic was a competitor, if not for profits, then certainly for patients.

The public meeting passed a general motion against entrepreneurial medicine; a week later, the *Melbourne Times* reported that Dr Geoffrey Edelsten had a plan to establish a 24-hour medical clinic across the road from the Hoddle Street flats: ‘*Although few details are available of the Collingwood application, Town Planner Marjorie Halls confirmed that the plans included a grand piano*’ (*TMT*, 1985, 6 November). Ellen Kleimaker, a community...
development worker at Collingwood, recalls staging an ‘action’ outside the Southern Cross Hotel, where Edelsten was giving a seminar in support of the superclinics. The ‘action’ was a theatrical occasion with actors in hot pink medical costumes caricaturing Edelsten and his wife Leanne, overserving bystanders with outsized hypodermic needles. “We did a demonstration,” Collingwood doctor Ruth Borenstein said, “and I spoke, and I just felt like a complete idiot, but never mind”. Public protests and political campaigns in defence of community health were becoming almost regular events; standard practice, part of the job description.

Fitzroy Council’s planning committee soon rejected Alexeyeff’s application on the grounds of insufficient parking and ‘substantial disruption to the adjoining neighbourhood’ (TMT, 1985, 13 November). Alexeyeff however told The Age, ‘It was explained to me that the Labor people and a number of independents were not to be seen to vote for private enterprise’ (Birnbauer, 1985b). In January 1986, Alexeyeff appealed to the Planning Appeals Board, which overturned the Council’s decision; the same month, the Health Department approved a grant for the acquisition and outfitting of new premises for Fitzroy Community Health Centre. When the Viscount clinic opened a short time later, the Weekend Herald reported business to be ‘quiet’. Perhaps it was clear to potential ‘customers’ that the 24-hour clinic was not for everyone: the receptionist told the reporter that ‘there were problems with drug addicts when the clinic opened. ‘We turned some of them away about 50 times, but [now] they seem to have given up’ (Evans, 1986). Dr Edelsten’s Collingwood clinic never eventuated.

Premier John Cain opened the new Fitzroy Community Health Centre in December 1987. “We [had] looked around for about 18 months for a rental property and couldn’t find anything in Fitzroy that didn’t need major renovations”, Terri Jackson said. Eventually, after an offer from the Brotherhood of St Laurence both organisations shared the cost of purpose-built facilities in an old building that had been the first home of Community Aid Abroad. Brian Stagoll says the generous gesture of the Brotherhood in sharing their land was vital. The centre at 75 Brunswick Street continues to operate today.
Chapter Six: I own a health centre


Peter Hollingworth, Brotherhood of St. Laurence, speaking while Health Minister David White and Maria Wright look on.

Anne Horrigan-Dixon tells Premier John Cain and Nancye Cain what Community Health is about. Terri Jackson and Brian Stagoll lend support.
A 1988 Herald article correctly compared Fitzroy’s new ‘modern, light-filled and welcoming’ new centre with the ‘shabby, faded and crowded’ conditions of the Victorian Aboriginal Health Service (VAHS) around the corner in Gertrude Street (Ryan, 1988). Jackson told the Herald she was ‘embarrassed’ to invite VAHS staff to her building’s opening, so glaring was the contrast in working conditions: the VAHS dentist called his facilities ‘Third World.’ Fitzroy had a good relationship with the VAHS, ‘lending’ its dietitian to them once a week, but the services were different beasts. Neither Fitzroy nor Collingwood Community Health Centres had particularly focused on tailoring services to significantly large local indigenous populations; the VAHS had filled the gap since the 1970s. Running entirely on volunteer support in its early years, the VAHS later received funding via the auspice of Collingwood Community Health Centre. Funding, however, came via the Department of Aboriginal Affairs rather than through the health system. This put VAHS on a parallel, and not always preferable, course of development to its neighbouring health services. By 1988, the VAHS had managed to secure a long-term lease on its ‘dilapidated…antiquated’ building, but told the Herald that the Department of Aboriginal Affairs had ‘refused to give…an assurance of continuing funding’ (Ryan, 1988). In later years, VAHS moved to a grand building in Nicholson Street. By contrast, the staff numbers for Fitzroy Community Health Centre expanded from an initial twelve workers until there were over twenty employees occupying the new building.

Maria Wright, Sally Mitchell and Terri Jackson worked together to articulate formally the relationship between their everyday work, the View of Health, and the implications of the multidisciplinary, developmental, structurally-alert approach to health that was burgeoning at Fitzroy. This was the ‘Community Development Continuum’, a document the three authors later presented to acclaim at a Community Health Association national conference. The Continuum described a process of ‘progress towards control over larger and larger realms of life’, with the ultimate goal of ‘more equitable distribution of social and economic power’ (Jackson, Mitchell, & Wright, 1989). This progress was not necessarily linear, nor cumulative, but was conceived by the authors to occur across a spectrum of key ‘modes’ of work ‘appropriate to particular communities, sub-communities and individuals at particular times.’ These modes were developmental casework that emphasises individual empowerment; mutual support in the setting up of self-help groups to combat isolation; issue identification with public campaigns; participation and control of services; and social movements that mobilise people in changing the issues of their lives. On ‘participation and control of services’, the authors added a
cautionary note, perhaps informed by the continuing struggle of community health to fully realise the notion:

‘Workers must also deal with complex issues of readiness and motivation of the disempowered people they encourage to participate. Whilst it can be agreed that creating power may be associated with building personal self-esteem, it is also true that exposure to formal organisations with semi-bureaucratised procedures and reliant on government funding can, without careful attention to processes, be thoroughly demoralising.’

When considering their own track record in fostering community participation in Fitzroy’s Committee of Management, the authors admitted to feeling ‘discouraged.’ ‘Not many’ Fitzroy clients had shown interest in participating in the Centre’s management, though several had taken up roles in external groups associated with the Centre. “There were difficulties”, Jackson laughed, when community members did take a seat on the Committee—mainly, the promotion of personal interests. “People had political affiliations, but that’s what communities are—people bring their political perspectives and their experiences...There’s that famous phrase, I think it’s Churchill: Democracy is the worst form of government except compared to all the others.”

There was, in fact, no alternative. The Community Development Continuum had emphasised the handing back of professional power, and to the cultivation of autonomy amongst clients: ‘it encourages people to demand services better suited to their needs and wishes.’ The ‘messiness’ of these demands was native to the model; the success of Community Health Centre management came down to navigation and negotiation.

Explicit recognition of the ‘ownership’ of the Fitzroy centre by its users was part of Terri Jackson’s approach from day one. Every person who paid a $2 membership fee received, along with their voting rights, a custom-made Fitzroy Community Health Centre t-shirt. ‘I Own a Health Centre’ proclaimed the slogan. Eventually, this was more than even Dr Edelsten himself could claim. He would later be struck off the medical register and served a short jail term. He lost his clinics, his helicopter, his mansions, cars, and his wife. In later years, he was to rebuild his medical empire, but remained deregistered.
Chapter Seven

Life on Easy Street

If the political economy of the 1980s favoured the concept of the individual, the decade’s major public health issues demanded quite the opposite: it was an age of epidemics—complex, cure-less and population-based. The first Australian death from HIV/AIDS occurred in Melbourne in July 1983; drug use, homelessness and suicide affected the population, especially young people, in unprecedented numbers throughout the decade. Major policy responses adopted community health-style approaches, endorsing the ‘function’ of the model, but continuing to question the validity of the form, in particular, community control. For the services themselves, definitions became increasingly important, not only in their communication with an increasingly managerial state bureaucracy, but in their relationship with new, and newly marginalised, client groups.

Carlton Community Health Centre had begun operating from its permanent address at 622 Lygon Street on 1st October, 1979. The character of the Carlton centre is perhaps best represented by long-time Committee of Management Senior Vice President, Betty Lawson. Lawson had been Deputy Matron of the Geelong Base Hospital, Matron of the Victorian Eye and Ear Hospital, and for 22 years she was Matron of the Royal Women’s Hospital. Lawson had attained the rank of Australian Army Nursing Corps Captain in World War II, travelling ten times around the world working in the hospital ship ‘Wanganella’ before serving in New Guinea. She was awarded the International Red Cross Florence Nightingale Medal, and began her role at Carlton Community Health Centre fresh from being presented an MBE for her contribution to nursing.

Lawson recruited Robert Watts to be one of Carlton’s five Trustees. “Matrons had to be tough as old lead”, Watts said. “Betty still had that aura about her.” Watts’ family has run the shoe store on the corner of Grattan and Lygon Streets since 1895. While records of Carlton’s activities are few and far between, Watts recalled that the COM was “fairly political. You’d get a lot of intellectuals and a lot of common sense would be left out. If they’re too intellectual there’s a lot of bloody theory and not enough practice on the ground. You need a streetwise person on there too, to keep them on the straight and narrow. That was probably me…” Other trustees were closely
affiliated with the University of Melbourne. The University’s Vice-Chancellor, Professor Sir David Derham held a position, as did Jean McCaughey, former Research Fellow at the Melbourne Institute for Applied Economic and Social Research, and wife of the University’s Deputy Vice-Chancellor (and later Governor of Victoria), Davis McCaughey. The Carlton centre, in comparison to Collingwood and Fitzroy, was generally held to be more ‘establishment’, quiet and orderly—at least from the outside.

Carlton, like neighbouring Fitzroy and Collingwood, had cycled through waves of demographic change. It was a densely-populated, slum-riddled suburb in the 1800s (with attendant social reformers setting up shop in the district), a post-war haven of affordable housing for low-income workers, a vibrant community of immigrants in the 1950s and ’60s, that became a steadily gentrifying real estate hotspot from the mid-1970s. Carlton, too, had been cleared for public housing with no shortage of opposition from a vocal and effective Resident’s Association. Over time Carlton ceased to be identified as a centre of poverty and, with the additional pressure of rising property prices, many welfare agencies moved out of the suburb. The Carlton centre was born out of community recognition of a gap in local services, but the centre would expend a great deal of effort in trying to identify its target population and service priorities. Carlton had no doctors, but a small number of staff provided a familiar range of services: physiotherapy, dietitian, ethnic health workers, social workers, and community health nurses. Perhaps most important of all was the podiatrist—Carlton’s clients were overwhelmingly elderly, a fact that the service had ‘to accept’ (Carlton CHS Annual Report, 1981).

Tensions amongst staff, and between staff and management, seem to have been an almost constant feature at Carlton. The circumstances surrounding a Carlton worker leaving the service in 1985 for reasons that, even now, have not been disclosed, sparked a run of resignations, alarming neighbouring services. Both Collingwood and Fitzroy Community Health Centre staff sent letters to Carlton’s management expressing concern.

Consultant Frances Donovan, a Social Work professor, was engaged to review the structure and operations of the service. Donovan reported that ‘all the well-known features of high-tension and low morale are being exhibited, e.g., break-down in communication, projection, scapegoating, ‘double-bind’, self-fulfilling prophecies, trivialisation and distortions, inward-looking patterns, denial and withdrawal’ (Donovan, 1985). Moreover, there was ‘much confusion about the interpretation of ‘managerial’ functions, with very different views and expectations. Words such as facilitating, enabling, controlling, co-ordinating, accountability and responsibility were all used.
in different ways.’ Donovan noted that divergent notions of accountability and a lack of definition of terms were causing a weakening of morale at the centre. Most importantly, Donovan’s report identified that the successful management of Carlton, or perhaps of any community health service, depended a great deal on the definition of what is an effective Community Health Centre.

Tom Roper’s Ministerial Review of Community Health Services, launched a few years earlier in 1983, was coming to similar conclusions:

‘One of our difficulties has been that community health is full of vigorous statements of opinion expressed in completely undefined terms. Some of these terms are central to the issues being discussed by this Review and must be defined in order to permit us to continue useful discussions’ (Victoria. Ministerial Review of Community Health Services & Henry, Gary & Health Commission of Victoria, 1984, p. 5).

The Review Committee believed lack of definition was responsible for both differences of opinion and ‘imaginary agreement’ in the sector; perception played an important role:

‘It has been strongly suggested to us that it is not the nature of the specific services delivered that characterises a Community Health Service, but the way in which they are delivered. That is to say that whether or not a service is a Community Health Service depends not on the problem nor on the solution, but upon the way people get from the problem to the solution’ (Victoria. Ministerial Review of Community Health Services & Henry, Gary & Health Commission of Victoria, 1984).

In practice, this emphasis on the mode of delivery did seem inevitably to concentrate de facto power in those directly responsible for service delivery, the workers. At Collingwood, new manager Bruce Hurley found something more akin to a “staff collective. [Staff] would pay lip service to the decisions being made by the committee of management—they wouldn’t say it that way, but in reality I would say the important decisions were made at the staff level”. Hurley recalled a meeting to discuss his wish for a clearer organisational structure, because “when you’re a CEO with fifty staff and no organisational structure it makes you feel pretty impotent”. During the meeting, “Chris O’Neill said rather gently from the back, ‘Bruce, I think you’ll find we don’t do things that way in Collingwood.’” Hurley added that at a later meeting, still debating organisational structure, “one of the doctors gave me a letter. Then they all stood up and walked out. The letter said the staff were going on strike because of a lack of consultation in introducing
the latest organisational structure...‘What’s this? I hadn’t heard of this!’
Everyone walked back inside and said ‘April Fools!’”

It was no joke, this permanent, low-intensity insurrection; soon Fitzroy would also have to endure a debilitating period of instability and mistrust.

Management troubles, too, were being noted by the Department of Health. A state election in 1985 returned Labor to power, but saw Tom Roper shuffled to Transport. The new Minister for Health was David White, previously Minister for Mines, Minerals and Energy. Caroline Hogg, a long-time patient at Collingwood Community Health Centre became Minister for Community Services. Where Roper’s Ministerial Review had focused on accountability in terms of the relationships of services to their communities, White’s new health policy emphasised the obligations of services to the Department; management problems at Community Health Centres could be addressed by ‘a series of Ministerial actions to sanction, suspend or dismiss committees’. Furthermore:

‘Accountability means more than annual reporting, financial audits and statistical returns to the Health Department. It involves an agency having specific objectives and being held accountable for progress towards them’ (HDV, 1987, p. 15).

Where Roper’s review recommended $121 million be spent on community health by 1987, White opted for a grant of just $29 million, accompanied by a set of performance measures for each funded service. “It was a fairly dramatic change to being concerned with what are we achieving with the dollars being given,” Bruce Hurley said, “rather than controlling what you’ve bought with the dollars.” While in one regard these Health Service Agreements liberated centres from haggling over individual budget line items, they imposed clear and overwhelmingly quantitative performance targets that tended to define priorities along general, rather than community-specific, lines. According to Brian Stagoll, “in the end, this rebounded in the Centre’s favour as the community context seemed to result in workers being more efficient, harder working, more committed (or something); the performance targets set by hospital models and standards were easily surpassed”.

Bill Newton, who had moved from managing West Heidelberg Community Health Centre to staffing Roper’s review, saw at close range another more fundamental shift:

“I think you’d have to say that the bureaucrats in the department never really liked community health because it was untidy and fractious and people argued and that kind of stuff. There was this feeling that they wanted to turn the community health services into just service delivery
outlets, and get rid of the underlying political objectives that they all had in the early days when we started.”

In this age of epidemics, however, community health was perfectly placed to respond where local interests did intersect with government policy priorities. The ominous feeling that community-controlled health was falling out of political favour was tempered somewhat by the proven ability of community health to respond effectively to major national public health issues. North Yarra Community Health continues to provide a number of crucial services born out of the public health crises of the 1980s.

Chris Hardy was a clinic nurse at Collingwood Community Health Centre. “I had a particular interest (I don’t know why) in viruses and infections, and I was particularly interested in Chlamydia. Nick Crofts and I did some research into Chlamydia as a sexually transmitted infection in women.” Crofts had left Collingwood in 1986 for Fairfield Hospital, where he followed his interest in epidemiology. Hardy was running a pap smear clinic at Collingwood and began swabbing women routinely for Chlamydia, which was not yet standard practice, for Crofts to analyse. “But then this strange thing called HIV came along.”

“I was just aware of it from the media”, Hardy said. “Originally it would just be small little snippets that you would find in the paper about a person with a mysterious illness…It was in the days when one guy in San Francisco got it, another guy in New York got it and then someone in England got it, and my ears just pricked up.”

It soon became evident that while the disease primarily affected narrowly-defined risk groups, such as gay men and people who inject drugs, it had the potential to affect the broader population, for example, through blood transfusion. The name, acquired immunodeficiency syndrome, AIDS, was agreed upon in 1982. The virus that caused the syndrome was isolated in France in 1983, and in the US a year later and HIV/AIDS soon came to dominate public consciousness.

At Collingwood, HIV/AIDS dovetailed with other, more localised epidemics: injecting drug use and youth homelessness.

Homelessness has always been a problem in Collingwood. As recounted in Chapter One, Dr. Singleton had established the Temporary Home for Fallen and Friendless Women, a handsome six-room house on Islington Street purchased for £1200 pounds. In his autobiography, Singleton gave the story of one the Home’s residents:
‘Sarah W, aged twenty, whose parents were residing in one of the outlying suburbs. Was seduced by an unprincipled villain under promise of marriage, but who had abandoned her, and left the country almost immediately after. On her state of pregnancy being discovered at home, her father harshly drove her from the house without a penny. She came to Melbourne broken-hearted, and was providentially met on the Sunday morning on which she arrived, her finder being directed in a remarkable manner to where she was. At once she was admitted to the Home. This girl gave evidence of deep sorrow for her sin, and—previous to her being removed to the Lying-in-Hospital—of her having found rest and peace in Christ her Saviour’ (Singleton, 1891).

Singleton later built a number of cottages behind the house, which widowed women could rent for a nominal sum; one woman lived there until she was 109 years old. The Night Shelter for Women soon opened close by and, according to Singleton’s records, ‘10,000 women and 300 children slept and breakfasted there in its first year.’ The reaction from parts of the local community is aptly summarised by The Argus (1886, 27 July):

‘They say that the ‘female casuals’ are most un-desirable visitors to a respectable neighbourhood, that their conduct and language entitle them rather to a place in gaol than in a ‘home’. Even Dr. Singleton admits that some of them, while intoxicated, have to be arrested, and the petitioners allege that at times in the open street the women are given to vagaries which outrage public decency and disturb domestic life. After the ‘home’ is shut for the night, gardens and outhouses, it is complained, are invaded and made camping places by those who have failed to reach the refuge in time. Why, it is asked, should Islington Street be made the reception place for all the aged, dissolute and irreclaimable women of the metropolis?’ (p. 7).

From: Singleton, 1891, p. 246.
Homelessness was, to many in society, the special fate of loafers, a direct consequence of fecklessness; providing meals and shelter could only result in a race of paupers. Singleton’s more comprehensive understanding of the issue drove him to be a more compassionate advocate, particularly during the 1890s when economic depression created a surge in unemployment and swelled the ranks of the homeless; men in search of work formed a newly itinerant population in Collingwood and beyond. A rudimentary labour exchange was established at Singleton’s Dispensary, and Singleton granted the newly-formed Committee for the Unemployed the use of his Mission Hall in Little Bourke Street. He became the Treasurer of the Committee, and wrote detailed letters to local newspapers, supporting the Committee’s request for government intervention.

The depression era cemented Carlton, Collingwood and Fitzroy as centres of charity for those experiencing homelessness. The suburbs were also known for their strong drinking culture, with a pub on every corner and, over time, for illegal drug use. Heroin was legal by prescription in Australia until 1953 and was available on the black market as a recreational drug by the 1960s. The availability of drugs and alcohol to a population vulnerable to misuse and addiction, combined with a ageing demographic, created both a type and stereotype of homelessness, the ‘overcoat brigade’ of men that Chris O’Neill recalled from his early days at Singleton’s.

But throughout the 1980s, the image of the frail aged male alcoholic as the dominant homeless ‘type’ was being replaced by the reality that homelessness could occur to people of any age and any gender. “There was lots of stuff in the media then about young homeless people and how terrible it was”, Chris Hardy recalled. “Now I think people almost take it for granted that there are young homeless people.” People experiencing homelessness age rapidly, are more at risk of communicable diseases, hypothermia, malnutrition, respiratory complaints, sexually transmitted diseases, skin disorders, diabetes, dental problems, emotional and mental health problems, and conditions mostly unheard of in the general population, such as tuberculosis.

“Not all, certainly not all, but the majority of [homeless youth clients] injected drugs. If they didn’t inject, they would be big drinkers”, Chris Hardy said. “We used to have kids die from alcohol poisoning. They would drink so much that they would die; we lost a couple that way.”

People who inject drugs were identified as being at risk not only from HIV/AIDS, but also from Hepatitis B and C. Hardy saw clearly, too, how drug use was tied up with the emotional consequences of homelessness. “I think there is a percentage of people who get into it because it can be a bit like a family.
I know some users whose best friend is their dealer and if they [did not have] contact with other users they would be absolutely lost…That is their community.”

“What did they hope to get [from drug use]?” asked Nick Crofts. “Time out; time out of an existence which promised them nothing but more of the same. When we talk about poverty, we don’t tend to talk a lot about one of poverty’s almost inevitable accompaniments, boredom, and its inevitable companion, frustration…And if the time out was for a few hours, that was good; if longer, a day or two, that was better; and if you hit the jackpot and overdosed, you get the ultimate time out. Why do we say it’s about the drugs when it patently isn’t, it’s about life?”

A bleak outlook was not the sole province of drug users. The 1980s were hard on young people: youth unemployment averaged above 20 per cent. The Commonwealth Department of Health published a report, ‘Youth Unemployment: The Disease of the 80s’, documenting the apathy, housing problems, anger, loneliness, depression, substance use and risk-taking behaviour prevalent amongst unemployed young people. Suicide amongst young men was reaching unprecedented levels; popular culture was saturated with anxiety as the US and the USSR (as it was then) contemplated Mutual Assured Destruction through nuclear warfare. HIV/AIDS seemed in many ways to be a most intimate manifestation of this larger feeling of risk, a sign of the meagreness of existing protections and the potential for self-destruction. The things that had fostered the personal beliefs and career trajectories of community health advocates, such as economic security, social optimism and political influence, had fallen away almost entirely for this next generation, leaving instead an often overwhelming ‘present orientation’.

The penetration of drugs, particularly heroin, into society had been made evident dramatically a few years earlier, when Prime Minister Bob Hawke wept publicly over his daughter’s heroin addiction in a 1984 press conference. That even the Prime Minister’s family had not been immune to addiction, and the extent of Hawke’s personal suffering, affected the tone of what might otherwise have been a strictly moral or ‘law and order’ drug debate during the 1984 federal election. In 1985, a re-elected Hawke announced a national Drug Summit with the aim of formulating a cohesive national strategy.

Drug policy was debated hotly in the press for months before the Summit; some public submissions to the Summit advocated for the introduction of the death penalty for drug traffickers and the sterilisation of ‘hopeless cases’ (Humphries, 1985). For his part, Victorian Premier John Cain flagged a preference for a zero tolerance approach:
‘I’ll be taking a hard-line approach to penalties for serious drug offences. That’s what I believe is required at this time: a tough approach as part of an all-out attack on this pernicious evil, an evil blighting the lives of so many of our young people in particular’ (Metherell, The Age, 25 March, 1985, p. 6).

Federal Health Minister, Neal Blewett, argued for the discussion on drugs to be put in context, citing the fact that alcohol and tobacco cause many thousands more deaths every year compared with heroin. (Bans on tobacco advertising began to be debated at this time.) The Summit settled on a co-ordinated approach called ‘harm minimisation’—the policy in place to this day.

Since the Summit, the definition of harm minimisation has expanded and contracted in line with dominant social and political attitudes towards drugs and people who use them. The ‘harm minimisation’ approach endorsed in 1985 is perhaps now best understood as ‘harm reduction’. Harm reduction is based on a strong commitment to public health and human rights. It recognises that people will use illicit drugs regardless of supply reduction strategies and that, while they continue to do so, there are benefits to reducing the associated harms to people who use drugs, their family and their community. Needle exchange programs and funding for drug user organisations, for example, were key to early strategies; this consumer-focused approach was adopted directly from the community health model. ‘Harm minimisation’ has over time, through political influence, differing notions of harm and moral assessments, come to include a broader range of programs, including aspects of ‘zero tolerance’ approaches, previously seen as the opposite of harm minimisation.

There are now three main approaches to illicit drug policy within the harm minimisation framework: supply reduction, demand reduction, and harm reduction. Supply reduction looks to the police, customs and the courts to attempt to reduce drug supply. Demand reduction includes detox units, rehabilitation and treatment programs. Harm reduction programs continue to include needle and syringe programs and consumer advocacy. Pharmacotherapy programs (including making heroin available through prescription), and supervised injecting facilities are recent and more controversial additions to the strategy.

Collingwood Community Health Centre had documented the need for a youth-specific program that included harm reduction services some years earlier and, in 1987, established the Youth Health Team. Nurse Chris Hardy and GP Sue Crockett were responsible for the Team. Crockett had spent
five years as a doctor at Turana and Baltara Youth Training Centres before coming to Collingwood; frustrated by the limitations of the institutional environment, she turned to community health to explore wider aims. Crockett and Hardy saw a clear need for a needle exchange program at Collingwood; staff debated the potential impact the program would have on the rest of the centre:

‘Concern was expressed about security and safety, both to patients and staff. By attracting more IV drug users, would crime rates in the local area increase? What would our regular clients think about IV drug users being around? Would there be more needles and syringes in the gutter for children to play with or for adults to accidentally prick themselves? What if people started shooting up in the toilets? Will there be more aggressive clients for staff to deal with? Will the police start picking people up outside the centre?’ (A Brief Overview to Setting Up and Running a Community Based NEP, CCHC, 1989).

This was a new community of health centre users, initially unrepresented and disorganised, but with powerful and immediate needs. A Carlton Community Health Centre client recalled that the sudden increase of people seeking help for problems associated with homelessness and drug use was something of a ‘shock’ and a disruption.

While the multidisciplinary approach and social health models at Collingwood, Carlton and Fitzroy Community Health Centres were well suited to treating people with complex issues, it was clear there were barriers to access for this new client group. These included the rule that clients had to be living or studying in the local area, and the long waiting times due to the ‘no appointment’ system. Another set of problems arose when people would present to reception, such as an inability to fill out forms through illiteracy or confusion, lack of identification or Medicare cards, embarrassment, language barriers, and presenting to the service under the influence. Some clients tended to see the preventative health measures that Community Health Centres emphasised as less important than pressing health needs. The unstable and chaotic ‘routines’ of homelessness meant many people would only access health services when they perceived they were having a health crisis. In which case, people would often choose instead to visit a hospital emergency department (or perhaps a private 24-hour medical clinic, with no guarantee of being allowed through the doors). The limited contact and philosophical differences between Community Health Centres and hospitals became problematic in providing continuity of care.
Sue Crockett and Chris Hardy’s Youth Health Team saw that, in order to implement a harm minimisation strategy suitable for their client population, the centre would need to adapt.

Government policy on needle exchange was slow. Frustrated doctors in Sydney established an ‘illegal’ exchange to cope with demand there. It was not until 1988 that Collingwood was one of ten Victorian centres authorised to participate in the Needle Exchange Program (NEP) (an equivalent program is now known as NSP, or Needle Syringe Program). Initially, Australian law permitted only pharmacists to dispense needles and syringes. At Collingwood “the pharmacy got over it pretty quickly,” Chris Hardy recalled, “because there was a constant demand.”

After a change to the legislation expanded the categories of health professionals authorised to dispense needles and syringes, the NSP could operate equally from the nurses’ offices. The NSP ran with minimal barriers to users: no Medicare card or formal identification was required so anonymity could be preserved, injecting equipment was distributed in the same discreet packaging as pharmacy medicine, there were no limits on the number of needles and syringes dispensed per visit, and no questions asked:

‘We accept the fact some individuals may be trafficking in drugs and provide needles and syringes as a bonus. The basis of the program is to prevent the spread of disease rather than stopping drug misuse. Users are not confined to our usual centre guidelines of living, working, or going to school in the local area. Many come from outside the municipal area, some are visiting from interstate, some just want to avoid the stigma of walking into [other NSPs].’ (A Brief Overview to Setting Up and Running a Community Based NEP, CCHC, 1989).

In less than two years, the Collingwood NSP distributed more than 40,000 needles and syringes with little or no negative impact on the centre. Security and safety had not been a problem.

‘Generally speaking most [clients] are very passive and are grateful that someone is actually doing something for them. They do however want to be served immediately and preferably five seconds ago. Are they more aggressive than our other clients? The answer is no. In terms of local crime rates…We have no figures on this. What would our clients think? Most people do not know if an IV drug user is sitting beside them or not. These individuals come in all shapes and sizes, some are young, some are old, some are middle-aged, some carry brief cases, some backpacks, some look unwell, some look very healthy, some are well dressed others
“The needle exchange program was the best public health dollars we’ve ever spent in this country”, Chris O’Neill said. “In terms of numbers there was never the exposure [to HIV] that happened in other countries. In terms of health costs, in terms of human costs, a hugely successful program. It still is.”

A 2009 Commonwealth Department of Health and Ageing study entitled ‘Return on Investment 2: Evaluating the cost-effectiveness of needle and syringe exchanges’ revealed the program ‘directly prevented more than 32,000 cases of HIV infection and almost 100,000 cases of hepatitis C’. The prevention of these infections was found to constitute an estimated saving in healthcare costs of over $1 billion; the program saved four dollars for every dollar spent, a significant return on investment. A parallel program of condom distribution through Community Health Centres also did much to prevent the spread of HIV into the broader community.

The NSP was extended to operate out of what became known as ‘Easey Street’ — a building annexed to the centre, and dedicated to services for young people experiencing homelessness. Easey Street was designed to be a community centre within a community centre; a bespoke service. “Easey Street had its own little entrance and exit, so [clients] didn’t have to come through the rest of the health centre…they used to find that all quite threatening: it was a bit too big and a bit too medical”, Chris Hardy said. “Whereas if they could sneak in through the back, that was a lot better.”

A portion of the funding for Easey Street came in the wake of the release of the 1989 ‘Our Homeless Children’ report. Written by Human Rights and Equal Opportunity Commissioner, Brian Burdekin, the report further demolished the classic myth of the ‘whimsical’ youth running away after a family dispute. While family dispute in some form is often at the centre of youth homelessness, the distinction was made between the ‘dissenting’ youth and the ‘escapers’ from neglect and physical and sexual abuse; another re-definition. Collingwood conducted its own local research, the ‘Shifting Places’ report, which compiled the findings of ten weeks of action research amongst young people in the area. When asked about their ‘basic health needs’, the majority of young people told the researcher that friends — having them, being with them — was the most important health need of all (Chapman, 1989). ‘Only seven [young people] included ’shelter’ in their response, yet a majority of the young people asked were actually or effectively homeless…a clear priority for a sense of community’ was evident. (The report quoted one
young person as saying ‘fuck doctors’, and the sentiment was not unique.)

‘The overall theme,’ the report concluded, ‘is ACCESS’ (Chapman, 1989).

Easey Street provided drop-in access to doctor, nurse, and social worker, as well as to basic services essential to dignity and well-being: a shower, a washing machine and dryer, a little kitchen. It was managed by an advisory board that included five people from the client group. “I look back on it now and I remember always being busy, always having lots of kids there”, Hardy said. “There always seemed to be people there from the minute we opened the doors.” If youth homelessness was an epidemic, Easey Street was its field hospital. GP Sue Crockett gave a vivid description:

“I still find myself approaching each work session with a feeling of dread and frustration. When I analysed my dread of working for five hours a week in a health clinic for street kids, I realised my frustration was actually a feeling of helplessness which stemmed from working in a situation for which I am not trained and for which I have no answers. Throughout my medical training I was taught to recognise a set of symptoms, make a diagnosis and initiate treatment. Whilst working in community health, I have adopted a holistic approach, recognising that a wide range of factors—housing, nutrition, employment—can affect an individual’s health. However, after working with homeless youth, I feel there is another factor, a far deeper part of being, that cannot be ‘made well’ by medicine or housing or food, but only by changing society’s values. For the first few weeks I saw cut fingers, sore throats and drug problems. Now all I see is the anger and complete despair and loneliness of youth who come in one after another, weeping or yelling and asking for help” (Crockett, 1990).

Crockett, Hardy and staff treated clients for lice and scabies and taught CPR, cooked up vegetables, or bought hot chips for a treat; they arranged outings, or chats with a housing officer.

For Chris O’Neill, though, the best thing Easey Street did was to “take a pariah group and make them able to walk into a service and feel part of it”. “It was hard to get money,” he said “and hard to get things done against that attitude of, ‘Well, they’re junkies, they’re drug addicts. If they die that’s one less person that’ll be coming to rob my house’.” Here too, some re-definition was necessary. Chris Hardy was a stickler for terminology; not junkies, not drug users, but people who use drugs. There is a person and then there is their relationship with drugs. Chris O’Neill had seen plenty of people ‘slide’. “All you need is a peer group that uses, and then have something go wrong with your life, like your girlfriend leaves you or you fail an exam, something
happens and you’re using every day and it’s got you. Plenty of uni students, plenty of cops. Addiction is only this far away from any of us, it’s like a car accident.” The Prime Minister, tearful on television over his daughter’s addiction, would seem to be evidence enough of this proximity.

Consumer involvement in the design and management of services, which was second nature to community health, acquired a broader legitimacy around this period. Self-help groups had been acquiring authority steadily, but the emergence, and considerable success, of peer-based groups, such as gay men’s groups or injecting drug user groups, in the face of HIV/AIDS did much to increase the profile of a growing health consumer movement. This was no small thing, for members of disenfranchised or stereotyped communities, or sufferers of stigmatised disease, or the ‘invisibly disabled’, to advocate openly for their own health needs. The Gay Men’s Health Centre was incorporated in 1987, with Fitzroy Health Centre as the initial auspice body.

Frank Fisher had joined the board of Collingwood Community Health Centre in 1980, marking the beginning of a long career as a health consumer advocate. Fisher had suffered from Crohn’s disease, a gastro-intestinal condition, since he was a young man. The effects of Crohn’s were physically debilitating, and often personally ‘demeaning’. Fisher’s first wife, Robyn, was a physiotherapist at Collingwood, “and she really pushed me to come out of myself as sick. She taught me to let people know what my situation was... I would hide it...I’d suffer. I’d just put up with it. Vomiting and writhing in pain for 16 hours and just put up with it. I would go and eat people’s food, wouldn’t say anything, just appalling, idiotic stuff. But that was where I was at. And she helped me get over all of that”. Of his time on the board, Fisher recalled that ‘the health centre was of course in its heyday—fantastic times with people trying to inject into health centres then what was so good about them, all that variety and commitment and prevention and so on. They were fantastic times and for me a mind-blowing experience. I even became president there for a while. So that was incredibly liberating’ (Fisher, 2006). Fisher went on to hold many positions in health consumer groups, as well as being a consumer representative to government bodies. In 2011, he returned to the Collingwood board. Fisher has experienced first-hand the growing articulation of health consumers, and the increasing acceptance of their insights by the medical profession and its bureaucracy.

For Nick Crofts it was not the consumer-led response to HIV/AIDS that legitimised participation such as Frank Fisher’s, rather it was the other way around. Crofts believed that the early years of primary health care, of community health, in Australia, provided rich lessons in:
“…community ownership and accountability of our public sector in terms of structural determinants. One of the problems with [the response to] AIDS has been that exceptionalism, [the idea] that AIDS is new, that AIDS has gone about re-inventing the world. The involvement of communities—that’s all old hat to the primary health care, community health movement. But AIDS treats [consumer involvement] like it’s being invented for the first time. It’s like my kids thinking they invented sex, drugs and rock’n’roll when I know that we invented it.” Crofts echoed a familiar sentiment about the discoveries, the achievements of those early years of community health: “We didn’t write it up so it wasn’t disseminated. I think we felt that we were building it and that it would go on like that forever.”

Community health in Yarra represented some of the best practice responses to the decade’s social and public health crises, but lasting ‘forever’ was a political impossibility: both internal and external forces would come to bear before long. And although drug use and homelessness would never abate in Collingwood, Easey Street would shut its doors within four years.

The groups have been meeting at NYCH for over 30 years. Here they are in the Collingwood CHC waiting room under the 19th Century portraits of Dr. John and Isabella Singleton.
Chapter Eight

New structures

Terri Jackson resigned as manager of Fitzroy Community Health Centre in July 1988. Her departure signalled the beginning of an intense period of instability and discord at Fitzroy; a vivid illustration of how heavily a ‘flat’ management structure depended on the consensus created by, and embodied in, the manager at the core.

Jackson left to pursue a Ph.D, leaving Maria Wright as acting manager for several months. “I really wanted [Maria] to become my successor,” Jackson said, “because I thought she got what we were doing at Fitzroy…because of my friendship with her I backed off arguing her case, and I really regret that…I was trying to let the community decide what they thought was best for them”. Wright was interviewed by the Committee of Management for the job, but was not appointed. Edwina Mason, a health bureaucrat from South Australia, accepted the position and began work at Fitzroy in early 1989.

For staff, it had not always been smooth sailing under Jackson; she had, for example, introduced a ‘peer evaluation’ process, whereby staff provided feedback annually and anonymously on the performance of their colleagues. The lack of transparency and accountability in this process was often painful (a ‘wicked’ undertaking, in one staff member’s opinion), and led in one instance to a case at the Industrial Relations Tribunal. Like many of Jackson’s management techniques, the success of the evaluation depended on a high degree of collegiality and cohesion amongst workers. Small staff numbers, the ‘quiet persuasiveness’ of Jackson, and strong support from the Committee of Management were also important factors.

New manager, Edwina Mason, in contrast, inherited a much larger staff, and an inexperienced Committee. Between 1987 and 1989 the Committee lost ten of its thirteen members, several resigning after Jackson left. In 1988, the President, Anne Horrigan-Dixon, went overseas. Brian Stagoll reassumed the Presidency and Rena Pritchard joined the board. “Within a few months I found myself President”, Pritchard said. “I was invited on as a community person as someone totally innocent and out of the politics of it. I didn’t know what I’d let myself in for.” The policy to have centre users on the Committee meant several positions were held by non-English speakers, and multiple interpreters were required. “The meetings could go on for four hours,”
Pritchard said, “and the issues could be quite confusing...[one community member] just wanted a physiotherapist, [another] was on to make sure there were services for her”. Petitions were heard from centre users who wanted an improvement in the quality of coffee available in the waiting room. “[The Committee] was meant to set policy but it was asked to be hands-on and get involved in all the day-to-day stuff,” Pritchard said. When ‘day-to-day-stuff’ soon began to include escalating tensions between staff, the manager and some committee members, Pritchard found herself suffering “a lot of sleepless nights”.

This period was, by all accounts, difficult. People working for, or associated with, Fitzroy at this time variously recalled factions forming amongst professional groups, pressure exerted to ‘take sides’, new staff being warned off, committee members ‘reducing staff to tears’, and a steady erosion of confidentiality and trust. Sally Mitchell recalled that the upheavals in management also had an effect on the centre’s users:

“There was [new] limit-setting with the community about what was and wasn’t acceptable. It was less acceptable to do the drop-in stuff that suited a lot of our clients with chaotic lives. As soon as we put in new structures...the centre began to have some difficult behaviour. It was hard for some clients to accept the change, especially those with mental health issues.”

Pritchard had been elected as President following a health department intervention. Brian Stagoll had reported the problems at Fitzroy to the Health Department, and an investigator was dispatched—Jim Goode. Goode was uncharacteristically coy about the details of his intervention, but he did concede:

“Fitzroy was tragic. It was a personal tragedy. And it was an organisational tragedy...a whole lot of people were there at the time and saw all the things that were happening and I tried my very best...But it wasn’t a bureaucratic problem. It wasn’t a problem that lent itself to anything that I could have done.”

Goode suggested to Brian Stagoll that he step down. Stagoll was very happy to agree and an election was held to form a new Board, with the self-described ‘green and inexperienced’ Pritchard elected as President. The new stronger board included Geoff Barbour, Megan Stoyles (a former Roper advisor), and Tom Marino (a previous mayor). Things steadied, with Pritchard as President “but I still regard it as quite traumatic period”, she said. “In the end the manager resigned, but I think there were faults on both sides.”
Natalie Savin observed with hindsight that “in the early days of community health, [committees] were structured in a way that left them vulnerable to sectional interests. Just about every Community Health Centre across Melbourne had a coordinator who was run out of town by the staff.”

In her sleepless nights, Pritchard asked herself:

“Was the problem the manager? Was the problem the staff? Was the problem the structure? I would say now that the problem really was the structure and the others flow from that. I think any manager would have run into problems at that time unless they were very strong... But in that period of time remember that we didn’t want leaders with a capital ‘L’, we wanted leaders to be one of us... you did things cooperatively.”

Pritchard saw a contradiction between a structural need for a strong leader, and a sociological preference for shared responsibility. “So, a person coming in who was a so-called strong leader would probably have been rejected anyway.” Theresa Swanborough found the flat management structure unrealistic. “Within a team different people have different areas of expertise and knowledge and power... People also assume power, don’t they? There is official power and there is unofficial power... [and] as a service gets bigger that doesn’t work. In fact, has it ever worked? There is still some question about that.” For his part, Brian Stagoll refuted the structural thesis, claiming instead a “lack of engagement, disregard for the Board and non-involvement in the community on the part of the manager as the cause of the upheaval”.

Eileen Hurley joined Carlton Community Health Centre as a social worker and family therapist in 1988. Hurley had previously worked in Melbourne’s semi-rural suburbs, around Eltham and Panton Hills; Carlton was an unknown to her. “I walked around the suburb. I didn’t have any experience with different cultures, all these different people and the housing estates... Carlton would say it didn’t have any resources, but they had a lot compared to where I’d worked before, and they had all this access to politicians.” Hurley loved her work at Carlton, and was connected closely to her fellow staff members, “but it was true, we had this flat structure and we tried to run the place”.

Meanwhile, Collingwood Community Health Centre was experiencing its own internal meltdown. Kristine Olaris was a physiotherapist at Collingwood:

“I started out at St Albans Community Health and they had gone through the whole thing of the Committee of Management being sacked and staff being given memos the day before Christmas saying they were
no longer required, so I thought ‘No, I don’t need this’ and got out...Six months later I started at Collingwood because it had this great name for advocacy and strong ethos around that stuff...and it was just ugly, if not uglier than St Albans. I just thought, ‘Oh my god!’”

Ruth Borenstein, Marion Oke, Nick Crofts, Peter Sago and Lyn McKenzie had all left Collingwood by the late 1980s. Mary Lescun had resigned from the Committee of Management after being involved with the centre since 1945, and Frankie Thompson had also resigned his Committee position. GP Chris O’Neill and Yvonne Turner were the only ‘original’ staff members remaining. As at Fitzroy, staff numbers had ballooned, putting pressure on ‘old’ forms of management, and turning the participatory, consultative decision making process into an often agonising debating marathon; staff meetings would go all day if they could. O’Neill believed that, while internal structural problems contributed to the difficulties of managing Collingwood, the centre was also experiencing some negative effects of its closeness to local politics:

“You were on the committee of management [at Collingwood Community Health Centre], then you got onto Collingwood Council, then you waited for your turn as mayor, then you got a safe seat somewhere. That was the path for Labor hopefuls...[The nature of the committee] changed when people became apparatchiks, they just wanted what was at the end of the rainbow rather than being committed to the causes along the way.”

O’Neill also perceived a shift in the expectations of some new staff. The rationalising, competition-driven climate of the 1980s could generate new attitudes towards work, and to the relationship of work to the rest of life:

“I can remember when [job applicants to Collingwood] first began to change and started parroting American corporate speak; ‘My goals are to become dah-dah-dah and such-and-such in so-many-years and this and that.’ And I thought, ‘this is really strange, I’m a bit shocked!’ Maybe I’m an old-fashioned fuddy-duddy but I started to think it was, not quite naked ambition, because people were just stating the facts I suppose, but it was almost breaking the rules of etiquette by exposing your ambitions in such an obvious way.”

This attitude was not necessarily better nor worse than the outward motivations of the ‘first wave’ of community health workers; it was simply distinct. The first wave had been influenced collectively by post-Vietnam, Whitlam-era ideas of the individual’s relationship to their society; this next
generation of workers had their own collective references, and a different set of expectations.

The context of community health had also evolved, and what worked in the 1970s was no longer feasible in the 1980s; the 1990s were looming with their own challenges. While politics, who was in power at any given time, had an obvious effect on community health, changes in the health bureaucracy had just as significant an influence.

Bill Newton recalled that in the early 1970s:

“...the [health] minister’s office was just a floor. There weren’t great doors and security and a receptionist and that sort of stuff. You want to talk to the minister’s adviser, you wander in and talk to the minister’s adviser.

In a sense, the only thing we contracted to do with our grant was to spend it, and that’s it really. Even more bizarrely, in the early days, if you had a deficit at the end of the year, you’d write to the department to say, ‘Dear Department, We seem to be $20,000 over-spent. We’d be grateful if you’d send it to us, so we can balance up’. It probably wasn’t quite as simple as that...[but] certainly the [departmental] culture in the ’70s was to a very great extent to enable us to just get on with our business. In fact, I can remember Jim Goode on a celebrated occasion writing to the department...and saying ‘Dear Sir, I’ve received your instruction of whatever-it-was date, with which I will not comply’. And that’s what community health agencies used to do in those days; it was a different sort of a time.”

The Health Commission, formed in 1978 under Premier Rupert Hamer, amalgamated the Health Department with the Public Health Commission, the Mental Health Authority, and the Hospitals and Charities Commission. It was a significant move that increased greatly the power and profile of health as a function of the state, and centralised much decision-making. Hamer’s ‘mega-department’ increased the input of hospital boards into state policy, at the same time as it gave itself the right to make appointments to these same boards. A professional and bureaucratic elite formed.

The configuration of health administration bodies had been tweaked constantly since Federation, but the practice of amalgamating, renaming or restructuring departments increasingly would become common practice for incoming governments over the next decades. Reshuffling had symbolic and political purposes; it also obliged disparate bureaucratic cultures to merge with varying results. Community Services Victoria was created in 1985,
for example, and assumed responsibility for some areas seen traditionally as the domain of health administration, such as infant and maternal health and disability services. Alison Hughes, who had written the 1982 report recommending the creation of the Fitzroy Community Health Centre, was at this time a member of the Health Department. She comments:

“Health bureaucrats are steeped in a different tradition; we come from a different school of thinking on health issues, the epidemiology of health, health policy. The people from Community Services Victoria come from the welfare sector, different training, different background. So we have this immediate, and I don’t want to say ‘clash’, but there are differences of culture taking place…you suddenly see a change in language but there’s no associated meaning to any of it.”

Three days after the Hawke Government was re-elected in July 1987, a massive restructure was announced in which 27 federal departments were rationalised into 13 mega-departments. The reach and power of Treasury was extended, whereas the ‘unproductive’ departments were unpicked, amalgamated, or re-branded to reflect a concern for economic functionalism. Education, for example, was recast as a function of Employment and Training. Later, the amalgamation of Commonwealth Departments of Health and Community Services in 1987 laid the direction for a new understanding of health and welfare services as ‘human services’. The abiding change, though, was the reconfiguration of health services into a quasi-market. Increasingly, it was also less necessary to be a health specialist to become a health bureaucrat. “The health system is this big building,” Chris O’Neill said, “and they’d never go out the bloody door unless it’s to buy a sandwich”.

In Victoria, the 1988 ‘Health Services Act’ replaced the 1958 ‘Hospitals and Charities Act’ and moved Community Health Centres into the ‘Associations Incorporation Act’. The new Act set standardised rules and responsibilities for health centre Committees of Management, with clear guidelines about who was eligible to govern, and how they may do so. (Fitzroy, for example, developed a new constitution in order to comply with the Act.) Where Community Health Centres had operated previously with the traditional autonomy of a hospital, the new Act stipulated something more akin to a business model that, particularly when combined with Health Service Agreements, increasingly posited the state as simultaneous parent company and major client.

The New Focus report of Health Minster, David White, had also flagged the notion of ratios: Community Health Centres should be located on a population basis, rather than solely on the ability of a community to organise
for one. A 1990 Health Department of Victoria Community Health Task Force (CHTF) discussion paper expanded on the point:

‘The development of health service agencies over time in response to community demands results in both community pride and ownership as well as inequitable access. The result of well-organised communities succeeding in gaining resources during periods of economic growth has inadvertently led to structural inefficiencies in the system… ’

The Task Force described community health service provision as ‘fragmented’, which restricted the ‘quality and quantity of services for consumers and limits the capability of providers to furnish them’ (CHTF, 1990). ‘Localism’ also led to idiosyncratic program offerings ‘defined by the interest/skills of staff…and/or some members of committees of management’. While the report reaffirmed community involvement as a major strength of community health, it also noted that ‘a possible consequence of strong community ownership and pride is the splitting of loyalties across a range of agencies which have basically similar goals, albeit with specific and distinct briefs’. The paper proposed that greater levels of integration, from joint programs and co-location to shared management, could address the stated issues. One of the authors, Stephen Duckett, who had spoken at Collingwood’s Crisis in Health Care seminar years before, was also Terri Jackson’s partner. It should be noted that, while community health had also undergone major previous reviews in 1985 and 1987, there had been no reviews of the hospital sector or general practitioners in this time.

By the time the Task Force made its final report, Caroline Hogg had taken over as Victoria’s Minister of Health. “Being Minister for Health can be the worst job in the world”, Hogg said. “I wouldn’t wish it on my worst enemy. If you make any decision against the conservative hospital agenda or media, or if you try to balance your local community wishes with the larger society, you automatically become the Minister for Death.” Hogg would have to endure ire from much closer quarters, as a struggling state government slashed spending, including in community health.

The collapse of the Tricontinental Bank, the Pyramid Building Society, and the State Bank of Victoria had seen hundreds of millions in private savings and investment dissolve overnight. In the face of large debt, skyrocketing unemployment, and the collapse of the manufacturing sector, John Cain’s Premiership became untenable. His resignation saw Joan Kirner become the state’s first female Premier in 1990. The high costs of treating illness and public hospital waiting list ‘blow outs’ had garnered much negative attention for the Labor government, leaving the health system vulnerable to expedient
‘streamlining’. In that year, Collingwood Community Health Centre had its budget slashed by 14 per cent. The centre campaigned hard against the cuts, and hung a sign on the Hoddle Street footbridge proclaiming, ‘Labor Government Slashes Community Health’ under which Minister Hogg was obliged to drive on her way home. “There was nothing personal in a campaign like that,” Bruce Hurley said, “it was just that our funds were being cut”. The cuts were pared back to 7 per cent, which nevertheless resulted in an increase in the cost of pharmacy subscriptions and significant staffing reductions.

In 1990, after nine unsuccessful attempts, Collingwood won the AFL Grand Final for the first time in 32 years. “Doing well with the AFL, but not doing so well with the Community Health Centre,” Hurley said.

The 1990 Task Force report included a strong recommendation that community health service provision be rationalised on a statewide basis. The report prioritised the general over the particular: nationally-set goals would guide service provision, statewide coverage would influence service location, population parameters would weight funding; accountability was given high priority. Municipal boundaries should also guide service provision: ‘while a community health service may cover more than one local government area, there should be no more than one [service] in any one local government area’ (CHTF, 1990).

On funding, the report recommended that the ‘overall funding of community health services should be maintained…While the consolidation of the community health program should be ‘cost neutral’ in the short term, over time there would likely to be a need for an increase in program resources…’ Of significance, the report signalled a clear preference for a break with ‘historical’ approaches to community health: ‘the challenges confronting the community health sector today are not those of the 1970s...The program must take advantage of the current climate...’

Bill Newton, from within the health department, saw that the ‘current climate’ was a rapidly cooling one:

“I think that people in the department found it possible to feel that if you are a health centre you should just be doing health and you shouldn’t have housing people and employment people and legal services in the Community Health Centre, because that’s not health. Whereas I think our view probably was that anything that is relevant to or affects your health, like whether your housing is any good, or whether you’ve got a job, or whether you’re being harassed by the local police constables, it’s all to do with your health, so it’s a perfectly
legitimate thing to have in as a sort of all-in-one-stop shop. The climate of the times was beginning to change a bit...there definitely wasn’t a very supportive attitude from the Health Department in those days. I left at the end of 1991 and the reason for that was the direction in which community health was going, and this was still under the Labor government…”

Carlton Community Health Centre had appointed Gavan Podbury as Manager in 1988. Podbury came from a community development background, but took a distinctly ‘evidence-based’ approach to community health and made service delivery a focus. Podbury described community health as intrinsically ‘messy’, but made efforts at Carlton to minimise the incidence and significance of ‘internal drama’. A cool head at the helm was timely, for in 1990–91, the centre suffered a significant cut to the budget, a ‘revenue target’ for fees charged for ordinary services and programs, and Health Department proposal to participate en masse amalgamation of the Kensington, Flemington, Ascot Vale and North/West Melbourne Community Health Centres.

Doug Thompson, Carlton’s President, called the directive astounding “because it didn’t make sense geographically. Our neighbours were Fitzroy and Collingwood. The people who used our services were mortified. They’d either have to travel to Kensington or lose a lot of services in a merged situation.” Carlton, along with North Melbourne and Kensington management, declined to attend a formal amalgamation working party, turning instead to a tried and true defensive measure: a public meeting. “Every man and his dog turned up to the meeting at the Church of All Nations. Geoff Lavender [Health Department representative] would have wished he wasn’t present at the meeting.” The ‘overwhelming view’ was that Carlton should remain an autonomous centre. Carlton’s formal response to the amalgamation proposal turned the numbers rhetoric back onto the department:

‘HDV has proposed there be one service with a catchment area of 58,300 people serving Carlton, North and West Melbourne, Kensington, Flemington and Ascot Vale. Current Government policy states that the catchment size for a Community Health Centre should be between 15,000 and 25,000 people. This proposal therefore goes completely against this policy. There is another disturbing aspect to the paper. This is the formula that Community Health Centres should be staffed at a constant rate of 1.0 staff per 1000 people. This formula assumes that people have equal health needs regardless of age, ethnic background, or social and economic factors. It is well known that there are higher rates of illness amongst low-income earners and the elderly. For example,
the Victoria Health Plan 1st Edition (HDV, 1987) clearly shows that there is a higher rate of premature death amongst lower income groups compared to higher income groups. The provision of community health resources should take these factors into account so that areas with higher numbers of low income and elderly people should receive more funding per capita than areas with relatively young or well-off populations. To do otherwise would be to distribute resources on the basis of a simplistic if convenient administrative formula instead of on the basis of need.’

“Eventually,” said Doug Thompson, “the health department changed personnel and the new guy changed his outlook after some meetings. We said that if it was necessary to merge with others then we wanted the people next door, not in the Western area.”

As geographically proximate as many inner-city Community Health Centres were, they often had very little to do with each other. Eileen Hurley, at Carlton, was barely aware of Collingwood’s existence. At Fitzroy, Brian Stagoll recalled that “we’d occasionally ask [Collingwood] for something…but were too busy trying to run a Community Health Centre to worry about externals. In fact, one of the weaknesses of community health is that we were too decentralised.” “You might think the city of Yarra is a small place,” Chris O’Neill said, “but they are all distinct communities”. The suburbs were microcosms, and their services had evolved under precise conditions.

In 1991, four Community Health Centres serving the area comprising Flemington, Kensington, North and West Melbourne, and Ascot Vale were amalgamated to form the Inner West Community Health Service. Carlton had won the first round, but the amalgamation genie was well out of the bottle.

In 1992, Rena Pritchard was succeeded as Fitzroy President by Geoff Barbour, who continued in the role for almost twenty years. “Really, I think there were better people who could have been President of the health centre rather than myself. But I did my best. We did turn it around and it still exists”, she said. 1992 was also an election year. It was inconceivable that Labor could be returned, and thoughts turned to the possible consequences of a Liberal victory. In June 1992, Bruce Hurley resigned after seven years as Collingwood manager, and his final report was gloomy:

‘One of the main difficulties the Centre has faced in recent years is to meet the increasing health needs caused by the recession. Research evidence has shown that poverty and unemployment are major causes of ill health. Unfortunately, regardless of what government is in power, people of low income are the ones that suffer most from recessions…Current signs are that, particularly if there is a change of Government,
there will again be a threat of major cuts to our funding. It is likely that the Centre will need to be defended again’ (CCHC, 1992).

Collingwood was in no great shape to be on the defensive—internal divisions continued, and a new manager would struggle to pull the place together. “What happened at Collingwood happens in political parties,” Chris O’Neill said, “it happens wherever you have human beings who are supposed to cooperate for a common cause but let personal animosity or whatever else get in the way. You have this destructive behaviour happening...It was the absolute worst time. I was saying to people, ‘Don’t you know what’s going to happen next?’”
500 people ‘choke’ Brunswick Street Fitzroy, May 17, 1993. (Fitzroy Secondary College closed by Kennett in 1993 was re-opened eventually in 2004 as a result of community action.)

‘Health Cuts Anger: Protestors from Fitzroy’s various ethnic communities turned out in force to protest the drastic funding cuts to local community health centres.’ Front page of The Melbourne Times, May 19, 1993.
Chapter Nine

‘Jeffed’: Occupation, amalgamation and renewal

In October 1992, Liberal party leader Jeff Kennett was elected Premier of Victoria in a landslide. Inheriting a ballooning state debt and latching onto a debt crisis narrative as justification, Kennett immediately escalated budget-cutting and privatisation measures begun under Labor. Within weeks of assuming power, the largest public demonstration since the Vietnam War, an estimated 100,000 people, was outside Kennett’s office protesting massive budget cuts, retrenchments and closures of schools and other public services. Kennett himself called his measures the ‘Kennett revolution’; for those on the receiving end, it was being ‘Jeffed’ (Costar & Economou, 1999; Warren, 1995). Kennett would oversee one of the most activist, controversial and ideological governments the state had ever seen, with direct and irreversible consequences for Carlton, Collingwood and Fitzroy Community Health Centres.

Marie Tehan became Minister for Health and Community Services in the Kennett government, and quickly made her preferences and priorities known. A fundamentally neo-liberal approach guided Kennett policy across the board. During his two terms in office, Kennett would vigorously sell off public infrastructure to the private sector, aggressively reform industrial relations, slash the public service, liberalise gambling laws and partially corporatise the state schooling system. In the health sector, budget cutting was a top priority. The $4 billion budget of the Department of Health and Community Services was the largest of all Victorian Government departments, consuming 27 per cent of the entire State budget. The Treasurer demanded that $381 million be trimmed from health with cuts to health and community services to account for more than half of all Victorian government savings.

Minister Tehan positioned herself as a managerialist, and left political statements to her Secretary of the Department of Health and Community Services, John Paterson, who was publicly critical of trade unions and interest groups; he was heartily in favour of de-funding advocacy programs, describing them as ‘piss and wind’. “I have offended literally hundreds of interest groups over the years when I have sought to interpose my body
between their snouts and the public trough”, he later told the Australian Health Review (Paterson, 1994, p. 24). Eileen Hurley, Carlton social worker, could see some value in this rationalisation, “It could be a good ride, this community health, and there was some slack. It did need cleaning up to some degree.”

The Health Department announced a set of principles that would guide the state’s health services platform, as well as direct ‘productivity gains’. In language excruciatingly familiar to many, government would focus on ‘people and not institutions. It will fund services, not agencies’ based on performance; services would reflect value for money; resources would be distributed ‘equitably’, and a better health status and outcome would be achieved for all Victorians. In practice, a ‘units of service’ definition of funding cemented the market-instruments approach to health that had been developing since the 1980s. Paterson was explicit about his plans for the Victorian health system: ‘Within a short time the economics of the operations of public hospitals, individually and as a system, will become indistinguishable from that of Target, Safeway, General Motors Holden or McDonald’s’ (Paterson, 1994).

Casemix funding arrangements, developed under the Labor Government by Stephen Duckett, were introduced to Victoria’s public hospitals. The introduction of Casemix was integral to the creation of a human services ‘market’ in which government positioned itself as a ‘purchaser’ of services, rather than a funder of agencies or positions. A key instrument of this project was to measure and fund the work of health care providers in ‘units of service’ to replicate a marketable commodity. Eventually, funding incentives caused hospital bed closures and job losses (including 3000 nurses from the public system) and Community Health Centres were put under pressure to deal with increased client loads without funding or infrastructure to match. Duckett left the Department a few months after the introduction of Casemix, and argued the failings of the new arrangements were a result of the massive funding cuts that attended the introduction of the new system. ‘More than $250 million has been taken from the hospital budget since 1992, the equivalent of closing down the Royal Melbourne and the Royal Women’s hospitals together,’ Duckett told The Age, ‘the excess fat in the hospital system has gone, and the Government has begun to cut into the bone’ (Davies & Rollins, 1994). Within a year, community health services were subject to similar benchmarked funding arrangements. Health Service Agreements were restructured to reflect the new system, and were renamed ‘corporate funding agreements’.
In May 1993, Tehan proposed a massive funding cut to inner city community health services. Questioned in parliament on the cuts by Tom Roper, the Member for Coburg, the Minister for Health, Marie Tehan replied:

‘The Honourable Member will know that in 1986 the Department of Health established eight different regions. Fitzroy and Collingwood are the inner area of the northern region, which runs out through Doncaster to the Yarra Valley and up to Healesville. It takes in a range of northern suburbs through that whole sector and has a population base of about 1 million people. The honourable member for Coburg might also like to know that in the per capita distribution of community-based services in that region the inner city area attracts approximately $60 per person; it is about $6 in the central part of the region; and about 60 cents in the northern part of the region. We do not have an equitable distribution of the limited health dollar in this State’ (Parliament of Victoria. Legislative Assembly, May 18, 1993, p. 2103).

The Health Department had begun using the Index of Relative Socio-economic Disadvantage developed by the Australian Bureau of Statistics to formulate more ‘equitable’ funding. The formula applied a weighted ‘population disadvantage factor’ to Collingwood and Fitzroy, and calculated that the ideal per capita expenditure on community health services in the area was exactly $27.60. Collingwood’s per capita funding in 1993 was $93.81, and Fitzroy’s was $34.94 (Tierney, 1993).

Tehan informed Parliament: “What is proposed is to amalgamate the administration of the Fitzroy and Collingwood Community Health Centres, which are very close together…and move some of the per capita funding more equitably across the rest of the region” (Parliament of Victoria. Legislative Assembly, May 18, 1993, p. 2104).

From 1 July 1993, less than two months from Tehan’s announcement, $1 million was to be ‘moved’ from the combined operational grants of Collingwood and Fitzroy, a 53 per cent reduction. Carlton Community Health Service would lose 40 per cent of its budget.

Immune to arguments that high need areas such as Collingwood required high levels of funding, Tehan also had reason to doubt the ability of the centre to meet any needs at all. Collingwood staff had written a letter to the health department asking for the Committee of Management to be removed. The department duly removed Collingwood’s Committee and sent in an Administrator from St Vincent’s Hospital. Chris O’Neill had signed the letter, despite his reservations about the wisdom of advertising the centre’s weakness: “…here we are with a razor gang for a state government who
are just looking for the chance to slice big chunks of public health, public education, public everything, and you silly bastards are doing this”. O’Neill called the factionalism and strife that had prompted the letter “a loss of perspective”, and described how any organisation can self-destruct “when people lose track of the point of why they’re there. They’re spending public money for the public good. And if you let your personal politics get in the way, and override the job you’re meant to be doing, then things fall apart at the seams...”. Across all three centres, the cuts were salt in the wounds of longstanding internal ructions and there was an exodus of exhausted, disillusioned staff on voluntary redundancies, and “a lot of people took packages and left, thinking it was okay for them. Basically the centre rolled belly up and said, ‘Here we are, do what you like’...the State government says, ‘We’ll chop a million dollars off their budget and let them sort it out.’ Which is what they did. ‘They’ll expire and that will be the end of them, we won’t have to worry about them anymore.’ That was the intent.”

An Amalgamation Project Management Group (APMG) had been set up early in 1993 to investigate the possibilities of the local centres of Carlton, Collingwood, Fitzroy and North Richmond combining forces. The Department of Health and Community Services had requested Community Health Centres provide a detailed evaluation of all services as well as a ‘strict priority order’ for programs; the request flagged a clear intention to ‘make decisions’ about program funding. A consolidated, multi-site service was seen by all parties as a sensible way to secure the future of community health in the area. But the massive, and very sudden, budget cuts and political pressure gave the talks a new urgency, and removed the voluntary nature of the discussion; neither Carlton, Collingwood, nor Fitzroy could continue operating independently on their horrifically reduced budgets. North Richmond opted to go it alone. For services with such significant histories of autonomous and consultative decision-making, it was a shock and disappointment to be so dramatically hamstrung. Jim Killeen, on staff at Fitzroy and soon to play a major role in the amalgamated service, characterised the government’s proposal as ‘retribution’. “What lay behind this was an incredible amount of resentment built up over a long period of time at the activism of Carlton, Collingwood and Fitzroy Community Health Centres.”

Fitzroy Community Health Centre users were rallied to protest cuts to the centre’s budget. “We cannot understand how the government can speak of cutting our services in favour of low-need areas like Doncaster or Templestowe”, Fitzroy President, Geoff Barbour, told the Melbourne Times. The cuts would mean the loss of the centre’s ability “to care for the whole
person. No longer will we be able to provide interpreters for individuals, undertake projects on nutrition, safety...counselling and advice on issues from domestic violence to accommodation crises”. These losses were exacerbated by concurrent cuts to local agencies: “We have lost our youth workers and a local school...the Fitzroy-Carlton Credit Co-op has lost its poverty action program, and local public housing estates will deteriorate with reductions in cleaning and home maintenance services.” The size of a May 17 march of supporters from the town hall to the Community Health Centre ‘choked’ Brunswick street traffic, according to the Melbourne Times: police ‘appeared to have underestimated the crowd’ and admitted to being ‘caught out’ by the strong turnout of more than 500 people.
The day after the protest, Collingwood staff received a letter from a centre user, chastising them for their woebegone reaction to the cuts, their acceptance of voluntary redundancies and ‘lack of support for the community…This Centre has 124 years of history behind it…You made one misguided mistake by putting a vote of no confidence in the Committee of Management’, don’t make another. If you have forgotten [sic] how to campaign then come and join those in the community who are doing all they can to save the Centre.’

“We had a very vocal community group who were saying, ‘You bastards, you shouldn’t have accepted the cuts’”, Chris O’Neill said. “As if we had a choice…but they were just really angry. And so they didn’t realise it was the State Government and not the Federal Government, and that we had no choice because the money just wasn’t in the bank. You don’t get to choose to have the cuts or not.”

Within weeks of Minister Tehan’s announcement, the APMG, with Geoff Barbour as Chair, had convened a working group, and the painful process of amalgamation was begun. Urgent measures were required to reduce staff numbers by at least twenty positions across Collingwood and Fitzroy, share programs and services, and dramatically reduce administrative costs. The three centres would become a District, with a single CEO. Existing staff would have to apply for their own jobs, reduce their hours, or lose their position altogether. Helen Barlow, Fitzroy’s podiatrist, remembered this period as being “probably the worst time in my working life”. Maureen Schleiger recalled that, “The staff [at Fitzroy] were really divided about the amalgamation, whether it should happen and what we should do about it”. Internal discord at Fitzroy, which kept rumbling even under new manager, the well-regarded Steve Hyndes, who was also Acting District CEO, was exacerbated by the deep job cuts. “All the staff were bitching and I thought it would have been a good time to get out of here”, said Schleiger. “There were four people going for the one position. At the time I didn’t really care if I got it, but I did. I’m still here 25 years later.” Chris O’Neill found himself named Acting Manager of Collingwood; he spent all his time handing out terminations. “There were people who weren’t permanent employees who I had to give notice to and basically get rid of them. It was awful because they were the gems of the place, like Brett Roberts, our bus driver and handyman. Ripping the heart out of the place, really. We’d spent years building it up.” Kristine Olaris remembers discussions amongst the staff about pooling their wages to help keep jobs: “I don’t know if I would have liked actually handing some of my salary over to someone else, but I liked the idea of it”. Many Carlton staff left, including Eileen Hurley.
Staff from the three centres were also wary of each other, or more accurately, each other’s presumed cultures. Fitzroy was tough, and hard to manage; Carlton, genteel and somewhat remote; Collingwood, sprawling and activist.

The discussion over the staff profile and employment conditions for remaining staff in an amalgamated centre was a difficult one. In a series of meetings, staff decried a lack of consultation, the lack of job descriptions, downgrading of positions, uneven gender balance on interview panels, retrospective notification of critical decisions, and APMG’s failure to adhere to the procedure required by the Industrial Relations Act. The Victorian Trades Hall Council advised staff not to sign new employment agreements, or to apply for new positions, or accept any further voluntary redundancies. In July, the Australian Nursing Federation launched an industrial dispute claim against Carlton, Collingwood, Fitzroy and the health department over ‘non-consultation’; Steve Hyndes resigned as Acting District CEO the same day.

Shortly after, at Collingwood, the former Easey Street venue was occupied, ostensibly in protest at the cuts to the centre. Occupations were a form of protest unique to the Kennett government era. The forced closures of Northland Secondary College in East Preston, Richmond Secondary College, and Fitzroy Secondary College in 1992 had all resulted in occupations of school buildings by protestors. (Over three hundred schools were closed across the state.) The imperviousness of the state government to local concerns generated the conditions for the occupations. Rena Pritchard, who went from Fitzroy Community Health Centre to join the occupation at Fitzroy Secondary College, explained that, “the difference between the Labor government and Liberal was that once Kennett got in you couldn’t lobby anyone. With the school [closures] there was no-one to talk to”.

The occupation of Northland, where the highest numbers of indigenous students in the state were educated in a model backed by the Equal Opportunity Board, Supreme Court, and the Royal Commission into Aboriginal Deaths in Custody, was notable for the leadership of Gary Foley. The school was reopened eventually after the Full Bench of the Supreme Court ruled the closure was discriminatory. The two and a half year court battle cost the government more than $3 million. Premier Kennett later amended the Victorian Constitution so that the Supreme Court could not rule on the closure of schools in the future. The Richmond Secondary College occupation was joined by Steve Jolly of the International Socialists (later a Yarra councillor) and was intended not just to oppose the school’s closure, but to model an alternative use for it:
“I ran an illegal school with unemployed teachers. We kept the place open for community members, we turned the place over into a community space. I guess it was an example of how better a socialist society could operate whereby we use community facilities, not just from 9 in the morning to 5 in the afternoon, but 24/7. Homeless kids were hanging out there and accessing normal society. We had unemployed teachers, who would otherwise have been home watching TV, teaching. We had kids who had nowhere else to go actually getting an education. It became a centre for protest. It was a cultural space as well for artists and so on and so forth. It was a magnificent centre and that’s why we were so popular.”

The precise chain of events that led to the occupation of Easey Street, which had become home to the Dental Service, established after fifteen years of lobbying, is unclear, though Steve Jolly recalls giving some general advice about what to do after climbing in through the window:

“…[It was just] the basic advice that an occupation is quite a radical thing, but most people are quite conservative and don’t like change. And while there will be a lot of latent sympathy for you to keep the Community Health Centre open, unless you win over the community and maintain the trust of the community, and if it turns into a ‘scene’ rather than a political action to defend a Community Health Centre that’s vital to the needs of the people of Collingwood and that part of Melbourne, then you’ll lose the battle. So the first thing is to keep the place spotless, no drugs, no alcohol. You’re running it just as much as if the CEO is running it in a normal Community Health Centre.”

It was good advice, poorly followed. “[The occupiers] had no understanding of what the issues were about …”, Chris O’Neill said:

“We had a dental service that was federally funded and they trashed the dental surgery: all the drills went missing. $80,000 worth of dental equipment went to Cash Converters… It went on forever. We had the cops there half a dozen times…There was no way you could go into that part of that building and not be beaten over the head with a bit of four-by-two if they didn’t want you to be there. I went to a meeting out there one time, saying, ‘Can’t we at least open the dental clinic? Can’t we do something here?’ And there were people who thrived on it, they were important; they were on [radio] 3CR every day. They didn’t want it to end.

The government didn’t want to know. The local cops were quite good. But I’d get phone calls from a distraught mother in Clayton who thought
her 13-year-old girl was living in our building. What could I say? What if something happened to her? Was I responsible?”

Dental funding initially had been halved by the state government, but after ‘strenuous representation’ from the Amalgamation committee, funding had been restored to its original level; the occupation had played no part at all in the success, but had instead acquired another purpose: the occupiers were refusing to leave because they were otherwise homeless.

Chris O’Neill recalls: “The local Ministry of Housing office manager took pity on us and said, ‘[The occupiers] are basically saying to us they’ve got nowhere else to go, you’re actually committing a crime by making them homeless and chucking them out.’ They really had run out of any other arguments at that stage, so he offered them a flat. It was Edith Morgan...who finally negotiated the last squatters out of the building...They said, ‘Thank you very much for the flat, we’ll return the keys to the building’. And while they were saying that to us they left a window open and some more squatters climbed back into the building and reoccupied it. Oh dear, it went on and on.”

It is not an exaggeration to suggest the three health centres could have gone under at this time. They might have just collapsed into irrelevance as they lost their community base, or been taken over by larger hospitals. It had been less than ten years since Fitzroy had been part of St. Vincent’s and Depaul, and there were anxieties this could happen again. But it didn’t, and renewal was soon to come.

The occupation lasted nearly nine months, but during this time the amalgamation process was completed and the Carlton Collingwood Fitzroy District Health Service (‘CCFDHS’) was constituted legally on 7 September, 1993. This was the turning point.

Minister Tehan appointed an Interim Committee: Edith Morgan and Michael Coyne represented Collingwood, David Sharpe and Sim Beow Lim Carlton, Geoff Barbour and Brian Stagoll, Fitzroy. The three councils each nominated an additional representative to the Committee. Financial circumstances remained straitened and the task of integrating the three centres, on both the organisational and human level, was enormous; the Interim Committee resolved to meet every two weeks. At the end of October, Bryan Sheridan was appointed CEO, with Jim Killeen brought in from Fitzroy to be Program Coordinator.

These new positions were a response to the exigencies of the new arrangements, but were also, in many ways, a resolution to the long-running
debate about the ‘best’ way to structure a service. The Program Manager created a rung, for the first time, between the staff and CEO separating the delivery of services from their management. It was effectively the end of the flat structure. Chris O’Neill was in support of the more hierarchical set-up. “A lot of the collectivism of the ’60s and ’70s was wasteful, it wasted people’s energy, things didn’t get done, people weren’t interested in results, and too much time was spent talking.” For Sally Mitchell, who had left her community development position in Fitzroy in 1989, only to later return as Manager of Community Programs, there were losses too. “When we had a flat structure and more flexibility, people on the ground could be looking at some of the wider issues. Whereas when workers are tied to service delivery, managers are the ones participating at that level…Sometimes I think we lose something when workers can’t contribute to those broader issues.”

In 1994, the Fitzroy, Collingwood and the North Carlton part of Melbourne Council amalgamated to form the City of Yarra. The amalgamation of local councils was another key Kennett initiative—210 Victorian councils were reduced to just 78, with 11,000 local government jobs lost. Elected councillors were replaced controversially, in a transitional arrangement, with appointed commissioners—Frankie Thompson, former member of Collingwood’s Committee of Management during Jim Goode’s tenure, was one of three commissioners appointed to Yarra.

The Commissioners’ decision to close down the Fitzroy Pool, as an apparently economically unviable service, sparked a large and brilliantly organised community protest reminiscent of the freeway campaign. It woke up a dispirited community that remembered it had a long history of effective action. The community joined together like it had in freeway protests. This time the difference was that it won. The swimming pool was reopened, bigger and better. The community became confident again and the confidence spread, firing up other actions such as the two year occupation of Fitzroy Secondary College, again ultimately successful.

But while the CCFDHS staff and clients took their part in the protests, it was clear that one of the consequences of the amalgamation—or more precisely, of the loss of staff, the imposition of targets and the subsequent time pressures—was, as Sally Mitchell put it, that “there are less opportunities for some of the more political things because there’s less flexibility. Individual workers have targets they need to meet with client contacts and other things…they are less inclined to take risks because they need to meet their targets.” New corporate funding agreements did not allow for much of the parallel or intangible activity that had always been part of the work of community health—BUGA UP, the Doctor’s Reform
Society, Austin Paterson’s protests on the steps of the welfare office. Staff remained committed and engaged, but focused necessarily on targets. Soon, the CCFDHS decided to incorporate the name of the new municipality into its own. After much discussion, consideration of alternatives that included the word ‘Singleton’s’, and a protracted and often absurd process to gain departmental approval, the name North Yarra Community Health was agreed upon, and a logo selected after a community competition. Committee and staff focused on maintaining the quality of services, even if their quantity was reduced. Collingwood leased out space in its building to services such as the AIDS Housing Action Group, a women’s prison services group, and a welfare rights advocacy group; these were complementary services that helped fulfil the broader community health remit, as well as offsetting the costs of managing the building. Slowly, staff, management and supporters began to appreciate the advantages of the amalgamated service, especially as other services in the area steadily folded. “I think it was better”, Anne Horrigan-Dixon said of the amalgamation. “Some really good people from Collingwood became involved. The influence of someone like Chris O’Neill was substantial. People with like minds could link up and services could be expanded and diversified. [There was] more synergy between workers.” The dust, gradually, began to settle; community health was, after all, nothing if not adaptable.

In time, NYCH found itself in a position to take advantage of new state and federal funding models. Bruce Hurley had moved into the Victorian Hospital Association as its first community health project officer:

> “Certainly just prior to the Kennett government coming in they had community health in their sights. And there was talk they might have been wiped out completely by Kennett... there was a constant danger of it happening in the first six months or so, but through negotiations we survived that period. And then when the Kennett government approached in terms of bidding and outsourcing, community health came to be successful in attracting money...we went about our business with our heads down using the same philosophy and principles.”

While core operational funding had contracted heavily, the proportion of money available for program delivery actually increased under the Kennett government. The health department was outsourcing its functions and programs, in keeping with the overall private enterprise model, and community health—well established, with significant expertise—was well- placed to win grants to provide services. “The logic of having a community-based platform to deliver community services was undeniable”, said Chris O’Neill. It had the supreme advantage of the proven ability to
provide quality services at a relatively low cost; community health was, as it transpired, competitive. “It wasn’t that the Community Health program expanded,” Hurley said, “but the funding for Community Health Centres as agencies—the funding they managed—increased quite significantly during the Kennett era.” Commonwealth funding became available for adult dental, psychiatric and pharmacy services. Medicare-funded services looked set to expand. Funding for Needle Syringe Programs re-emerged, as a street trade for heroin very publicly established itself in Smith Street.

Homelessness was newly identified as a priority issue by Marie Tehan’s successor, Rob Knowles. An ongoing process of the de-institutionalisation of people with physical and mental disability had accelerated under the Kennett government, and statewide housing and support services struggled to cope with the increased volume and complexity of the client load. Theresa Swanborough recalled that when she began at the Homeless Persons Program (HPP), “it was frail aged alcoholics, although they were frail by the age of 45, but increasingly we saw women, people with intellectual disability and mental illness…there were more complex ethical issues confronting workers at the coalface.” HPP received government support to expand. “It started out as one nurse, me, working twenty-four hours a week to three nurses working out of NYCH. It’s a great example of how community health can meet the needs of homeless people…” HPP continues to provide services in close partnership with NYCH. The downside to the competitiveness of NYCH was that it did indeed have to compete where it might ideally be co-operating. Services were obliged to tender for contracts to deliver programs, demonstrating their ability to deliver a better product for a lower cost than their neighbour. From a government perspective, this jostling between services improved the market; NYCH soon adopted its own approach, preferring instead to consult with neighbouring services prior to tendering. (This kind of consultation within a catchment was, in fact, very close to the Health Liaison Committee proposed originally by Sidney Sax.) Community development programs also became harder to fund, resisting, as they had always done, quantitative or short-term measurements. The patience and imagination key to community health’s long history of success in this area was in short supply at government level.

NYCH steadily regained its fiscal footing, elected a new Board of Management, reaffirmed its mission (which continued to include Fitzroy’s View of Health, introduced by Terri Jackson), and began looking ahead. One of the most important things NYCH did at this time was to look carefully at its single most sustaining relationship—that of the service to the community.

Government policy had obliged that NYCH prioritise clinical services over ‘soft’ programs such as community participation, community liaison and
community development. Most job losses were from these areas—workers who had previously nurtured relationships with various community groups had disappeared, and the ties they had forged were weakened, or broken altogether. The community that NYCH served also required redefinition. The amalgamation had brought together three centres, each with their own history and character, from three proximate but distinct communities; the creation of the City of Yarra had also brought thousands of new people into NYCH’s catchment. For all that the principle of community representation had always added ‘mess’ and a degree of chaos to the practice of community health, it was an abiding and necessary principle after all. NYCH perceived that it was, perhaps for the first time in the cumulative history of the three centres, uncommonly isolated, alienated from the community. “Morale was terrible”, Brian Stagoll recalls. “People were very suspicious of the other Community Health Centres, and we had no community voice at all. We had to find a way of overcoming this.”

In response to these concerns, in August 1994, the Community Liaison Committee (CLC) was born. Members of the public and long term groups still coming to each centre were invited to participate in monthly meetings, where speakers presented topics of interest, opinions were gathered, and crucial links were re-forged, or forged anew, between NYCH and the community. Board members Edith Morgan (OAM 1989) and David Sharpe, both now deceased, were vital in this process with their connections and the deep respect they had built up over many years. A typical meeting brought members of the Over 60s Group, Fitzroy Indo-Chinese Group, North Carlton Italian Group, Yugoslav-Australian Pensioners Group, Vietnamese Elderly Group, Spanish and Greek Women’s Groups and the Fitzroy Ethnic Communities Council together with representatives from the City Of Yarra, Neighbourhood Houses, and NYCH Board and staff. A presentation on council policy might be made; Clinic Nurse Chris Hardy gave a demonstration of resuscitation techniques. A battery of translators was provided, as was transport to those who needed it and a post-meeting afternoon tea, with food provided by the various groups.

Vera Boston was appointed NYCH CEO in 1996. She was a strong advocate of community participation. The following year, the CLC was further strengthened when participating groups were asked to nominate representatives to a formal sub-committee, whose task would be to provide more direct and detailed input into NYCH governance. By this time, attendance at the CLC meetings had swelled to sometimes more than 150 people.

Fundamental to the ongoing success of the CLC was Bich Ha. Ha began working at Collingwood Community Health Centre in 1984.

The Community Liaison Committee receives an award from Health Minister, Daniel Andrews. Bich Ha is in the centre. C 2009.
“I applied as reception staff. It was just three months after I came from Vietnam. At the start people were still very discriminatory. I had clients who told me to go back to China, and I was in tears. But the staff were really supportive. The thing I remember most about that time was the three doctors. They were all tall. They all had beards. And I had no idea whose name was what. It was Peter Sago, Nick Crofts, Chris O’Neill, but I could never distinguish who was who at first. Now I think Chris is an inspiration for many people. He looked after my family, my kids. I studied Welfare at the Philip Institute of Technology. The Centre paid for my study leave and gave me time to study. Then I became the reception co-ordinator.

After amalgamation the board members from the three sites were very committed and they decided to build up a new position of Community Liaison Coordinator. At that time I’d just finished my Masters in Social Sciences, and I got the job.

At the beginning, it was more about getting people to know and connect with each other. It was very hard and it took a lot of time. At first we just got them talking with each other…”

Ha is now the site manager of the Carlton Centre and NYCH Manager of Community Building and Health Promotion. In 2012 she was made Yarra Woman of the Year. The Community Liaison Committee continues to meet seventeen years later, with Brian Stagoll still as Chair. At the beginning of every meeting, each group present is introduced, their introduction is translated into multiple languages, and they are welcomed with a burst of enthusiastic applause. “And then you keep adding bits on it”, Stagoll said. “You have some speakers. You tell the speakers to be slow. You encourage people to ask questions through their interpreters. You say ‘could you all discuss the question and give your response to the interpreter?’ And you create some sort of order out of the chaos.”
The story in this book stops around twenty years ago, but of course it has never ended. In time, NYCH emerged from the amalgamation and cut backs in a stronger form. Today Community Health is flourishing in Yarra. Vera Boston joined as CEO in 1996, and Geoff Barbour continued on as President for many years, going on to become Mayor of Yarra. They shepherded in an era of relative calm and steady growth after all the turbulent years. NYCH now has over 100 staff across four locations. Its budget has grown every year as NYCH has creatively extended its range of funding sources. In 2011 this was around $10 million. Over 100,000 individual services are delivered every year, or 350 services every day. Clients come from eighty separate countries, with 54 per cent Australian born. NYCH has the largest medical practice of any Victorian CHC, which liaises closely with its unique Pharmacy/Dispensary. The result is a model for prescribing medications according to best practice guidelines at costs significantly lower than private pharmacies (Roughead, 2011).

In addition, there is a wide range of groups and health promotion programs. All of these can be viewed on the NYCH website at www.nych.org.au. NYCH has received numerous awards and wide recognition. The Community Liaison Committee, now renamed CLAP (Community Liaison and Participation) has been honoured by Multicultural Victoria on several occasions. The Café Meals Program provides a membership card for homeless people to purchase cheap meals at local cafes. It has been adopted widely elsewhere and won a Public Health Award (2004). The Yarra Bike Fleet, a program which provides bicycles for use by public housing residents, has also been recognised through an award in 2009 as has the Billabong BBQ, a multi-agency and multidisciplinary program which brings services to a park in Collingwood where a large group of homeless and high need Aboriginal people gather. It has been going ten years, and is an outstanding achievement in reaching a group who tends to not access health services. And, in 2002, NYCH sponsored Dr. Tim Lightfoot to set up the first asylum seeker specialist medical clinic in Victoria.

In 1996, NYCH established the Yarra Drug and Health Forum, which continues to be an influential network and advocate on drug issues and drug law reform. In 2002, a primary health care service facility was opened for people who inject drugs. This service has since been co-located with the existing Needle and Syringe Program in a spacious old factory in...
Johnson Street named ‘Inner Space’. This provides a range of health and harm-reduction services, in an integrated, non-judgemental and accessible way to some of the most marginalised in society. It is a magnet for those who otherwise shun health services. Inner Space is regarded widely as on the leading edge of practice nationally and internationally.

These are just some of the innovative and inventive programs NYCH has developed in recent years. There are many more. Behind this activity has been a renewed focus on governance and partnership. Formal systems of quality assurance, functional information management, and fiscal controls are embedded. The Committee of Management has evolved into the Board of Directors of a Public Company and draws on the range of expertise available from the many professionals who have come to live in the city of Yarra in recent years.

Strong partnerships with other organisations and services continue to be a feature of NYCH. Stakeholder surveys of agencies and services in Yarra indicate a very high level of trust and sense of collaboration with NYCH. This is of the utmost importance. For effective community health is more than a simple summation of individual and technological interventions. Its power resides in linking different sectors and disciplines, in taking the social determinants of health seriously, and including the community in shared decision making. These strong traditions at NYCH are now recognised formally and monitored continuously in its strategic plans.

But the battle of taking on the social determinants never goes away. These have been called ‘the causes of the causes’, the social, environmental, economic and political forces that underpin health. They resist change. As we noted in our introduction, Dr. Singleton would still recognise many of the problems of his day. Our health systems still barely make a dent on health inequalities. Indeed, they may sometimes amplify them by favouring the better off. This is painfully obvious in inner city Melbourne where a newer class of wealthy professional lives beside the pockets of disadvantage that haunt the city.

But NYCH has never accepted that inequality is inevitable. The challenge has always been to match the changing needs of the community with whatever resources can be found, while never losing sight of the wider social determinants. We hope this history shows how NYCH has gone about this in such vital areas as the empowerment of women, the development of trust and cooperation in the community, the reduction of barriers to care that result from social marginalisation, and advocacy for health promotion legislation.
We would like to think the political commitment, passion and persistence will go on. The staff of NYCH remain as fired up as Dr. Singleton ever was. The Directors offer their skills, expertise and, above all, a spirited engagement in directing NYCH. Most importantly, the clients express a continual confidence and concern for NYCH, based on their sense of ownership and belonging. ‘I Own a Health Centre’ has real meaning here. This history is a record and a celebration of all of this. Long may it endure.

We would like to thank everyone who has helped us write this history; the Directors of NYCH for their patience and encouragement, the staff of NYCH, present and past, for their commitment and sense of duty, all those who agreed to interviews, our author, Hamish Townsend, and Liz Sheean and her team at PsychOz Publications for their publishing knowledge and skill.

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Fitzroy Centre.
75 Brunswick Street, Fitzroy 3065.
Inner Space.
4 Johnston Street, Collingwood 3066.

Collingwood Centre.
365 Hoddle Street, Collingwood 3066.


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Interviewees

Helen Barlow
Ruth Borenstein
Philip Bull
Moss Cass
Jack Charles
Nick Crofts
Sister Maria Cunningham
Doug Everingham
Jim Goode
Bich Ha
Chris Hardy
Caroline Hogg
Anne Horrigan-Dixon
Alison Hughes
Bruce Hurley
Eileen Hurley
Terri Jackson
Steve Jolly
Jim Killeen
Sally Mitchell
Bill Newton
Marion Oke
Kris Olaris
Cas O’Neill
Chris O’Neill
Austin Paterson
Rena Pritchard
Barry Pullen
Tom Roper
Peter Sago
Joseph Santamaria
Natalie Savin
Maureen Schleiger
Solange Shapiro
Brian Stagoll
Theresa Swanborough
Doug Thompson
Frankie Thompson
Yvonne Turner
Robert Watts
Peter Whyte
Jenny Wills
Maria Wright
Richard Wynne
Missionaries, Radicals, Feminists is the story of North Yarra Community Health (NYCH). Established by John Singleton in 1869 in gold rush Melbourne and based on British models, the Collingwood Free Medical Mission Dispensary was among the first of its kind in Australia.

It drew on 'a social model of health' and a focus on 'social determinants of health'. The mission provided medical and social services over the next 140 years alongside radical political action and advocacy against poverty, homelessness, discrimination, and substance abuse.

Singleton's was the first place in Australia to employ women doctors and was associated with many other reforms in health care, especially after it evolved into Collingwood Community Health Centre in the 1970s. These included campaigns around lead in petrol, cigarette advertising, free needle exchanges, welfare rights, and work injuries.

Later amalgamations with Carlton and Fitzroy Community Health Centres created today’s North Yarra Community Health.

The book reflects the traditions, triumphs and struggles of a Community Health Centre in providing quality clinical services, while building community trust and participation, enabling the empowerment of women, reducing barriers to care caused by social marginalisation, and advocating for prevention and health promotion legislation.

Historian Charles Rosenberg has argued that the history of the Dispensary Movement and its successors has been neglected but can provide 'would-be reformers with a useable past'. This history aims to redress that neglect by telling for the first time a fascinating story of what became of Dr. Singleton's mission, and its lessons for future health policy.