12 Settler Colonial Social Medicine and Community Health

Australasian Adaptations, Reinventions, and Denials

Warwick Anderson, James Dunk, and Connie Musolino[*]

Social medicine emerged during the long economic depression in 1930s Australia, nebulous and indefinite. A few socialist physicians and fellow travelers advocated structural reform of capitalism and the expansion of state medicine, while several senior public health officers, often sympathetic to European fascism, aimed to enhance vitality of "the white race" in supposedly hostile environments, whether in the burgeoning urban slums or the tropical north and harsh desert interior. Disparate in their politics, the promoters of "social medicine," an elastic category, shared a belief in social and environmental influences on disease patterns and a conviction that the state must intervene to manage population health. Some radical pioneers of settler colonial social medicine, such as Eric P. Dark, sought inspiration from British social reformers, especially the Fabians, while others, more conservative and race-minded, such as Raphael W. Cilento, learned about the impact on health of socioeconomic conditions and cultural mores from experience in Australian colonies in the Pacific and the British Empire in Asia. For the first group, social medicine proved a potent criticism of the workings of capital, while for the latter, social medicine became a portable technology of imperial settlement. For those on the left, it was a means of combatting the pathologies of global capitalism, while for those on the right, it constituted a strategy for advancing white nationalism, a mobilization of the state to promote white racial hygiene.

In this chapter, we explore the multiple meanings of social medicine as it has developed in Australia since the 1930s. Inevitably, this requires us to situate its various and sometimes amorphous manifestations in diverse settings, including progressive politics, colonial health services, and tropical medicine. As a label, "social medicine" was used sparingly. Rather, the common concern

[*] We are grateful to Anne Kveim Lie, Hans Pols, Jeremy Greene, and other participants in the Rosendal workshop for comments on earlier versions of this chapter. We also thank the interviewers and those who consented to be interviewed for the "History of Community Health in Australia" research project, led by Fran Baum. Our research has been supported by grants from the Australian Research Council (SR200200920 and DP220100624).

to recognize and manage the sociological dimensions of population health was likely to find expression through various surrogates like social work, occupational health, maternal and child health, geriatrics, non-institutional mental health services, nutrition, racial hygiene, and later Aboriginal health programs and generic "community health." Gradually, the colonial racial ties of social medicine in Australia were loosened and shed. An influx of white South African medical firebrands, such as Sidney Sax, in the 1960s and 1970s, strengthened connections with progressive politics and structural reform. A new generation of medical liberals and renegades – clustered around the medical schools of Monash, Adelaide, Queensland, and Sydney – felt comfortable talking about critical health social sciences and imagining national health schemes. Within those national imaginaries, some began to see the society implied by social medicine more ecologically. For Adelaide physician Basil Hetzel, the health of Australian society became ever more a matter of assisting individuals and communities to adapt to the distinctive Australian physical and social environments. Hetzel's student A. J. "Tony" McMichael, galvanized by the threat of nuclear catastrophe, worked to bring the entire planet into this ecological frame. He and others turned their attention to the impact on global human health of the destruction of planetary life-support systems, thereby offering to return to social medicine its neglected, almost forgotten, environmental and ecological purposes – a reinstatement still largely unacknowledged or refused.

From the late 1960s, reformist politicians and public health leaders in Australia began to support nation-wide projects in "community health," influenced by models in North America and Southern Africa, as well as endorsing strong local campaigns for women's health, sexual health, Indigenous health, and worker's health. The network of community health centers found some inspiration also in earlier settler-provided Aboriginal health services, women's health organizations, Australian colonial health services in the Pacific, and urban charitable initiatives. The goal was to "develop" communities through interdisciplinary and integrative centers (including social workers, nurses, mental health workers, and sometimes medical practitioners), embedded in and engaging with local structures and leadership. Collaboratively, they would practice a mixture of disease prevention, counselling, and conventional therapeutic intervention or primary care.

We will examine here the distinctive (and occasionally contradictory) concepts of human collectivity implied by social medicine and community health. Was "community" simply a substitute for "society"? Or did it suggest a different politics of life? What was lost and what gained through the shift from structural elements of social medicine to community health rollouts in the 1970s? Perhaps most tellingly, how did the difference in the constitution of the two – one thoroughly medical, one mostly medicine-adjacent – shape their health interventions? Due consideration of the history of Australian

community health begs the question about where the "medicine" properly belongs in social medicine infrastructure. Did "community medicine" provide a means for the medical establishment to bring the problems of social medicine into its domain, on its own terms, allowing community health to rise and fall, comfortably at arm's length? Did the later decline in the 1990s of community development models, at least in some Australian states, allow a resurgence of social medicine – expressed structurally as a desire for "health equity" – or did it really mean the rise of neoliberal forms of health management? How does this history enable us to reimagine possibilities for social medicine and community health in the contemporary health field in Australia, the Pacific, and elsewhere?

Settler Colonial Dawn: Cilento and Dark

Growing up in South Australia, Raphael Cilento worried about the perceived taint of his Italian ancestry, attempting to expunge the smear through devotion to literary nationalism, boxing, and other demonstrations of manly white virtue.[1] At the end of the First World War, he served briefly as a medical officer in Rabaul, New Guinea, which Australia had acquired from Germany under a League of Nations' mandate, becoming enthralled by opportunities in tropical medicine. In the 1920s, he took over as director of the Australian Institute of Tropical Medicine in Townsville, Queensland, while seconded long-term as the director of public health in colonial Papua and New Guinea.[2] (In 1926, on the island of New Britain, momentarily abandoning public health responsibilities, he proudly reported turning a machine gun on some rebellious Nakanai people, who had threatened local whites, killing several of the "savages."[3]) Shaped by colonial experience, Cilento dedicated his career to the surveillance and regulation of potentially degenerate white bodies in the tropics and the urban slums, seeking to fashion for them a corporeal white armature. Dispelling older fears of the insalubrious tropical climate, he believed that the Australian state should intervene to protect the health of pure white

[1] Although we focus on Cilento, attention should be given to an earlier generation of advocates of state medicine and national health insurance – especially J. H. L. Cumpston and J. C. "Jack" Elkington – who were also votaries of a purely white Australia. See Warwick Anderson, *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia* (Durham, NC: Duke University Press, 2006); and Milton J. Lewis, *The People's Health: Public Health in Australia, 1788–1950* (Westport, CT: Praeger, 2003).

[2] Fedora Gould Fisher, *Raphael Cilento: A Biography* (St Lucia: University of Queensland Press, 1994); A. T. Yarwood, "Sir Raphael Cilento and The White Man in the Tropics," in Roy M. MacLeod and Donald Denoon (eds.), *Health and Healing in Tropical Australia and New Guinea* (Townsville: James Cook University, 1991), 47–63; Anderson, *The Cultivation of Whiteness*; and Alexander Cameron-Smith, *A Doctor across Borders: Raphael Cilento and Public Health from Empire to the United Nations* (Canberra: ANU Press, 2019).

[3] R. W. Cilento, "Story of a Massacre," *Sydney Morning Herald*, December 30, 1928.

settlers especially vulnerable to "disease-ridden natives," unhygienic Asians, dirty Jews, and dubious swarthy immigrants.[4] Once any "native reservoir" of disease was removed or any "foreign pool" of disease contained, whites might flourish anywhere, with proper conduct and care of the body. Cilento therefore fervently demanded improvements in nutrition, housing, clothing, exercise, and behavior. Indeed, productive male labor became for him the main index of success in implanting the white race in harsh and stressful Australian conditions.[5]

As director-general of health and medical services in Queensland from 1934, Cilento expressly began to couple social medicine to his white nationalist aspirations. The goal was still to impower the state to intervene to prevent white decadence and degeneration – only now social medicine seemed to offer a fresh rationale and new methods to do so, thereby arresting white population deterioration. Cilento's earlier work in New Guinea and the Pacific had taught him that racial purity and social homogeneity conferred public health benefits; it divulged to him the risks supposedly attendant on contact with other races; and it imparted the value of surveillance and prevention, organized by the state and focusing on hygiene, nutrition, and housing. Since populating the continent was imperative, he resisted any negative eugenic measures such as sterilization of the "unfit" – in exigent circumstances, no white body could be regarded as irredeemably unfit, all must be salvaged for the nation. More and more, Cilento supplemented his colonial know-how with close reading of social medicine tracts by Alfred Grotjahn, René Sand, and Arthur Newsholme – along with growing enthusiasm for fascist techniques of governance in Italy and Germany, which nearly led to his incarceration during the Second World War.[6] An honorary professor of Social and Tropical Medicine at the University of Queensland from 1937, Cilento agreed with Sand that, "almost every medical question ends in a social question."[7] In his *Blueprint for the Health of the Nation* (1944), the Queensland health officer defined social medicine as "an attempt to determine the principles by which circumstances can be scientifically influenced in the interests of the

[4] R. W. Cilento, *The White Man in the Tropics, with Especial Reference to Australia and Its Dependencies*, Department of Health Service Publication No. 7 (Melbourne: Government Printer, *c*.1925).

[5] Warwick Anderson, "Coolie Therapeutics: Labor, Race, and Medical Science in the Australian Tropics," *International Labor and Working-Class History* 91 (2017): 46–58.

[6] Alfred Grotjahn, *Soziale Pathologie*, 3rd ed. (Berlin: Springer, 1923); René Sand, "The Rise of Social Medicine," *Modern Medicine* 1 (1919): 189–91; and Arthur Newsholme, *Health Problems in Organised Society: Studies in the Social Aspects of Public Health* (London: P.K. King and Sons, 1927). On Cilento's adoration of Benito Mussolini, see Fisher, *Raphael Cilento*.

[7] Sand, "Rise of Social Medicine," 190. See Patrick Zylberman, "Fewer Parallels than Antitheses: René Sand and Andrija Stampar on Social Medicine, 1919–1955," *Social History of Medicine* 17 (2004): 77–92.

individual and of the race." He adhered to the "ideal that a health service is intended to provide positive health, preventive care and medical aid at need, to every member of the community" – by which he meant the fortified *white* community.[8]

Cilento's advocacy of group practices with salaried medical staff irritated his professional colleagues after the war. The Australian branch of the British Medical Association denounced his proposals along with the plans of the Labor federal government for a national health service.[9] Social medicine thus was first associated with eugenic ideas and then, in time, elided by "socialized medicine," falling into disfavor in those flat post-war years. Cilento departed for ravaged Europe, becoming director of the British zone of occupied Germany for the United Nations Relief and Rehabilitation Agency, trying to suppress infectious diseases among refugees and displaced persons. Later, as director of disaster relief in Palestine, his fierce antisemitism alienated incoming Jewish settlers. Returning to Australia, Cilento struggled to find a position in the health bureaucracies or medical schools and failed as a parliamentary candidate for various far-right groups. Increasingly bitter and disillusioned, he ended up ever more stridently denouncing inferior races and imagining Jewish conspiracies everywhere.

As a communist fellow traveler, Eric Dark grounded his ideal of social medicine in very different political terrain. He agreed with Cilento, however, that in the 1930s a choice had to be made between fascism and socialism – but he, unlike the two-fisted Queenslander, would join the "rising tide of socialism." He thus uttered a "plea for socialism as the only alternative to a recoil into a darker age."[10] But regardless of which pole they drifted toward, both Cilento and Dark came to understand social medicine in relation to the augmented role of the nation-state in everyday life. A medical graduate of the University of Sydney, Dark distinguished himself in the army medical corps on the Western Front in the First World War, before taking up general practice and rock-climbing in the Blue Mountains outside Sydney. War had radicalized him, so unlike most of his class he joined the Australian Labor Party, while cautiously skirting the margins of communism. His wife Eleanor Dark, from a raffish literary family, became a celebrated novelist, known especially for *Prelude to Christopher* (1934), an exploration of mental illness and eugenics, and *The Timeless Land* (1941), a critical narrative of the European invasion of Australia. In a series of articles in the *Medical Journal of Australia*,

[8] R. W. Cilento, *Blueprint for the Health of the Nation* (Sydney: Scotow Press, 1944), 91, 48.

[9] National Health and Medical Research Council, "An Outline of a Possible Scheme for a Salaried Medical Service," *Medical J. of Australia* ii (1941); 710–25. See James Gillespie, *The Price of Health: Australian Governments and Medical Politics, 1910–1960* (Cambridge: Cambridge University Press, 1991).

[10] E. P. Dark, *Medicine and the Social Order* (Sydney: F.H. Booth and Son, 1943), 116, 6.

published in the late 1930s, Eric Dark explained how "health is bound up with the political and economic structure of society."[11] The Great Depression had revealed the impact of the workings of capital on the health of the people. Dark perceived the urgent need to improve labor practices, nutrition, and housing – which would imply nothing less than the overthrow of the existing social order. Reading the encomiums of Henry Sigerist, Arthur Newsholme, and radical Melbourne psychoanalyst Reg Ellery, left Dark enamored of Soviet experiments in social medicine.[12] Medicine in the Soviet Union is "PREVENTIVE medicine," he joyfully announced. As living conditions and diet were ameliorated, and medicine reformed, morbidity and mortality rates plunged. "Nothing like them could have been achieved," Dark enthused, "except by a socialized medical service, backed by all the resources of the community."[13] But as the campaigning general practitioner learned after the war, the time was not ripe for avocations of socialized medicine. There was some support for Dark's approach from his colleagues – one correspondent described the sociologists as prophetic figures, "like those crying in the wilderness" – but most others, like University of Sydney-trained physician Harry Herbert Lee, expressed aggressive opposition to the national health insurance legislation then being drafted and to any peers supporting it.[14] A long period of conservative government in Australia, compounded by the encroaching Cold War, soon saw support for social medicine dry up and wither, tainted as it was both by communism and eugenics. In Australia, at least, the fortunes of social medicine followed the global contours of ideological conflict.

The 1960s and 1970s: The Revival of Social Medicine

In the late 1960s, medical reformers began infiltrating state and federal health bureaucracies, concerned about persisting limitations to medical care and pervasive inequality in population health outcomes. Sidney Sax, an émigré medical doctor from South Africa, was one of the more prominent of these advocates of social medicine and the establishment of a national health service. Sax's training at Witwatersrand in the 1940s and subsequent experiences

[11] Dark, *Medicine and the Social Order*, 7. Dark was particularly indebted to Beatrice and Sidney Webb, Harold Laski, and René Sand for his analysis. See E. P. Dark, "The Inductotherm," *Medical Journal of Australia* (September 19, 1936): 397–99; "Some Recent Advances in Physical Therapy," *Medical Journal of Australia* (August 1, 1938): 243–44, and "Property and Health," *Medical Journal of Australia* (March 4, 1939): 345–52.

[12] Henry E. Sigerist, *Socialized Medicine in the Soviet Union* (New York, NY: W. W. Norton, 1937); Arthur Newsholme and John Adams Kingsbury, *Red Medicine: Socialized Health in Soviet Russia* (Garden City, NY: Doubleday, Doran, 1933); and Reg S. Ellery, *Health in the Soviet Union* (Melbourne: Rawson's Bookshop, 1942).

[13] Dark, Medicine and the Social Order, 107, 114.

[14] Harry H. Lee, "National Health Insurance," *Medical Journal of Australia* (March 4, 1939): 369.

working in African communities had sensitized him to how socioeconomic disadvantage and racial discrimination under settler colonialism determined patterns of illness and immiseration.[15] Appalled by the rigid system of apartheid, he immigrated to Australia in 1960, where he soon became director of geriatric services in New South Wales, a field of clinical endeavor he regarded as a proxy for social medicine. He developed aged care assessment teams and promoted community healthcare delivery across the state. During this period, momentum for change within the Labor Party culminated in a meeting on June 6, 1967 convened by Moss Cass, the founding medical director of the Trade Union Clinic in Melbourne, to discuss the merits of an alternative health insurance program.[16] Attendees included influential Labor politicians, key figures in the healthcare services, and University of Melbourne health economists John Deeble and Richard Scotton.

After the election of the reforming federal Labor government in 1972, Sax was appointed to lead a new Hospitals and Health Services Commission – a body that would bridge the administrative gap between hospital and community. For a decade, the Commission directed the vast expansion of national responsibilities in disease prevention, clinical care, and medical funding, developing policies for the effective allocation and distribution of new federal health programs. Together with Scotton and Deeble, Sax helped to devise Medibank, Australia's first national health insurance scheme, which aimed to provide universal free access to medical care.[17] When a conservative government in the late 1970s abolished the Commission and closed Medibank, Sax became chair of the national Social Welfare Policy Secretariat. Like other health reformers in this period, he was dedicated to increasing state action to improve the living conditions and health outcomes of citizens, regardless of race.[18] Influenced by his reading of Sigerist and Thomas McKeown, Sax hoped "social and economic progress [would enable] people to live in an environment from which present health hazards had been removed." But, he lamented, "as the pursuit of technology became a dominant feature of our healthcare system, concepts of health maintenance and social well-being were relegated to positions of low priority."[19]

[15] Sidney Sax, "The Introduction of Syphilis into the Bantu Peoples of South Africa," *South African Medical Journal* ii (1952): 1037–9.

[16] Jennifer DeVoe, "A Policy Transformed by Politics: The Case of the 1973 Australian Community Health Program," *Journal of Health Politics, Policy and Law* 28, no. 1 (2003): 77–108.

[17] Richard B. Scotton, "Medibank: From Conception to Delivery and Beyond," *Medical Journal of Australia*, 173 (2000): 9–11.

[18] Sidney Sax, *Medical Care and the Melting Pot: An Australian Review* (Sydney: Angus and Robertson, 1972).

[19] Sidney Sax, "Are Health and Medicine in Conflict?" *Medical Journal of Australia* i (1977): 357–62, at 357, 358. Sax refers to Henry Sigerist, *Medicine and Welfare* (New Haven, CT:

Sax worked instead through the federal government to improve health education and promotion, while ensuring wider access to reliable medical, nursing, and supportive services, focusing on the health of the whole person rather than the failing of specific organs.

The bureaucratic or governmental matrix for social medicine was thus enriched in the 1970s, in parallel with the proliferation of medical school teaching and research in the subject. Over the course of the decade, it became increasingly likely that medical students would learn a little about social aspects of healthcare. A few departments of social and preventive medicine opened, offering research pathways in connecting medicine with critical social sciences and somewhat more rarely, with political economies of health. These advances were not unprecedented. Fleeing grim post-war England, Eric Saint had earlier found opportunities to develop or augment programs in social medicine in Western Australia and Queensland. His medical training had revealed to him the health effects of poverty in Tyneside, Newcastle, an "unpropitious and conscience-awakening milieu." There he felt the influence of James Spence, the leader of social pediatrics, who studied nutritional deficiencies in poor families and taught students "to look beyond the individual problem, to the ecology of disease."[20]

Arriving in Australia in the early 1950s, Saint worked initially in the asbestos-mining town of Wittenoom, trying futilely to alert authorities to an impending industrial health disaster, the emergence of the world's largest cluster of asbestosis. He also spent time in Aboriginal communities, where he sought to eliminate yaws and leprosy. By the time he took up clinical research at the Perth Hospital, and then the new chair of medicine at the University of Western Australia, Saint was all too familiar with disease as "a social problem requiring administrative action." He became a leading advocate for social medicine, by which he meant "an attitude of mind which views the pattern of disease in a population as a reflection of the cultural structure of society and the occupational pursuits of its members."[21] Sometimes he wondered if the name bore "a rather dreary connotation with sanitary inspectors and water closets"; perhaps "human ecology" was a more appealing description, signaling as it did the "total environment," internal and external to the human body. In any case, as dean of the medical school at the University of Queensland in the 1970s, Saint continued to explore "the no-man's land which lies between medicine and sociology and social anthropology," urging curriculum reform and

Yale University Press, 1941); Thomas McKeown and C.R. Lowe, *An Introduction to Social Medicine* (Oxford: Blackwell, 1966); and Thomas McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis?* (London: Nuffield Provincial Hospitals Trust, 1976).

[20] Eric Saint, "On Men and Institutions," *Medical Journal of Australia* ii (1971): 67–71, at 67.

[21] Eric Saint, "Social Perspectives in Medicine," *Medical Journal of Australia* i (1955): 161–5, at 162, 161.

stronger medical engagement with social science research.[22] "The reminder that medicine has a sociological and humanitarian content," he wrote, "is important in an era when a visitor from another planet might think that its practice was either a technology or a business." It was evident to Saint that the typical Australian medical professional:

> should listen with patience and understanding to what the psychologist and social scientist have to tell him [*sic*] about cultural patterns and human behaviour in relation to the origins and consequences of disease, and that he should learn to work in close and friendly collaboration with a new generation of social workers, hospital administrators, industrial personnel officers, rehabilitation officers, child guidance workers, infant health nurses, all of whom have accepted and share responsibility for the prevention of mental and physical ill health.[23]

As Saint repeatedly observed, "the good doctor develops an awareness of his place in a complex network of social interrelations."[24]

An expert in human nutrition, Basil Hetzel had been attracted to social medicine in the 1940s through the Student Christian Movement at the Adelaide medical school. The social gospel convinced him "of the importance to health of social and community life and the social environment."[25] He became engrossed in medical research in colonial Papua New Guinea (PNG) – but with motives and inferences quite distinct from Cilento's. Hetzel's experiences of the health aspects of "native administration" underscored the medical significance of nutrition and living conditions, as well as accenting the psychosocial dimensions of well-being. On the remote Huon Peninsula of PNG, he determined that iodine deficiency was causing endemic goiter and cretinism and he showed that dietary supplements might remedy it.[26] Through the Iodine Global Network, he campaigned tirelessly for dietary iodine supplementation, attempting to eliminate iodine-deficiency disorders worldwide. Associating his nutritional studies with the "holistic" approaches of social medicine, Hetzel founded in 1968 the Department of Social and Preventive Medicine at Monash University, in Melbourne, based on an ecological model of health, which included human biology, environmental health, health services analysis, and social and behavioral sciences.[27] "Social medicine," he wrote, "is concerned with the importance of social factors in prevention,

[22] Saint, "Social Perspectives in Medicine," 162, 163.
[23] Saint, "Social Perspectives in Medicine," 164.
[24] Eric Saint, "On Good Doctoring," *Medical Journal of Australia* ii (1972): 121–6, at 124.
[25] Basil S. Hetzel, *Chance and Commitment: Memoirs of a Medical Scientist* (Adelaide: Wakefield Press, 2005), 108.
[26] Mandy Brener, "Infectious Personalities: The Public Health Legacy of Three Australian Doctors in Papua New Guinea," *Health and History* 17 (2015): 73–96.
[27] Basil S. Hetzel, *Health and Australian Society* (Melbourne: Penguin, 1974). See also Basil S. Hetzel, *Life and Health in Australia: The Boyer Lectures* (Sydney: Australian Broadcasting Commission, 1971).

cause, and treatment of illness."[28] According to Hetzel, "the ultimate goal that confronts us in social medicine is the provision and delivery of medical care, including the benefits of medical science and technology, to the whole community."[29] Increasingly, he concentrated on problems in urban health, particularly the social environment of new suburbs, on Aboriginal health, and on the need more generally to bolster teamwork in community medicine – but in most of this, eschewing interest in more fundamental questions of structural accountability.[30]

The new program in social medicine at Monash – like those developing at the medical schools of Sydney and Newcastle universities, among others[31] – became a nidus for training and research in the health social sciences and in preventive medicine. Social medicine gradually shifted from the singular expression of isolated charismatic men to an institutionalized orientation toward the relations of health and social structure, a more democratic and diffuse point of view shared among teachers, and sometimes students, of medicine and public health. Never a popular movement, social medicine in the 1970s eventually came to appear a didactic necessity in major schools of medicine and public health, even if marginalized and discounted, rendered anodyne and abbreviated, in most curricula. Reference to socioeconomic determinants of health generally was muted. As John Powles, briefly a leading figure in the Monash department, put it, there was simply a widespread, if grudging, admission that teaching the technics of medical diagnosis and treatment –

[28] Basil Hetzel, Report on Special Leave, 1968, Monash University, in Basil Hetzel collection, University of South Australia archives, series 1, box 15.

[29] Basil S. Hetzel, "The Role of the Behavioural Sciences in Medicine: Social Medicine," *Medical Journal of Australia* ii (1969): 47–51, at 51. Hetzel referred to the sociological studies of Robert K. Merton, Elliot Freidson, Howard Becker, and David Mechanic.

[30] See Basil S. Hetzel, "Health for Aborigines: A New Approach?," *Medical Journal of Australia* ii (1972): 693; Basil S. Hetzel and H. J. Frith (eds.), *The Nutrition of Aborigines in Relation to the Ecosystem of Central Australia* (Melbourne: CSIRO (Commonwealth Scientific and Industrial Research Organisation), 1978); Basil S. Hetzel, "The Impact of a Changing Society on Community Health Programmes," *Medical Journal of Australia* ii (1971): 881; and comments on Glenn McBride, "Social Adaptation to Crowding in Animals and Man," in Stephen V. Boyden (eds.), *The Impact of Civilisation on the Biology of Man* (Canberra: ANU Press, 1970), 154–8. Hetzel returned to Adelaide as the director of the CSIRO's Division of Animal Nutrition.

[31] The program at Sydney, and the activities of Charles Kerr, John Last, and Michael Marmot (as a medical student), should also receive attention. The University of Melbourne's medical school, in contrast, proved especially resistant, aside from tolerating a few figures such as Ross Webster, David Christie, and Hedley Peach in what was fundamentally a department of general practice, though sometimes called "community medicine." When Warwick Anderson, fresh from the Department of Social Medicine at Harvard, set up the Centre for the Study of Health and Society (now the Centre for Health Equity) in 1997, he was advised (perhaps facetiously) not to mention "social medicine" at Melbourne as it sounded too much like socialized medicine. In 2000, the Centre, focusing on social sciences and medicine, was merged into the new School of Population Health, separate from the medical school.

medicine as an "engineering strategy" – was no longer sufficient. According to Powles, medicine now had to abandon its "technological 'overreach'" and instead address "the wider crisis in industrial man's [*sic*] relationship to his environment," coming to grips with the diseases of "civilization" consequent on social maladaptation.[32] Having inserted the "social" into the medical curriculum, Powles wanted to find further space for ecological perspectives. Thinking about social medicine became for him "an urgent precondition for the articulation of an alternative 'ecological' strategy for the improvement of health."[33] But he soon found there were limits to the medical school's embrace of social medicine and disease ecology, both at Monash and later at Cambridge University. Medical deans might gesture favorably, if vaguely, toward things social or ecological, but laboratory research and individualized clinical care would always take precedence.

At least one Monash graduate student, Tony McMichael, heeded the teaching of Hetzel and Powles. As a radical medical student and antinuclear activist at Adelaide in the 1960s, McMichael had been inspired by Hetzel's commitment to social medicine and engagement with the politics of healthcare. He followed his mentor to Monash to undertake graduate studies, where he conducted research in the health consequences of lead pollution, UV radiation, solvent exposure, alcohol consumption, and passive smoking. McMichael then spent a few years in the 1970s in public health at the University of North Carolina, Chapel Hill, at the suggestion of the planetary-minded disease ecologist René Dubos, before returning to Adelaide as professor of Occupational and Environmental Health, his concerns becoming ever more ecological and less sociological.[34] At Chapel Hill, McMichael encountered an epidemiology

[32] John W. Powles, "On the Limitations of Modern Medicine," *Science, Medicine and Man* 1 (1973): 1–30, at 13, 1. As a medical student at the University of Sydney, Powles had taken leading roles in the local campaign for nuclear disarmament and in Student Action for Aborigines, participating in the 1965 Freedom Ride across outback New South Wales. Influenced by René Dubos, McKeown, and Stephen V. Boyden, Powles was in the Science Policy Research Unit at Sussex University between 1970 and 1975, when he moved to Monash to join Hetzel; from 1991 he lectured in public health at Cambridge University.

[33] Powles, "On the Limitations of Modern Medicine," 23.

[34] A. J. McMichael, "Global Warming, Ecological Disruption and Human Health: The Penny Drops," *Medical Journal of Australia* 154 (1991): 499–501; and A. J. McMichael, *Planetary Overload: Global Environmental Change and the Health of the Human Species* (Cambridge: Cambridge University Press, 1993). See Colin Butler, Jane Dixon, and Tony Capon (eds.), *Health of People, Places and Planet: Reflections Based on Tony McMichael's Four Decades of Contributions to Epidemiology Understanding* (Canberra: ANU Press, 2015); Howard Frumkin, "The Sage of Canberra: Tony McMichael on Climate, History, and Health," *EcoHealth* 14 (2017): 425–47; James Dunk and Warwick Anderson, "Assembling Planetary Health: Histories of the Future," in Samuel S. Myers and Howard Frumkin (eds.), *Planetary Health: Protecting Nature to Protect Ourselves* (Washington, DC: Island Press, 2020), 17–35; and Warwick Anderson and James Dunk, "Planetary Health Histories: Toward New Ecologies of Epidemiology?" *Isis* 113, no. 4 (2022): 767–88, doi.org/10.1086/722308.

department in the act of establishing an interdisciplinary "social epidemiology," shaped by the experience of John Cassel and Sidney Kark at the Pholela Community Health Centre in South Africa.[35] That experience in rural, multidisciplinary health work embedded both in social and ecological systems proved formative for epidemiology's pivot to the social causes underlying patterns of health and illness – though ecological interest at the time was typically limited to the neighborhood environment, filled with occupational and industrial work threats, the products of social injustice.[36]

The ravaging of the environment and the dire consequences for animal life and human health, were always front of mind in a settler colonial society, in an ecologically transformative polity like Australia, especially in a sensitized desert city like Adelaide, McMichael's early habitat.[37] In the 1990s, as Professor of Epidemiology at the London School of Hygiene and Tropical Medicine, McMichael continued to sound a tocsin to the world to address the human health impacts of degradation of the earth's life-support systems, principally through the effects of anthropogenic global heating. By the turn of the century, he demanded that epidemiologists try to "understand the determinants of population health beyond proximate, individual-level risk factors."[38] "Modern epidemiology's search for specific proximate causes has deflected us from social-contextual models of disease causation," McMichael wrote. "We epidemiologists must broaden our causal models and recognize the important ecologic dimensions of social-environmental influences on health and disease."[39] Against simplistic assumptions of contamination and pollution, McMichael posed more complex and biologically realistic epidemiological models that drew on social science and systems ecology. But he no longer called this social medicine. That mode of inquiry had long ago, in Cilento's time, jettisoned its connections to medical geography and environmental reckoning on a large scale, so it seemed inadequate to his task. Moreover, the bonds of social medicine with the declining nation-state still seemed too adherent to permit the earth-system vision and global action that was required. Eventually, then, McMichael's proposals to address the health

[35] Judith Winkler and Victor J. Schoenbach, *The UNC Department of Epidemiology: Our First 40 Years, 1936–1976* (Chapel Hill, NC: The UNC Gillings School of Global Public Health, 2018), 11–12.

[36] Ana V. Diez Roux, "Social Epidemiology: Past, Present, and Future," *Annual Review of Public Health* 43, no. 1 (2022): 79–98.

[37] Anderson, *Cultivation of Whiteness*, chapter 7; and Libby Robin, "Ecology: A Science of Empire?," in Tom Griffiths and Libby Robin (eds.), *Ecology and Empire: Environmental History of Settler Societies* (Melbourne: Melbourne University Press, 1997), 215–28.

[38] A. J. McMichael, "Prisoners of the Proximate: Loosening the Constraints on Epidemiology in an Age of Change," *American Journal of Epidemiology* 149 (1999): 887–97, at 887. See Warwick Anderson, "The History in Epidemiology," *International Journal of Epidemiology* 48 (2018): 672–4, doi.10.1093/ije/dyy247.

[39] McMichael, "Prisoners of the Proximate," 895–6.

impacts of global heating would acquire another name, planetary health.[40] Few discerned its origins in settler colonial social medicine.

The Rise of Community Health: Substitute or Elaboration?

"I was always quite cynical about medical dominance, always looking for it," Fran Baum, Professor of Health Equity at the University of Adelaide, reflected in 2021. "And I guess for me, social medicine might have been a turn off … It's a claiming of space by medicine that shouldn't have been defined by medicine."[41] As an insurgent health social scientist, Baum was more attuned to community health programs, dependent on multidisciplinary teamwork, as they were developing in Australia and elsewhere during the 1970s. Social medicine also seemed too biomedical to Denise Fry, a leader of the community health movement in Sydney: "I think [social medicine] was a way for medicine to expand its view, and address social issues, and social concepts. It did privilege doctors of course, but that's how things were at the time." Certainly, for non-medical activists like her, it was not a usable framework.[42] "You see, the medicine word was used as an exclusion," Chloe Mason told James Dunk.[43] Jim Birch, the manager of a South Australian community health center, recalled social medicine was "very much associated with trying to move the medical model into social settings or situations beyond the traditional structures and hierarchies that they formerly existed in, or still exist in, but it's not a term I use very much."[44] Some saw a neat progression which displaced medical dominance from what some fashioned – provocatively, perhaps – as "social health."[45] "Social and preventive medicine was the forerunner of community health and epidemiology," recalled Howard Gwynne.[46] Other community health campaigners were more dismissive. "That's something the British invented," Tony Adams insisted. "It doesn't mean anything, it's too waffly."[47]

[40] Dunk and Anderson, "Assembling Planetary Health"; and Anderson and Dunk, "Planetary Health Histories." After 2001, McMichael became director of the National Centre for Epidemiology and Population Health at the ANU.

[41] Fran Baum, interviewed by Connie Musolino, June 22, 2021. The term "medical dominance" was popularized in Australia by Evan Willis, *Medical Dominance: The Division of Labour in Australian Health Care* (Sydney: George Allen & Unwin, 1983).

[42] Denise Fry, interviewed by Connie Musolino, June 24, 2021.

[43] Chloe Mason, interviewed by James Dunk, November 24, 2021.

[44] Jim Birch, interviewed by Paul Laris, July 22, 2021.

[45] Peter Ruzyla, interviewed by Virginia Lewis, February 26, 2022. Rusyla, a psychologist who directed Maroondah Social Health Centre, recalls that at an earlier chair, Clarrie Armstrong, had been influenced by social health movements in Scandinavia when the center was founded in 1974.

[46] Howard Gwynne, interviewed by Connie Musolino, May 4, 2022.

[47] Tony Adams, interviewed by James Dunk, November 11, 2021.

Like social medicine, community health was a global movement – but neither simply diffused from some "central" northern site to the remainder of the world. To be sure, in Australia, models of social medicine derived mostly from European and colonial endeavors, while the community health movement in the 1970s often found its exemplars in North American experiments. But the aspirations and practices of both social medicine and community health would be adapted and transformed in local usages, giving rise to fresh visions and unanticipated actions, and taking on vernacular forms. Though ostensibly different – even, for some, incommensurable – social medicine and community health in Australia corresponded at several points. There was common advocacy of disease prevention, attention to the "person" more than the specific pathogen, recognition of the importance of the socioeconomic matrix, and an emphasis on multidisciplinary approaches, sometimes including teamwork. Several community health leaders who were familiar with the language of social medicine (typically those who had trained in medicine), saw the two as members of the same family. "Community health is an attempt at social medicine," reflected Ben Bartlett, a medical doctor who worked in women's health and workers' health centers and in Aboriginal health. "I don't really see a fundamental difference."[48] Other medicos saw a divergence in emphasis, with community health a sort of parochial enterprise preoccupied with primary care and social medicine standing above with a wider vision. "Community health is much more related to primary healthcare delivery at the community level," stated one medical doctor. "Social medicine probably encompasses that but places more emphasis on what we now call the social determinants of health, looking at health within the broader social context, not just the local community context."[49]

From the 1970s, many advocates for social medicine pragmatically reframed their arguments in terms of community health or community medicine. As Hetzel observed in 1971: "I believe that new thinking in healthcare should be going outside the traditional medical viewpoint of health into a much wider context of society and the individuals in it to health in the community."[50] Accordingly, Sidney Sax laid out the "community" agenda in *A Community Health Program for Australia* (1973), a report of National Hospitals and Health Services Commission. His ambitious recommendations focused on primary healthcare and whole-of-life care in a community setting, conscious of interdependent "medical and social aspects" of health and illness, including family breakdown, poverty, school truancy, alcoholism, and child abuse.

[48] Ben Bartlett, interviewed by Connie Musolino, September 20, 2021.
[49] Anonymous doctor, South Australia, interviewed by Fran Baum, December 8, 2021.
[50] R. McEwin, Opening Address, Community Health Action Seminar, North Ryde Staff Development Centre, August 6–8, 1975 (Health Commission of New South Wales), 3–4.

Better individual understanding of disease and disability conditions, for the sake of prevention and effective care, would be promoted in community settings. Led by a reforming Labor prime minister, Gough Whitlam, the federal government at the time was eager to invest in such new modes of disease prevention and healthcare delivery, conventionally domains of the states.[51] The new community health services were explicitly modelled on women's health centers and the clinics established by the union movement, along with the Aboriginal urban medical services, which had been inspired by Black Panther initiatives in the United States.[52] Although activists could look to some isolated exemplars in Britain, including the Peckham Experiment, it was clear that community health work was more advanced in North America, frequently in association with US medical schools.[53] The international institutional shift, at the WHO especially, toward expanding access to primary healthcare, culminating in the 1978 Alma-Ata Declaration, also shaped and encouraged local campaigns.[54] In Australia, nurses, social workers, and local representatives tended to dominate the ramifying network of community health centers, often in tension with medical doctors who were either incorporated in the agency or competing in the surrounding neighborhood. The emphasis was on disease prevention and health education and integrated, multidisciplinary care – not routine medical consultations. Although most community health workers recognized the socioeconomic determinants of health, they rarely had the time and resources to address them critically and structurally. Nonetheless, community health managed to improve the lives of the poor and disadvantaged in Australia in ways that formal social medicine, despite its lofty goals, never did – though it could still be contended that community health actually was a practical, if partial, instantiation of the concept, despite the protestations of its participants.

At least initially, community health was imagined as constructing networks of care, clusters of multidisciplinary local health centers, from the ground

[51] Parliament of the Commonwealth of Australia, *A Community Health Program for Australia: Report of the Interim Committee of the National Hospitals and Health Services Commission* (Canberra: Government Printer of Australia, 1973); and Gough Whitlam, "1974 Election Policy Speech," delivered at the Blacktown Civic Centre, April 29, 1974, at: https://whitlamdismissal.com/1974/04/29/whitlam-1974-election-policy-speech.html.

[52] Kathy Lothian, "Seizing the Time: Australian Aborigines and the Influence of the Black Panther Party, 1969–1972," *Journal of Black Studies* 35, 4 (2005): 179–200.

[53] W. R. Willard, "Report of the National Commission on Community Health Services: Next Steps," *American Journal of Public Health* 56 (1966): 1828–36. A notable UK center was the Pioneer Health Centre, in southeast London, home to the Peckham Experiment, in which physicians looked to diet, exercise, and community itself to build health (rather than treat illness). See Philip Conford, "'Smashed by the National Health'? A Closer Look at the Demise of the Pioneer Health Centre, Peckham," *Medical History*, 60, no. 2 (2016): 250–69, doi.org/10.1017/mdh.2016.6.

[54] As did the 1986 Ottawa Charter for Health Promotion, also sponsored by the WHO.

up, generated or supported by local groups, rather than a function of medical dominance in the interests of the nation-state.[55] Certainly the Aboriginal and women's health centers which were co-opted into the community health movement by the lure of federal funding had emerged from the periphery of power, and from specific communities, writing their own mandates to care for those who were overlooked by existing, centralized systems.[56] From 1973, the Community Health Program sought to enfold those centers and services into a model of centralized health provision. Although community health might be imagined from the ground up and invested, at least theoretically, in the idea of community involvement, it turned out to be largely driven in Australia by a concern to rationalize and economize health delivery, both across regions and states and between levels of government and health specializations.

It proved hard to ward off creeping medical dominance, often under the rubric of *community medicine*, not community health. Boundaries blurred between social medicine, community medicine, and community health during the 1970s, in part because rapidly expanding medical schools saw professional opportunities in their erasure. The slippage from social medicine to community medicine, often evading community-grounded *health*, became commonplace in the medical profession.[57] Thus B. A. Smythurst, a reader in Social and Preventive Medicine at the University of Queensland, could write, eliding any distinction: "Social or community medicine is that branch of medicine which deals with populations or groups rather than with individual patients."[58] Other medicos also were prone to amalgamate social and community medicine while hedging on community *health*. "Community has to do with aggregates of people, and medicine has to do with alleviation of suffering which presents as sickness and disability," Ian W. Webster, a leading medical reformer, explained in 1984, "community medicine is about societal analyses and prescriptions, and about individual therapeutic action in the community."[59] He

[55] Health Commission of New South Wales, *Community Health Book No 1: General Concepts* (Sydney: Health Commission of New South Wales, 1977), front matter.

[56] The original Aboriginal health center, in Redfern, Sydney, emerged in response to a rapid influx of Aboriginal people from rural NSW after the 1967 referendum precipitated the repeal of mission and reserve legislation. The Aboriginal Legal Service – the first of the "community-controlled, community-survival programmes" – helped protect those arriving from prejudicial enforcement and sentencing, and the need for a community *health* center grew from the intertwined legal, social, and medical concerns of this "community of refugees." See Gary Foley, *Redfern Aboriginal Medical Service 1971–1991: Twenty Years of Community Service* (Sydney: Aboriginal Medical Service Cooperative, c.1991), 5.

[57] Raymond G. Brown and Henry M. Whyte, *Medical Practice and the Community* (Canberra: Australian National University Press, 1970).

[58] B. A. Smythurst, *Fundamentals of Social and Preventive Medicine* (St Lucia: University of Queensland Press, 1976), 1.

[59] Ian W. Webster, "Where Healing Starts," in Rex Walpole (ed.), *Community Health in Australia*, 2nd ed. (Ringwood, Vic: Penguin, 1984), 37–52, at 37.

spoke for many advocates of social medicine and community medicine when he observed: "Illness takes place at the point of intersection between biology, emotional experience, and the physical and social environment, and a prior decision to deal with one and not the others cannot be justified." He wondered whether the biomedical sciences had anything more than marginal relevance to community health. "The greatest need for the future," Webster concluded, "is a conjunction across the boundaries of the biological and social worlds because herein lies the greatest opportunity for our society to benefit human health and set people free from suffering." Accordingly, "social policy and health policy need to be developed simultaneously – and in this process social justice and health justice are the overriding principles."[60]

The Australian Universities Commission's Committee on Medical Schools reported in July 1973 that virtually all universities were looking to give community medicine more weight in medical training, which had until then included at best gestural treatments of the subject. Those universities looking to create new medical schools – like Newcastle and Wollongong – saw a special need to "fit the doctor better for community practice."[61] The Committee described a "mutually" beneficial relationship for community health centers and the medical schools, with centers offering necessary training in primary healthcare for medical students as well as employing medical staff. The Whitlam government was rarely accused of moving slowly and later that year it awarded the Royal Australian College of General Practitioners a large grant to establish a Family Medicine Programme.[62] What would later develop into a specific program of "general practice" or family medicine training was initially channeled into support for new hires or even departments in community and social medicine. Announcing the funding, Whitlam linked the new community practice schools and courses with community health centers, including extra funding to accommodate teaching within the centers themselves.[63] Sidney Sax noted, with satisfaction, that in the ten years from December 1973, departments of "community practice" had been created in every medical school in the country. The medical graduates partly shaped by such departments, which generally offered some social medicine teaching,

[60] Webster, "Where Healing Starts," 43, 51.

[61] Expansion of Medical Education: Report of the Committee on Medical Schools to the Australian Universities Commission, July 1973, Parliamentary Paper No. 110, ordered to be printed 11 September 1973 (Canberra: Commonwealth of Australia, 1973), 84.

[62] Stephen C. Trumble, "The Evolution of General Practice Training in Australia," *Medical Journal of Australia* 194, no. 11 (2011): S59–62, doi.org/10.5694/j.1326-5377.2011.tb03129.x.

[63] The Federal Government offered $35,000 funding in the first year and $75,000 in subsequent years, with an added $50,000 to facilitate teaching in community health centers associated with university departments. Prime Minister's Press Conference, Parliament House, Canberra, December 4, 1973, at: https://pmtranscripts.pmc.gov.au/sites/default/files/original/00003093.pdf.

entered uneasy relations with community health services, with some health centers employing general practitioners and others not – whichever way the prejudice ran – and with frequent tense debates about fee-for-service and salaried employment.

In the 1980s, the community health movement in Australia entered the doldrums. "Then, of course," said Kathy Eagar, a community health leader in New South Wales, "the Commonwealth turned the tap off and froze everybody where they were."[64] Some states were more advanced than others, having done more "community development" earlier and more effectively – but even so, their health centers felt the strain. Throughout the process, it had never been clear what "community" was signifying, or how a community might announce itself, or be fashioned into a functional entity. As Chris Scarf told us, "I'm struggling, I guess I didn't know what the community was, you know?"[65] Lou Opit, Hetzel's successor in Social and Preventive Medicine at Monash, tried to explain what it might mean. "Community health," he wrote, "expresses a desirable social state believed to be attainable without recourse to the orthodox medical approach to health care." And yet, the "community" in community health – like "health," too, of course – was an ambiguous concept, perhaps generatively so. It could imply "a collection of persons who share some attribute, and the property which is shared defines the nature of the community." But Opit still had to admit, "if community health has a useful unambiguous meaning, we cannot find it within the existing logic of language."[66] What had the discursive shift in the 1970s from "society" to "community" represented functionally? How had these different collective worlds shaped the configurations of medicine and healthcare? When, in the early years of the twenty-first century, health equity became ascendant, eclipsing or overshadowing community development, did this augur a return to social medicine, with its critique of the structural violence of capitalism and the nation-state? Or was it, yet again, just another means of mitigation and extenuation, of tinkering at the edges?

Conclusion

In reflecting on his career in social medicine in 1976, Douglas Gordon, Professor of Social and Preventive Medicine at the University of Queensland, observed that the postwar enthusiasm for biochemistry, pharmacology, and

[64] Kathy Eager interviewed by James Dunk and Warwick Anderson, October 13, 2021.
[65] Chris Scarf interviewed by James Dunk and Warwick Anderson, August 5, 2021.
[66] L. J. Opit, "Community Health," in Rex Walpole (ed.), *Community Health in Australia*, 2nd ed. (Ringwood, Vic: Penguin, 1984), 84–90 **,** at 84, 85. Another Adelaide medical school graduate, Opit, taught social medicine at Birmingham (1970–6) before taking up the Monash position (1976–85), after which he returned to Britain as Professor of Community Medicine at the University of Kent (1985–98).

genetics, medical attention had shifted in the late 1960s toward the impact of social disadvantage and environmental degradation on health. This decentering of molecular and cellular pathologies showed "balance being restored" in understandings of disease processes.[67] Influenced professionally, though not politically, by Cilento, Gordon regarded the increasing concern for the social, economic, and political dimensions of population health as a manifestation of social medicine. For him, it was an expansive category. "Social medicine," Gordon declared, "is the study of the collective health of groups of people, of the collective efforts which such a group takes to prevent disease and promote health, and of the manner in which the group organizes care for those suffering ill health."[68] Social medicine began, he argued, with epidemiology and demography, veered into "human ecology" (understood as studies of the interaction of physical environment and human health) and, in the interrogation of social determinants of health and disease, strayed even into sociology, anthropology, and history to plumb "the philosophies and essential mysteries of human behaviour insofar as these affect health."[69] These overlapping contexts and terms had led to "an unholy confusion" of fields, particularly since "departments of community medicine or community practice or community care are springing up like the flowers of the fields," especially in North America, where the phrase "social medicine" had never been "acceptable due to its probable confusion with socialized medicine."[70] Indeed, Gordon wondered if community medicine might be a convenient shorthand both for social medicine and preventive medicine since it avoided the inscrutability of the former ("since only the experts know what 'social' implies in this context") and the "mouthful" of using both terms. "Perhaps community health might be a more fitting designation," he ventured, apparently oblivious to his own assumptions of medical dominance.[71]

Gordon's concluding remarks on social medicine, a field he helped to reestablish in Australia, display an unstable mixture of assertion and vulnerability. Like so many others in Australia in the 1970s, he was acutely aware of the social and political dimensions of health and disease, especially at a large scale, at population level. He embraced the need for interdisciplinary collaborations, particularly with social scientists and epidemiologists – sometimes even with human ecologists. He understood that health professionals were inevitably part

[67] Douglas Gordon, *Health, Sickness, and Society: Theoretical Concepts in Social and Preventive Medicine* (St Lucia: University of Queensland Press, 1976), 11. Gordon was appointed to the position in 1957.

[68] Gordon, *Health, Sickness, and Society*, 3–4. [69] Gordon, *Health, Sickness, and Society*, 5–6.

[70] Gordon, *Health, Sickness, and Society*, 11. David Pennington, a dean of medicine at Melbourne, recalled that hospital clinicians tended to view social medicine and even community health as "wicked socialist medical activity" (interviewed by Tim Walsh and Bill Newton, May 25, 2016).

[71] Gordon, *Health, Sickness, and Society*, 11. See Willis, *Medical Dominance*.

of the political process, as advocates for their patients against health inequities. At the same time, he clearly had a sense that something else was happening in the 1970s, something he could never quite formulate. It sometimes seemed as if both the "social" and the "medicine" of social medicine were under erasure or at least subject to challenge. The rise of community health was shifting the ground on which judgments about health equity could be made – and by whom they could be made. Conceits and evasions such as "community medicine" neither revived the political agenda of social medicine nor shored up physician authority. Community medicine tended to dwindle into a medical teaching and training stratagem – while never quite restoring medical dominance in community health. As neoliberalism became entrenched in health arenas during the 1990s, neither the older statist social medicine nor the newer activist community health would thrive. Yet within a few decades, both timeworn social medicine and cognate community health now appear together again to offer potential blueprints for addressing health inequity and environmental injustice in Australia and elsewhere.