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SUMMARY

The way health services are paid for has a direct impact on access, on equity, however defined, on efficiency and on the shape of a health care delivery system and the kinds of services that it produces. Private financing favours those who are well placed in society, whereas public financing breaks down the financial barriers to access experienced by the poor and low and middle income earners. These considerations are of utmost importance to women because, overall, women earn lower incomes and are thus more likely to experience serious access difficulties. Women also experience more violence, more ill health, including more mental ill health, they use a greater number of services and they access services on behalf of others. The principle, widely accepted in most OECD countries, of access according to ability to pay is fundamentally important because of women's lower income status and higher service use.

Access issues, however, are broader than financial impediments to service use. They include the lack of a comprehensive range of services, the paucity of services in a great many geographical locations and lack of culturally and gender appropriate services. Financing methods have a direct impact on the shape and operation of health care delivery systems. Private financing favours the production of curative, treatment services and entrepreneurial medicine. Access to a full range of services, including preventive, supportive and information services is vitally important to health. Women's health groups have produced a trenchant critique of systems that focus heavily and narrowly on curative medical care. Public financing is the lever that the community, through elected representatives, can use to shape the health care delivery system to achieve population health outcomes. Publicly financed systems have the potential to achieve the comprehensive range of health focused services that women's health groups and primary health care reformers have been advocating for decades.

Traditionally, Australian 'health' policy debates have diverted attention from the issue of health itself. The question of public versus private financing has been largely settled

elsewhere in the OECD, allowing discussions to begin about the changes that might improve population health at an affordable price. Suggested reforms include increased spending on preventive and primary care services, especially for the most disadvantaged groups, proposals to reorganise health care delivery systems and the way doctors are paid to facilitate a change of focus towards prevention, information and support and increased public control over innovations and new technologies.

Following the World Health Organisation, the Australian Women's Health Network (AWHN) subscribes to a social view of health, which acknowledges that health is affected by wide range of social, economic and political factors, not just access to curative health services. In this view, health is the state of complete physical, mental, emotional, economic and social well-being, and not merely the absence of disease or infirmity. Consequently, good health depends upon access to secure income, adequate, affordable housing, education, physical and mental safety, as well as to a full range of public services, including health services.

As well as a mainstream system focusing on health for the benefit of men, women and children, special projects and programmes tailored to the particular needs of particular groups are required. For example, strong Commonwealth policy on women's health is necessary to ensure funding and commitment for broad-based women's health policies, strategies and programs in all States and Territories. Australian experience under the first National Women's Health Policy and Program (1989-1997) shows that Commonwealth leadership provided an overarching paradigm, which supported the work of activists and policymakers at the State and Territory levels to develop innovative and cost-effective policies, which were extremely popular with consumers (Broom 1996). AWHN looks forward to the development of a new national policy on women's health, as promised by the Rudd government.

Apart from women, groups with special needs include Aboriginal people, men, people with disabilities, people from non-English-speaking backgrounds, newly-arrived people, people living in rural and remote localities, prisoners, older people and people in aged care facilities. Men’s health, like that of women, is seriously affected by gender. The majority of older people and people in institutions for the aged are women. There is a large difference, for example, between the economic, social, health and educational needs of Aboriginal Australians and non Aboriginal Australians. The failure to effectively address issues such as racism, economic insecurity and education needs, as well as the failure to address violence, maternity and birthing issues, reproductive health and contraception issues and chronic illness is the major cause of the differences in health outcomes between Aboriginal and non Aboriginal Australians.

1. HEALTH SYSTEM FINANCING.

Financing issues, rather than health issues, have been the focus of Australian health policy in recent decades. In this sense, the term 'health' policy is a misnomer because policy making is almost completely concerned with ways of paying for hospital and medical services. The Australian focus on financing, however, has had a distinctive, if not unique, character. Whereas other OECD countries have largely concentrated on controlling super inflationary cost increases, the central issue in Australia has been whether financing should be predominantly public or predominantly private. The struggle on this point bears witness to the enduring, diametrically opposed interests that populate the health field.

The method of financing that a nation chooses for its health system determines the rewards that accrue to different groups. Contrary to classical liberal and neoliberal political theory, citizens do not find themselves living on level playing fields. Rather, as feminists have pointed out repeatedly, people are placed in very different positions in society and experience very different life chances (Tapper 1986:37-47). Public policies, therefore, impinge differently on different groups of citizens, depending on income, race, sex, culture and so on. Three of the most important factors influencing position and life chances are sex, race and socioeconomic status. The way health services are financed impacts on women differently from men and affects low income earners differently from those on high incomes. Financing methods shape access patterns: a publicly financed system has the capacity to deliver services with no cost at the point of service, whereas private financing almost always involves substantial user charges, sometimes called copayments or cost sharing. User charges collected at the point of service impede access and impact most heavily on the poor and on high users of services, both groups in which women and Aboriginal people are over represented.

The current Australian system runs counter, in several ways, to international evidence about the best ways of providing accessible services at an affordable price. It also operates contrary to evidence about the value of systems with strong primary health care services and is structured in such a way as to create obstacles to the development

of a real health focus. It is two tiered, creating serious access and equity problems and prone to excess and unnecessary health inflation.

1.1. A NOTE ON THE WORD "HEALTH".

The term, "health policy", is widely used in OECD countries to describe arrangements that focus predominantly on hospital and medical services. However, these services are not really health services at all. Instead, they are primarily sickness services, used, almost exclusively, *after* people become ill. While they are very important, health experts, especially women's health groups, argue they are not the only services that a system should provide. In Australia, as in many comparable countries, very little money is spent on preventive services, health promotion or on public health. As the Australian Institute of Health and Welfare (AIHW) pointed out in 2002, public health spending is very low in Australia, comprising less than 2 per cent of the health budget. However, public health spending is a good investment because "there is a double pay off -- people enjoy better health..... and the spending actually leads to reduced need in the future for the more costly treatment services" (AIHW 2002). The women's health movement in Australia, along with community health and public health advocacy groups, has been highly critical of the overemphasis on curative medicine and has argued for delivery system reorientation to provide comprehensive and diverse prevention and wellness focused services.

1.2. HEALTH FINANCING AND PROVIDER INTERESTS.

The principal reason that OECD governments intervened strongly in health financing after World War II was to remove financial barriers to access. However, hospital and medical costs became an area of hyperinflation, primarily because technologies advanced rapidly. Cost control soon became a major objective. Effective containment mechanisms were gradually developed but they met with strong provider opposition. Providers called for increased private funding to offset government reluctance to provide the "necessary" money, calls that were reinforced by the economic problems of the 1970s and the rise of neoliberalism. As Canadian health economist, Professor R.G. Evans, points out, in health, "all expenditure is, by accounting definition, income for someone - cost control is income control" (Evans 2002: vi). However, the reintroduction of private funding reintroduces the very

market forces that government intervention was intended to supplant. Access and equity objectives are rapidly undermined. It should be said here that all OECD health systems have some level of private financing, including user charges, particularly for services other than hospital and medical care, but Australian user charges are among the highest (OECD 2004).

1.3. THE IMPACT OF FINANCING SYSTEMS ON ACCESS.

The dilemma facing all OECD countries, given the proclivity of health care costs to rise faster than GDP, is how to provide access to a comprehensive range of health services at a sustainable price. The response to increasing costs in some countries is to increase user charges, as a means of both gaining revenue and dampening demand. A major problem with such a strategy, as international research clearly shows, is that user charges prevent people from accessing services, leading to more ill health and associated cost increases. Such a situation complies with the “inverse care law”, which identifies health services produced in this way as being available in inverse proportion to the need for them.

1.4. USER CHARGES AT THE POINT OF SERVICE

In publicly financed systems, hospital and medical costs can be completely prepaid from taxation, as in Canada, if that is the public policy goal. In privately financed or mixed systems, costs can also be fully prepaid, usually through private insurance, but the result is a high cost system with prohibitively expensive premiums because neither consumers not providers have any incentives to economise. Direct charges, levied at the point of service, are often invoked, therefore, as a cost control measure. The serious problem is that they fall most heavily on low income earners. And because low socio-economic status is associated with poorer health, the people most likely to have difficulty paying charges are also likely to be the sickest (Richardson 1991; Newhouse 1993; Evans, Stoddart, Barer and Bhatia 1994; Rice and Morrison 1994; Gray 1998; Gray 2004). As Evans (2002:39) argues, user charges "selectively deter access by those with lower incomes, thereby improving access for those with greater ability to pay".

User charges are high and rising in Australia. Real growth in expenditure from individual pockets between 1995–96 and 2005–06 was 6.0% per year, 0.9 percentage points above the real growth in total health expenditure (Australian Institute of Health and Welfare (AIHW) 2007: 36). Studies show that citizens are going without services because of cost, a very worrying finding in a system where the financial barriers to access are supposed to have been eliminated.

Increasing user charges in the last decade had a serious impact on access (Gray 2004: 65-77). For example, a 2002 study showed that 20 per cent of people thought the overall cost of medical care, including services to cope with chronic illness, was a major burden. 16 per cent did not seek services when they needed them, 23 per cent did not fill a prescription, 16 per cent did not get a test, treatment or follow up and 44 per cent did not get dental care because of cost. In relation to specialist care, 41 per cent of Australians experienced obstacles to access, 17 per cent reporting that they could not afford to pay. (Blendon et al 2003). Studies in New South Wales show that private patients were using the vast bulk of non-emergency, elective surgery in 2003 (Tridgell 2003), suggesting that those without private insurance were facing access barriers to these treatments.

Comparative research undertaken by United States researchers in 2007 suggests a slight improvement in access but shows that serious access barriers remain. In the year prior to the study, user charges caused 13 per cent of Australians to refrain from visiting a doctor when they were sick. Because of cost, 17 per cent of people skipped medical tests, treatments and follow-ups that had been recommended by their doctors. In addition, 13 per cent of Australians did not get their prescriptions filled or skipped doses in order to make their medications last longer. Questions about access to dental care were not asked in the latest survey but the situation can only have deteriorated since there was no improvement in the supply of public dental services during the period.

United States experience suggests that Australia's steady and continuing increases in user charges should be viewed with alarm. In that country, where user charges are considerably higher, 37 percent of adults surveyed in 2006 skipped medications, did not see a doctor when sick or did not obtain recommended care because of the cost.

42 percent of those with chronic conditions had not sought the care they needed. In contrast, according to the same survey, few people in Canada, the Netherlands or the United Kingdom reported making do without care because they could not afford the payment they would be required to make (Schoen et al 2007: W721).

There is an urgent need to address the problems created by the erosion of universal access to mainstream services in the Australian health system. AWHN supports a health system paid for through taxation and opposes the transfer of public money to support private health insurance and privileged access for those who can afford private insurance. Unimpeded access requires publicly funded, high-quality services.

1.4 THE IMPACT OF FINANCING ON GEOGRAPHICAL ACCESS

Public financing is fundamental to the removal of the geographical maldistribution of services between metropolitan and rural, regional and remote Australia (Lokuge, Denniss and Faunce 2005). The more private the funding of a health system, the greater the disparities in the availability of services between regions are likely to be. Where practitioners are free to set up services where they choose, experience shows that there will be a concentration of services in the most desirable areas of large cities, with a commensurate scarcity of services in regional, rural and remote areas. Australian Commonwealth governments have attempted to address these problems with special schemes, such as rural general practitioner training places, retention payments, rural medical scholarships and higher Medicare rebates for non-urban areas. However, in the context of entrepreneurialism and entrenched private practice, a maldistribution of services persists, along with high levels of user charges and lower rates of bulk billing outside cities. Only a concerted government effort, backed by strong political will, and in the context of a publicly funded system, can begin to address issues of geographical access in Australia. A planned, publicly administered, delivery system, focusing on strong primary care, could, over time, ensure a more more rational and equitable distribution of services and resources.

1.5. THE RELATIONSHIP BETWEEN FINANCING ON NOTIONS OF EQUITY

Financing methods have enormous implications for equity, whatever view of fairness and the good society is taken. Perspectives on what constitutes equity in health differ but there are two main approaches. On the one hand, there are those who favour

universal access to services and tax funding because it is linked proportionately to income. This we can call the social democratic or social liberal perspective (Sawer 2003). The community, through its government, provides a set of services for itself which would otherwise be accessible only to the well off. On the other hand, there are those who believe that choice and economic freedom are paramount goals: people who can afford it, should be able to spend their money as they please on the services of their choice. To the extent that tax funding is acceptable, in this view, it should be restricted to the very poor. The well off in society should not be expected to contribute towards health care for their less well off fellows, except for those on the very lowest rung of the socio-economic ladder. Private financing rather than tax funding is preferred. Low and even moderate income people either save hard or go without services.

A widely accepted principle in OECD countries is that contribution to health financing should be based on ability to pay. This is the same principle that underpins the Australian and most other income tax systems. If this definition is accepted, public financing is equitable because it is levied according to capacity to pay and private financing is inequitable because it is calculated at a flat rate, rather than as a proportion of income. Since women earn less than men, even if they work full-time, tax financing is clearly more equitable if a nonmarket view is accepted.

Most Australians agree with the social democratic or social liberal perspective. Medicare was supported by 93% of people in 1996-97 (HIC 1996-97: 42). A market research report, undertaken for HIC in 1998, found that the two strongest reasons for supporting Medicare were that "everybody is covered by it" and that it "helps low income earners". The report argued that

> support for Medicare was driven by an overriding sense of the equality it delivers. It ensures that everybody gets the same minimum level of access to health care and because it invokes a sense of security of assured treatment for those who cannot afford alternative sources of health care (sic) (Frank Small and Associates 1998: 30-31)

Further evidence of support is that most Australians wanted the 2004 budget tax cuts to be redirected to health and education, the two top policy areas in the 2004 election (Gray 2004:12; 73-6).

Public financing is fairer because it is drawn from taxation, which is generally levied according to income. Private financing, on the other hand, is not related to income: user charges and private insurance premiums are levied at a flat rate. Any shift, therefore, from public to private financing involves a reduced contribution from the well off and a higher contribution from those further down the income scale.

As Canadians, Roos and Frohlich, have put it:

> The more private funding we have, the more those with high incomes can assure themselves of first class care without having to pay taxes to help support a similar standard of care for everyone else (quoted in Evans 2002: 42).

The Australian equity situation is exacerbated by the 30 per cent rebate through which public money is expressly directed towards better off members of society. A related issue is queue jumping. Those with private insurance are able to avoid the queues of people waiting for elective surgery in the public hospital system and they are subsidised by taxpayers to do so. Thus, the public subsidisation of private health insurance runs counter to the equity concerns of the majority of Australians.

AWHN recommends that the 30 per cent private health insurance rebate be redirected towards the provision of publicly provided health services and towards the reorientation of the health system to the provision of prevention, information, support and caring services.

1.6. FINANCING AND EFFICIENCY: THE ADVANTAGES OF SINGLE PAYER SYSTEMS.

Financing methods impact heavily on efficiency. International evidence demonstrates that tax based funding, through so-called "single payer" systems, provides levers with which governments can monitor and control expenditures (Evans 2000). In contrast, in privately funded or mixed financing systems, so-called "multi-payer systems", an array of institutions and individuals pay for

services through multiple channels. The potential for coordination and oversight is weak. No single agency has the capacity to steer the system or to control total expenditure. Publicly financed systems are thus cheaper for the community as a whole (Hussey and Anderson 2003).

Women and other groups with lower socioeconomic status have an interest in efficiency and cost control as citizens and taxpayers but, more importantly, inefficiency resulting in health inflation translates into cost pressures and pressures on access. It follows from this evidence that a sustainable long-term national health strategy must move towards a single payer system, one not heavily reliant on funds raised by private insurance agencies and/or user charges.

2. REORIENTING THE HEALTH-CARE DELIVERY SYSTEM TOWARDS PREVENTION.

If control of health care costs were the only consideration, an obvious way of proceeding would be to achieve a healthier population so as to avoid unnecessary use of services, particularly expensive hospital services. New Zealand studies in the late 1990s showed there were thousands of unnecessary, expensive hospital admissions annually. Research also shows that systems with strong primary care have healthier outcomes. Therefore, a long-term health strategy should include a very strong focus on strengthening primary health care, one of the stated policy of the Rudd Commonwealth government. Such a change, however, would require significant structural changes, such as changes in the way the health system is organised and the way doctors are paid and would require committed political will.

Evidence exists that strong primary care systems produce better health outcomes at a lower cost. Starfield and Shi (2002), in a study of 13 industrialised countries, found that "the stronger the primary care, the lower the costs. Countries with very weak primary care infrastructures have poor performance on major aspects of health". They found that good health outcomes were particularly apparent in early life. However, there is overwhelming evidence that even access to good primary health care is a necessary but insufficient condition for good health outcomes. A serious commitment

to reducing health inequalities would have to include action outside what is generally perceived to be "the health sector " to reduce the ill effects of low income, inadequate education, unemployment, poor housing and social isolation, currently considered to be foremost among the social determinants of health.

Thus, although hospital and medical services are crucially important once people become ill, they are not the most important determinant of health (Evans et al 1994). The production of a more comprehensive system of integrated, preventive, caring and support services has been advocated for many years by health experts (Hospitals and Health Services Commission 1973; Starfield and Shi 2002).

2.1. MOVING TO A REAL HEALTH SYSTEM.

Public financing and leadership is essential to any move away from a narrow focus on hospital and medical services towards a system focusing on health. Since the 1960s, women's health groups, population health and community health advocates have urged that delivery systems be reformed to provide a comprehensive range of preventive, educational, rehabilitative and caring services, as well as hospital and medical services. In this perspective, primary health care should be radically strengthened. Multidisciplinary teams of diverse professionals should replace solo and small group medical practice, a system inherited from the cottage industry of the 19th century. Citizens should participate in decision making so that services can be tailored to their needs and the needs of local areas. These ideas were expressed at the Fourth World Congress on Women in Beijing in 1995 and form a central part of the health *Platform for Action* (United Nations 1995).

A large and independent private sector diminishes a nation's chances of moving towards a real health system because, as with costs, no one is in charge of system-wide policy making. In private systems, entrepreneurialism and profit motives are operative dynamics and there are few institutional structures through which change can be effected. System reform, especially in the absence of provider support, requires strong public leadership and responsibility.

While primary health care reform has taken place slowly in most OECD countries, in some nations, methods of paying doctors are under scrutiny, with moves towards the

replacement of fee-for-service with capitation, contract payments and/or salary, in the interests of removing entrepreneurialism from the medical sector (OECD 2003). Primary care reform has been high on the agenda of several countries, including Britain, Canada and New Zealand. Across the Tasman, the fee for service system for paying doctors has been completely replaced by contract payment at the general practitioner level.

2.2. ABORIGINAL HEALTH IN A REAL HEALTH SYSTEM.

As the Rudd Commonwealth government recognises, there are huge gaps between the health outcomes of Aboriginal Australians and non Aboriginal Australians. Any reform strategy, including the promised new National Women's Health Policy and Program should place prime importance on the social determinants for health of this population group. The first National Women's Health Policy did not give a high priority to Aboriginal health issues because a separate Aboriginal Health Strategy was being developed at the same time and it was thought that Aboriginal women's health would be better located there. Unfortunately, the Aboriginal Health Strategy was poorly funded and achieved very little.

In developing new policies and programmes, Aboriginal people should be widely consulted and leadership must come from Aboriginal people themselves. Issues identified as a high priority by the preliminary work done by AWHN's Aboriginal Women's Health Caucus include

- The achievement of access and equity rights in relation to all essential services enjoyed by the wider population, including housing, health, nutritious food and water.
- The implementation of the Cultural Respect Framework in all jurisdictions, which should then be monitored and evaluated. This Framework is a current document developed and endorsed by the Standing Committee for Aboriginal and Torres Strait Islander Health. It has been endorsed by State and Commonwealth Health Ministers.
- Mainstream health system adoption of responsibility for the appropriate funding of services to achieve good health outcomes for Aboriginal people.

- Programs to be put in place to progress agreed Aboriginal health priorities, including reformed birthing services and programs to address substance misuse, early childhood development, early intervention and recall services.
- Adequate and long-term funding should be made available for sustainable capacity building to achieve strong and healthy communities. This program should include specially developed, well funded programs to strengthen individuals, groups, families and communities and to increase the leadership skills of Aboriginal people.
- Data collection about Aboriginal health should be further developed and an ATSI identifier created to monitor health outcomes and access to services.

As well as access to hospital and medical services, and to a comprehensive range of medical and allied health services at the primary care level, Australians need access to dental services, improved aged care services, sexual and reproductive health services, including access to surgical and medical abortion, and access to alternative birthing services, particularly important for Aboriginal women.

2.3. SPECIFIC WOMEN'S HEALTH ISSUES

The Australian Women's Health Network recognises that groups of women in the community have "special needs" in relation to the delivery and administration of health services. In particular, culturally diverse women, including Aboriginal women, have difficulties accessing culturally and gender appropriate services. Refugee women in detention centre settings are particularly affected in this way. Barriers include the predominance of male medical practitioners (often coupled with male dominated telephone interpreter services), lack of toilet facilities, intermittent availability of health services, lack of reproductive health services and a lack of cultural and language appropriate information pamphlets. Health professionals of all kinds need to be trained to be able to work in a culturally competent manner and need to be adequately briefed in regard to religious, ceremonial and cultural matters.

Low levels of participation by non-English-speaking background women and refugee women in women's health programs as service users, health workers and decision makers is a concern. Lesbian health issues are invisible in mainstream services, especially the social and emotional factors that impact upon health. There is a lack of

research with which to inform policy and improved health system responses for lesbian consumers.

Mental health issues are a serious women's health issue. Research conducted in developed and developing countries clearly indicates that rates of common mental disorders, namely depression, anxiety and somatic complaints, are significantly higher among women than men. These complaints affect up to one third of people attending primary care providers. Womens' positions in the paid workforce exposes them to a number of documented risks for poor mental health. These include a higher risk of having insecure, part time or 'casualised' work that is poorly paid and has little decision making authority. Evidence suggests that there are strong associations between gender inequality, rising income inequality, low educational levels and increasing rates of common mental disorders.

Violence against women and children should be recognised as a serious health issue and seen as a crime. Recognition will enable relevant research to be carried out and appropriate programs developed. AWHN endorses the fundamental right of all women and children to be safe.

AWHN believes that all Australian women should have access to safe, legal and affordable abortion services. AWHN members are concerned that many Australian women do not have such access, despite 30 years of campaigning by women's groups and despite that an overwhelming majority of Australian citizens support a woman's right to choose. Abortion should be removed entirely from the criminal codes of all Australian jurisdictions and treated in the same way as any other medical procedure, subject to normal regulation under health legislation, as it is in the ACT. Women require access to the full range of safe and legal health and medical services which relate to their sexual health and reproductive lives.

Well researched, accurate and easily understood information is necessary to enable women to make informed decisions about health services and medical procedures. As part of comprehensive preventive health care, there needs to be access to free, unbiased, evidence-based information to assist in the development and maintenance of good health, across the life span. This requires a serious research and information

dissemination effort, an effort which must include the collection of gender disaggregated data.

A genuine reorientation of the health system towards the provision of comprehensive, preventive health services, based on a gendered perspective and on extensive consultation with Australians, would go far to achieving many of the objectives supported by women's health and population health experts. It would vastly improve overall population health and eventually lead to a reduction of the large chunk of national resources consumed by hospital and medical services.

2.2 TREATMENTS AND NEW TECHNOLOGIES: EVALUATION OF EFFECTIVENESS AND SAFETY.

Evaluation of the effectiveness and safety of services, treatments and technologies is an issue on the political agenda of some European and North American countries but not yet a major issue in Australia. Such evaluation is thought to be necessary from both quality and cost control perspectives. Until recently, this kind of evaluation was largely left to the medical profession but is recognised as having been 'haphazard' and lacking in rigour (Sax 1990: 35). In particular, international research shows a wide variation in practice patterns and use of interventions and technologies, with little evidence of which approaches are effective (Evans et al 1994). This unsatisfactory situation has given rise to an 'evidence based medicine' movement, which advocates evaluation in terms of quality and medical effectiveness. Some analysts go further, arguing, contentiously, that interventions should be also evaluated in terms of cost effectiveness (Maynard 1997). In other words, population health needs should guide resource allocation and physician decisions should be made within this framework. Altogether, the thrust of cutting-edge reform proposals is towards greater public control: over the production and delivery of services, especially strong primary care services, over the kinds of treatments, technologies and interventions used, over the way providers are paid and over the location and manner of service provision. Reorientation of the Australian health system to achieve better population health will require governments to grasp the nettle and address these contentious and politically difficult issues.

3. CONCLUSION

Public financing tailors health cost payments according to ability to pay, either through the tax system or through income related insurance contributions, and is fundamental to eliminating the serious barriers to access that currently exist in Australia. Through public administration of health systems, governments can achieve a significant level of control over health care costs and can preside over a redistribution of services geographically, with benefits for the community as a whole, and to particular communities. Public financing and leadership is essential in any move away from a narrow focus on hospital and medical services towards a system focusing on health. Reorientation towards prevention requires the introduction of new structures and the alteration of others. Public financing and leadership, in partnership and consultation with Indigenous people, women and special groups, is crucially important to improving Aboriginal health, women's and men's health and to filling the gaps in service provision that are crucially important to those with special needs.

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