



Promoting women's health and wellbeing  
AUSTRALIAN WOMEN'S HEALTH NETWORK

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## **Australian Women's Health Network**

# **SUBMISSION TO THE COMMONWEALTH GOVERNMENT ON THE NEW NATIONAL WOMEN'S HEALTH POLICY**

**1 July 2009**

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# Australian Women's Health Network (AWHN) Recommendations

AWHN recommends that the new National Women's Health Policy (NWHP) should:

1. Contribute to building healthy public policy, informed by a social view of health and the social determinants of health, through
  - helping to create supportive environments for health, to complement existing hospital and medical care systems
  - recognising and responding to gender as one of the fundamental social determinants of health
  - recognising diversity among women
  - endorsing the important role of women's health, community health and public health services in promoting positive women's health outcomes, especially for marginalised women
  - contributing to a reorientation of health policy towards preventive primary health care and support services
  - contributing to expanding and strengthening Australia's primary care system to ensure that prevention, health promotion and outreach services are provided
  - fostering intersectoral collaboration at and between all levels of government
  - moving beyond the traditional health portfolio to address the social determinants of health
2. Develop a plan for the implementation of a Gender Equality Scheme
3. Develop capacity building infrastructure to support women's and men's health, including:
  - a policy unit within the Population Health Branch of the Commonwealth Department of Health and Ageing
  - Women's, Men's and Population Health interdepartmental committees at national and State/Territory levels
  - expansion and repositioning of the role and resources of the Commonwealth Office for Women
  - a Gender Health Unit within the Australian Institute of Health and Welfare (AIHW)
  - an Australian Health Ministers Advisory Committee Subcommittee on Women and Health
  - establishment of State and Territory Women's (and Men's) health units, with dedicated sections for Aboriginal and Torres Strait Islander women's and men's health
  - funded initiatives for research priority areas, new models of service delivery and new and ongoing women's health services
  - continued funding of the Women's Health Longitudinal Study
4. Ensure that the health and wellbeing needs and experiences of vulnerable populations of women are specifically addressed in each aspect of the new NWHP
5. Take account of the issues raised and recommendations made by Women With Disabilities Australia (WWDA) in their submission for the NWHP
6. Include a new, appropriately funded National Women's Health Program to give effect to the new policy, which will facilitate:
  - the establishment of equitably dispersed Aboriginal and Torres Strait Islander Women's Health Centres
  - expansion and equitable distribution of Women's Health Centres and Services
  - expansion of equitably dispersed community health centres and public health and community health services
  - appropriate women's health workforce development

7. Actively promote the participation of women in health decision making and management
8. Develop a National Index of Women's Health and Wellbeing Data
9. Fund the Australian Women's Health Network (AWHN), including AWHN's Aboriginal Women's Talking Circle, to be a national clearinghouse for women's health information and to be able to carry out its consultation and other roles more effectively
10. Promote further research and understanding of health equity among women and develop measures to translate this knowledge into health policy and programs
11. Explicitly recognise the relationship between women's health and personal economic security and develop strategies to address inequitable economic structures, such as women's pay equity and the superannuation gap between women and men
12. Increase gender and diversity-sensitive research and research on women and mental health problems
13. Incorporate evidence-based understanding of the impacts of gender and diversity on mental health needs to be translated into practice across all policies and mental health sectors
14. Promote gender and diversity-sensitive practice across all government services and funded organisations
15. Apply a gender lens to the recommendations of the Senate Committee on Mental Health
16. Establish and fund a permanent Council for the Prevention of Violence against Women and Children
17. Recognise the adverse health impacts of violence against women within all national health policies and the policies of other relevant portfolios
18. Expand the capacity of existing women's health centres and services and community health centres/services to provide support for victims of violence and to engage in prevention activities
19. Review the current Medicare and PBS arrangements which control and often restrict women's access to contraception
20. Facilitate dissemination of information about access to and correct use of contraception
21. Develop a National Sexual and Reproductive Health Strategy
22. Facilitate removal of abortion from the criminal codes of those Australian States and Territories where it remains
23. Ensure that medical abortion is available to women in all jurisdictions of the country
24. Encourage the health system to be more responsive to the needs of women through the Australian Health Care Agreements by:
  - eliminating user charges for medical services through mandatory use of bulk billing
  - establishing specialised women's health units in public sector health institutions
  - reviewing medical and nursing education
  - establishing a permanent Health and Hospitals Reform Commission

## Endorsements of AWHN's Submission and Recommendations

The following national and state-wide organisations and individuals endorse AWHN's submission regarding the new National Women's Health Policy (NWHP):

- Wendy Abigail, PhD candidate, Flinders University (SA)
- Professor Dorothy H. Broom, National Centre for Epidemiology and Population Health, Australian National University (ACT)
- Family Planning NSW
- Fremantle Women's Health Centre Inc (WA)
- Gippsland Women's Health Service (VIC)
- Megan Howitt (NT)
- Key Centre for Women's Health in Society (VIC)
- Leichhardt Women's Community Health Centre (NSW)
- Patsy Molloy (WA)
- National Breast Cancer Foundation
- National Rural Women's Coalition
- Older Women's Network NSW Inc
- The Hon. Dr Jocelyne A. Scutt
- Sexual Health and Family Planning Australia
- Waminda, South Coast Women's Health and Welfare Aboriginal Corporation (NSW)
- WOMEN'S Healthworks, Health, Education and Resource Centre Inc (WA)
- Women's Health Grampians (VIC)
- Women's Health In the North (VIC)
- Women's Health In the South East (VIC)
- Women's Health NSW
- Women's Health Victoria

## Executive Summary

The Australian Women's Health Network (AWHN) endorses the social view of health adopted in the Commonwealth's consultation discussion paper, *Development of a New National Women's Health Policy*, (hereafter referred to as Consultation Discussion Paper)<sup>1</sup>. AWHN highlights the importance of a social determinants framework, including a gendered approach. As a major social determinant of health, gender is one of the root causes of avoidable health inequalities. A social determinants approach also reveals the presence of serious health inequalities between groups of women and between groups of men. AWHN stresses that the new NHWP must focus on the health needs of those women at greatest risk of poor health outcomes, including especially Aboriginal and Torres Strait Islander women and women in the lower socio-economic groups.

AWHN supports a multifaceted approach to preventive health care and health inequalities that incorporates both individual and population-focused activities. To be effective, the new NWHP must seek to influence sectors beyond the traditional health portfolio. In order to address the social determinants of avoidable ill-health, action needs to be taken both inside and outside what is normally designated the health system. AWHN recommends that the new NHWP is underpinned by the principles of the Ottawa Charter for Health Promotion (1986): building healthy public policy; creating supportive environments for health; strengthening community action; and developing personal skills and reorienting health services.

AWHN stresses the importance of strengthening and expanding primary health care, preventive and outreach services to complement the treatment services provided in the conventional hospital and medical care system. The primary health care sector is where real health services, including primary prevention and community development, at the local level can reach those groups most at risk of poor health.

AWHN places high importance on gender and diversity analysis and the collection of 'comprehensive gender-relevant evidence' through gender-sensitive data and research. The participation of women in health decision-making and management<sup>1</sup> is crucial, especially for socially excluded and isolated women.

While it is unclear from the Consultation Discussion Paper why the lifecourse approach is proposed as a particular approach for the new NWHP, there is a need to address women's changing health and wellbeing needs across the life stages.

Action needs to be directed towards achieving positive change with regard to the five women's health priorities identified by AWHN: economic health and wellbeing; mental health and wellbeing; preventing violence against women; sexual and reproductive health; and improving access to publicly-funded and financially-accessible health services.

**SUMMARY OF RECOMMENDATIONS IN RELATION TO THE PRINCIPLES AND PRIORITIES OF THE CONSULTATION DISCUSSION PAPER**

| <b>KEY CONSIDERATION OF NEW NWHP</b>                  | <b>RECOMMENDATIONS</b>   |
|---|--|
| <p><b>Progressing Women’s Health in Australia</b></p> | <p>1. The new National Women’s Health Policy should:</p> <ul style="list-style-type: none"> <li>• be based on a social model of health</li> <li>• contribute towards building healthy public policy informed by the social determinants of health</li> <li>• help to create supportive environments for health</li> <li>• recognise and respond to gender as one of the fundamental social determinants</li> <li>• recognise diversity among women</li> <li>• endorse the important role of women’s and community health services in promoting positive women’s health outcomes, especially for marginalised women</li> <li>• contribute towards expanding and strengthening Australia’s primary health care system</li> <li>• contribute towards a reorientation of health policy towards preventive primary health care and support services</li> <li>• foster intersectoral collaboration at all levels of government</li> <li>• go beyond the traditional health portfolio to address the social determinants of health</li> </ul> |
|   | <p>2. Develop a plan for the implementation of a Gender Equality Scheme</p>  |
|   | <p>3. Develop capacity building infrastructure to support women’s and men’s health, including:</p> <ul style="list-style-type: none"> <li>• a policy unit within the Population Health Branch of the Commonwealth Department of Health and Ageing</li> <li>• Women’s, Men’s and Population Health interdepartmental committees at national and State/Territory levels</li> <li>• expansion and repositioning of the role and resources of the Commonwealth Office for Women</li> <li>• a Gender Health Unit within the AIHW</li> <li>• an AHMAC subcommittee on Women and Health</li> <li>• establishment of State and Territory Women’s and Men’s health units, with dedicated sections for Aboriginal and Torres Strait Islander women’s and men’s health</li> <li>• funding initiatives for research priority areas, new models of service delivery and new and ongoing women’s health services</li> <li>• continued funding of the Women’s Health Longitudinal Study</li> </ul>  |

| KEY CONSIDERATION OF NEW NWHP               |  | RECOMMENDATIONS   |
|---|--|---|
| <b>Principles Underpinning the New NWHP</b> | <b>Gender Analysis and Gender Equity in Health</b> | Recommendations are not specific to this priority but are throughout  |
|   | <b>Health Equity Among Women</b>                   | 4. Health and wellbeing needs and experiences of vulnerable groups of women are specifically addressed in each aspect of the new NWHP   |
|   |  | 5. Department takes comprehensive account of the issues raised and recommendations made by Women With Disabilities Australia (WWDA) in their submission to the Department   |
|   | <b>Focus on Prevention</b>                         | 6. Develop a new, appropriately funded National Women's Health Program to give effect to the new policy and to facilitate: <ul style="list-style-type: none"> <li>• establishment of equitably dispersed Aboriginal And Torres Strait Islander Women's Health Centres</li> <li>• expansion and equitable distribution of Women's Health Centres and Services</li> <li>• expansion of community health centres and public health and community health services</li> <li>• workforce development</li> </ul> |
|   |  | 7. Actively promote the participation of women in health decision making and management   |
|   | <b>Translation of Evidence Base into Action</b>    | 8. Develop a National Index of Women's Health and Wellbeing Data  |
|   |  | 9. Fund the Australian Women's Health Network (AWHN), including the AWHN Aboriginal Women's Talking Circle, to be a national clearinghouse for women's health information and to be able to carry out its consultation and other roles more effectively   |
|   |  | 10. Promote further research and understanding of health equity among women and how to translate this knowledge into health policy and programs   |
|   | <b>A Lifecourse Approach</b>                       | No recommendations  |



| KEY CONSIDERATION OF NEW NWHP |  | RECOMMENDATIONS  |
|-------------------------------|--|--|
| Priorities for the new NWHP   | <b>Economic Health and Wellbeing</b>       | 11. NWHP to explicitly recognise the relationship between women's health and personal economic security and develop strategies to address inequitable economic structures such as women's pay equity and the superannuation gap between women and men  |
|                               | <b>Mental Health and Wellbeing</b>         | 12. Increase gender and diversity-sensitive research and research on women and mental health problems  |
|                               |  | 13. Incorporate evidence-based understanding of the impacts of gender and diversity on mental health needs and translate into practice across all mental health sectors  |
|                               |  | 14. Promote gender and diversity-sensitive practice across all government services and funded organisations  |
|                               |  | 15. Apply a gender lens to the recommendations of the Senate Committee on Mental Health  |
|                               | <b>Preventing Violence Against Women</b>   | 16. Establish a permanent Council for the Prevention of Violence against Women and Children  |
|                               |  | 17. Recognition of the adverse health impacts of violence against women in all national health policies and the policies of other relevant portfolios  |
|                               |  | 18. Expand the capacity of existing women's health centres and services and community health centres/services to provide support for victims of violence and to engage in prevention activities  |
|                               | <b>Sexual and Reproductive Health</b>      | 19. In developing the new NWHP, the Commonwealth to review the current Medicare and PBS arrangements which control and often restrict women's access to contraception  |
|                               |  | 20. Facilitate dissemination of information about access to and correct use of contraception   |
|                               |  | 21. Development of a National Sexual and Reproductive Health Strategy  |
|                               |  | 22. Facilitate removal of abortion from the criminal codes of all remaining Australian States and Territories  |
|                               |  | 23. Ensure that medical abortion is available to women in all jurisdictions of the country   |
|                               | <b>Improving Access to Health Services</b> | 24. Encourage the health system to be more responsive to the needs of women by: <ul style="list-style-type: none"> <li>• eliminating user charges for medical services through mandatory use of bulk billing</li> <li>• establishing specialised women's health units in public sector health institutions</li> <li>• reviewing of medical and nursing education</li> <li>• establishing a permanent Health and Hospitals Reform Commission</li> </ul> |

## **Introduction**

### **The Australian Women's Health Network**

AWHN congratulates the Commonwealth Government on its commitment to a new NWHP and welcomes the opportunity to respond to the Consultation Discussion Paper<sup>1</sup>.

The Australian Women's Health Network (AWHN) is a community based, non-profit, consultative organisation that provides a national voice on women's health issues. AWHN was established in 1986, as a national body to represent existing State and Territory women's health networks. Members were part of the movement that worked to achieve the 1989 National Women's Health Policy and have been calling for that policy to be updated and renewed since 1995.

AWHN has affiliated women's health networks and service provision agencies in all States and Territories, with each jurisdiction represented on the management committee. Aboriginal women are represented on the committee and have formed a subgroup, the Aboriginal Women's Talking Circle, which was established in 2007 to represent and advocate around the specific health issues facing Aboriginal women. The Talking Circle will be making its own submission regarding the new NWHP. Through its broad membership and networks, AWHN cuts across political, economic, social and ethnic barriers and works with a wide cross section of Australian women.

AWHN operates as a women's health advocacy, information and lobbying organisation, working with Government policy makers and other agencies to improve the health and well-being of Australian women. Drawing on the perspective endorsed by the World Health Organisation (WHO), AWHN views health in its 'broad social context, recognising that health is determined by a range of social, environmental, economic, gender and biological factors and that differences in health status and outcomes are linked to sex, age, socioeconomic status, ethnicity, disability, location and environment'<sup>2</sup>.

The aims of the organisation are to:

- To maintain and increase a national focus on women's health issues.
- To be a national advocacy and information sharing organisation.
- To be an umbrella organisation for State and Territory women's health networks and for other national women's organisations which embrace its objectives and philosophy.

Promoting gender equality and equality between women in health is part of the core business of AWHN. As identified in *Women's Health: The New National Agenda Position Paper* (hereafter AWHN's Position Paper), published in March 2008, the organisation's priority areas, as suggested by consultation and interaction with women Australia wide, are women's economic health and wellbeing, women's mental health and wellbeing, the prevention of violence against women, women's sexual and reproductive health and improving access to publicly-funded and financially-accessible health services<sup>3</sup>. Addressing the health and wellbeing needs of Aboriginal and Torres Strait Islander women has been a high priority for AWHN since 1995. These priority areas are elaborated below.

# Progressing Women's Health in Australia

## A Social Model of Health

AWHN commends the Commonwealth Government for adopting a social model of health and for its recognition of the impact of the social determinants of health. The 1989 NHWP made Australia a world leader in adopting a social model of health<sup>3</sup>, a perspective much more widely endorsed and supported 20 years later. The new NWHP has the potential to build on this strong foundation.

The social perspective recognises that the health of individuals, families and communities can only be understood within the broader social contexts in which people live and work. The role of social, environmental, economic, biological and gender factors on health outcomes<sup>3</sup> largely explains why different groups of people have very different health outcomes. According to the World Health Organisation (WHO), 'the social determinants of health are mostly responsible for health inequities' which are defined as 'unfair and avoidable differences in health status seen within and between countries'<sup>4</sup>. This perspective reflects the experiences of Australian women who, rather than identifying with a biomedical view of health, clearly prioritised a social determinants approach during the extensive Australian consultations undertaken by Liza Newby and her team in the 1980s for the first NWHP.

Addressing the social determinants is a fundamental step towards reducing health inequities between women and men and between groups of women, thereby creating a fairer and more equitable society, preventing a great deal of unnecessary ill health and avoidable and expensive hospitalisation. A social determinants approach conforms with the Commonwealth's aims of moving towards a stronger focus on preventive health care and strengthening the primary health care system. It also accords with the Commonwealth's social inclusion agenda.

Moreover, improving the health of women will improve the health of the families and communities into which they live, as women are the predominant providers of formal and informal caregiving, including the majority of health professionals<sup>5</sup>. Improving women's health outcomes will also increase women's ability to participate in the paid workforce, enhance productivity and decreasing demand for taxpayer-funded treatment services<sup>3</sup>.

Health experts recognise that improving population health, rather than concentrating efforts on treating disease, requires radical and sustained action on a number of fronts, both inside and outside conventional health systems. The United Nations Ottawa Charter for Health Promotion (1986)<sup>6</sup> identifies five key 'action areas' to guide thinking and planning around the improvement of health outcomes:

1. Building healthy public policy.
2. Creating supportive environments for health.
3. Strengthening community action.
4. Developing personal skills.
5. Reorienting health services.

Building healthy public policy requires that all public policy is inspected for its potential impact on individual and population health. It also involves education and awareness raising of this requirement both among decision-makers and in the general population. Activities might range from macro actions, such as addressing the destructive impact of economic and physical insecurity on individuals and families to micro actions, such as the transport problems that low income people experience, especially in outer urban and rural areas.

Creating supportive environments for health revolves around creating healthy public spaces and strengthening communities and their members. It can include a vast range of actions from making streets safe for children at the local level, to addressing the very serious health implications of climate change at the national level. Community development and the enhancement of personal skills involves efforts to empower individuals and groups through access to training, information and specially designed programs, enabling people to effect desirable lifestyle changes and changes in their communities. The re-orientation of health services involves moving from preoccupation with the provision of hospital and medical treatment services, towards building strong primary health care systems which focus on wellness, prevention and the provision of a wide range of support services. International evidence clearly shows that strong primary health care improves population health.

The successful reduction of health inequalities, then, requires a multifaceted approach<sup>7</sup>. The following table, developed from a diagram published in the Victorian Department of Human Services Integrated Health Promotion Resource Kit<sup>7</sup>, demonstrates the way in which interventions aimed at improving health outcomes – again grouped into five categories – are connected on a continuum, from those with an individual focus to those with a population focus.

| Focus  | Individual focus  | ←————→   | Community Action                     | Population focus                               |
|--|---|--|--------------------------------------|--|
| <b>Activities that Influence Health Outcomes</b> | Screening, individual risk assessment, immunisation, medical care | Health education and skill development through strong community infrastructure | Social Marketing, Health Information | Structural/cultural change, Policy development |

A comprehensive, multi-faceted approach provides a framework that addresses the key areas which influence health outcomes and the range of settings through which interventions need to be implemented. Each of these categories of intervention encompass multiple opportunities for the promotion of better health and wellbeing. Organisations at the local, state and national levels must therefore be appropriately funded to enable them to work effectively on the areas for which they have primary responsibility. Service delivery, including screening and individual risk assessment, health education and skill development needs to be provided alongside social marketing and other health promotion activities, the facilitation of community action and health focused local, state and national policy development. Community health centres and women's health centres and services engage in work that is vitally important from a population health perspective but form a very small sector of the health system. This arm must be expanded.

The national approach to tobacco control is an example of an effective, multi-faceted public health strategy. The campaign around tobacco consisted of 'epidemiological and behavioural research, legislation/regulation (ranging from advertising/sponsorship bans to warning signs at point of sale to smoke-free workplaces), price signals (tax), community education and personal health services'<sup>8</sup>. Measured by declining smoking rates, this has been an extremely successful program<sup>8</sup>. However, we know that those at risk of the poorest health outcomes are still the heaviest smokers, suggesting the need for strong preventive action at the primary health care level.

In addition to applying a gender and diversity lens, the use of this continuum framework as the basis for developing the new NWHP will ensure that the new policy is holistic in addressing a wide range of intervention activities to improve health outcomes and will involve organisations at the local, state and national levels.

### **Gender as a Social Determinant of Health**

The WHO Commission on the Social Determinants of Health identifies gender as one of the fundamental social determinants of health. The Commission was established in 2005 to 'marshal the evidence on what can be done to promote health equity', both within countries and between countries, and to 'foster a global movement to achieve [this objective]<sup>9</sup>'. The Commission produced an impressive body of evidence on social determinants and AWHN strongly recommends that the Commonwealth Department of Health and Ageing (hereafter the Department) use the findings and recommendations of the Commission as the foundation for all health policies, including the new NWHP.

The Commission identified three principles for action that are fundamental to 'closing the gap' between differential health outcomes:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health and raise public awareness about the social determinants of health<sup>9</sup>.

These principles constitute the 'overarching recommendations' of the Commission for tackling the 'corrosive effects of inequality of life chances'<sup>10</sup>.

The impact of gender and the need to promote gender equity in order to achieve health equity is a central consideration of the second principle, 'tackling the inequitable distribution of power, money and resources'<sup>9</sup>. The Commission's Women and Gender Equity Knowledge Network, one of nine networks established around the key social determinants, provides a succinct explanation of the effects of gender on health:

Gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health. They operate across many dimensions of life affecting how people live, work, and relate to each other. They determine whether people's needs are acknowledged, whether they have voice or a modicum of control over their lives and health, whether they can realize their rights<sup>11</sup>.

Governments have acknowledged the importance of recognising gender as a social determinant of health. For example, the Canadian Government's Women's Health Strategy recognises that 'gender has a strong influence on all [other] determinants'<sup>12</sup>. Importantly, the Knowledge Network is optimistic about change, arguing that 'gender inequality and inequity in health are socially governed and therefore actionable'<sup>11</sup>.

The framework for understanding the determinants of health, as laid out in the Consultation Discussion Paper, goes part of the way to recognising gender as a fundamental determinant of health. For example, under 5.1, gender along with sex, is identified as a general determinant of health. However, it is not included in the Paper's discussion of *social* determinants. Further, the 'Conceptual Framework for the Determinants of Health' diagram on page 8 of the Paper omits gender altogether<sup>1</sup>. While it is important to recognise the ways in which biological factors (sex) work in tandem with social factors to influence health, it is crucial within a social model of health to recognise gender as a social determinant. Doing so enables a

focus on the ways in which socially-constructed – and therefore changeable - gender roles, responsibilities, expectations and constraints affect women’s health.

The need to make a clear distinction between the impact of sex, compared to the impact of gender, is acknowledged by the WHO Knowledge Network. It warns that gender discrimination and the resulting bias must not be allowed to ‘masquerade as ‘natural’ biological difference’<sup>11</sup>. Distinguishing clearly between sex and gender effects on health enables policy to more accurately target the underlying causes of health inequalities. As the Knowledge Network argues:

where biological sex differences interact with social determinants to define different needs for women and men in health (the most obvious being maternity), gender equity will require different treatment of women and men that is sensitive to these needs. On the other hand, where no plausible biological reason exists for different health outcomes, social discrimination should be considered a prime suspect for different and inequitable health outcomes. Health equity in the latter case will require policies that encourage equal outcomes, including differential treatment to overcome historical discrimination<sup>11</sup>.

The work of the WHO Commission on Social Determinants provides a comprehensive and best-practice theoretical underpinning for the development of Australia’s new NWHP. Drawing on the work of the Commission and recognising gender as a fundamental social determinant of health will take the Australian Government to the forefront of international efforts to reduce avoidable health inequalities.

## **Beyond the Traditional Health Portfolio**

A framework of action that aims to improve the health and well-being of all Australian women and men, especially those with the highest risk of poor health, will fail unless it takes a preventive and intersectoral approach. For example, action to improve women's economic security will take place largely but not entirely outside the health system. On the other hand, improvement of women's sexual and reproductive health requires action largely within the health sector through publicly provided and non-government services. Even here, however, important services, such as information dissemination and training take place partly outside the health sector (e.g. in education). The elimination of violence against women as a top women’s health priority requires preventive action well beyond the health portfolio.

In the Consultation Discussion Paper, the Department clearly states that promoting a ‘level playing field’ between women and men in the health arena is crucial to achieving gender equity<sup>1</sup>. While the main focus of the new NWHP is to be within the



health portfolio, the achievement of a 'level playing field' will also involve addressing inequities in areas that stretch beyond the traditional parameters of that system, as the WHO Commission on Social Determinants acknowledges<sup>11</sup>. However, the Commonwealth Department of Health and Ageing can champion a social determinants approach throughout the Commonwealth's departmental portfolios, supporting all ministries to examine policies for their potential to influence the social determinants of health.

The new NWHP must therefore establish machinery and agencies that seek to intersect with and influence other portfolio areas, to increase the Commonwealth's capacity to apply a gender and social health lens to all public policies. As Sex Discrimination Commissioner, Elizabeth Broderick, argues, it is crucially important to address the structural barriers around paid work and informal caregiving that currently disadvantage women and, in turn, affect their physical and mental health<sup>13</sup>. Along with achieving 'attitudinal change and law reform', Broderick argues that the removal of structural barriers will help to create a society in which:

- all working women, or men, irrespective of job role, have the ability to stay at home with their newborn babies for at least the first 6 months without jeopardising their career prospects,
- both men and women have access to high quality flexible work at their skill levels,
- affordable, accessible, quality child care and elder care is available,
- attitudinal change is achieved, moving from a focus of 'fixing women' towards a situation where men and women work together successfully and equally<sup>13</sup>.

Broderick thus identifies paid parental leave, flexible working arrangements and the redistribution of caring responsibilities as central to improving the conditions of women's lives and achieving lasting, structural change<sup>13</sup>. The granting of 18 weeks paid parental leave, although well short of international best-practice<sup>14</sup>, will help to increase women's financial security during this period, allowing women to recover physically, bond with their babies and establish breast-feeding without severe financial stress. The continued payment of superannuation by employers will help to close the current gender gap in superannuation savings and increase women's long-term financial security. Such measures steadily improve the status of women in society, a necessary condition for other crucially important changes, such as the elimination of violence against women (and their children).

In other countries, broad ranging, whole of government measures have been devised to improve the status of women. A Gender Equality Scheme (GES), for example, has been developed in the United Kingdom. If adopted in Australia, such a scheme would help to eradicate structural barriers working against women and promote gender equity across all government departments and agencies, organisations, service providers and other public entities<sup>15</sup>. The British GES places a duty on

government departments and agencies and other public entities to proactively address discrimination and promote gender equality within all aspects of policy and practice, in 'recognition of the fact that women and men have different needs in relation to many public service areas, and that in both the workplace and as service users they can experience unfair and unequal outcomes'<sup>16</sup>.

Overlooking major health determinants that sit outside the 'conventional' health portfolio will undermine the effectiveness of the new NWHP. Intersectoral collaboration is fundamental to a preventive, social determinants approach to health and the establishment of dedicated government structures with the capacity to oversee whole of government work is essential. New agencies are needed to provide leadership, identify priorities, develop and implement policies and projects, monitor and evaluate and, most importantly, to promote cooperative action both within and between Commonwealth government departments and between the Commonwealth and other levels of government.

## **AWHN RECOMMENDATIONS**

### **1. The new National Women's Health Policy should:**

- be based on a social model of health,
- address the social determinants of health framework articulated and endorsed by WHO,
- recognise and respond to gender as one of the fundamental social determinants,
- recognise diversity among women,
- endorse the important role of women's and community health services in delivering a holistic, preventive primary health care and promoting positive women's health outcomes, especially for marginalised and hard to reach women and
- extend far beyond the traditional health portfolio, by setting up interdepartmental and intergovernmental institutional mechanisms, including a gender equality scheme.

### **2. Develop a plan for the implementation of a Gender Equality Scheme**

AWHN recommends that the National Women's Health Policy and National Men's Health Policy be linked to the development and implementation of a legislated Australian Gender Equality Scheme (GES), under which all agencies will be required to:

- prepare and publish a GES document which shows how the organisation intends to fulfil the duties, as set out in its gender equality objectives,

- prepare the GES in consultation with employees, service users and other stake holders, including unions,
- consider how policies and practices affect gender equality,
- consider the causes of the gender pay gap and
- set out in the GES how each organisation intends to:
  - gather information on the impact of its policies and practices on men and women, in employment, services and performance of its functions,
  - use the information to review progress towards achieving GES objectives,
  - assess the impact of current and future policies and practices on gender equality,
  - seek input from relevant employees, service users and others (including trade unions) and
  - ensure implementation of the scheme objectives<sup>16</sup>.

### **3. Develop capacity building infrastructure to support women's and men's health**

New and expanded structures are needed to progress intersectoral action to improve the health and wellbeing of Australian women and men, including:

**3.1 Expansion of the role and resources of the Department of Health and Ageing** to include a new unit with specific responsibility for leadership in Women's and Men's health, including a designated section charged with responsibility for advancing Aboriginal and Torres Strait Islander women's health. This office will work closely with the Office for Women and will participate in new interdepartmental committees.

The Women's and Men's Health Unit would:

- provide advice to the Minister for Health and the Minister for the Status of Women and, through them, to Cabinet,
- promote collaborative action at the Commonwealth level , in cooperation with State and Territory jurisdictions,
- undertake ongoing gendered analysis of the key social determinants of women's and men's health and the key priority areas: women's economic health and well-being, women's mental health and well-being, prevention of violence against women, women's sexual and reproductive health and access to publicly funded services,
- provide leadership in women's health, including Aboriginal and Torres Strait Islander, women with disabilities and CALD women's health, in cooperation with interdepartmental committees and the Office for Women, including ongoing priority identification, policy development and the promotion of collaborative action and

- be responsible for ongoing monitoring and evaluation of projects, programs and of overall improvement in the status of women and women's health, especially for Aboriginal and Torres Strait Islander women, women with disabilities and CALD women.

**3.2 The establishment of Women's, Men's and Population Health interdepartmental committees at both national and State and Territory levels** to promote cooperative federal action and monitor and evaluate intersectoral collaboration. Agencies responsible for Aboriginal and Torres Strait Islander health and other issues would be represented.

**3.3 Expansion and repositioning of the role and resources of the Commonwealth Office for Women.** The office should have ongoing responsibility for:

- promoting women's human rights, particularly the rights of Aboriginal and Torres Strait Islander women,
- raising the status of women, as a fundamental requirement for good health and an essential element of any strategy to reduce violence against women, and
- liaising between and across Commonwealth government departments and with States and Territories and establishing appropriate interdepartmental committees to develop and monitor policies.

The office of the Minister for the Status of Women should be upgraded to a cabinet position to enable the Minister to have greater influence over policy-making. This may be the 'single most important step' in accomplishing the recently released National Plans on addressing violence against women<sup>17</sup>, child abuse and neglect<sup>18</sup> and homelessness<sup>19 20</sup>.

**3.4 The establishment of a Gender Health Unit within the Australian Institute of Health and Welfare, with equal representation of women and having responsibility** for undertaking ongoing gendered analysis and monitoring, in cooperation with the Women's and Men's Health Unit, of the key social determinants of women's and men's health and the priority areas of women's economic security, women's mental health and well-being, women's sexual and reproductive health, violence against women and access to publicly funded services.

**3.5 The reestablishment of the AHMAC Subcommittee on Women and Health.**

The AHMAC Subcommittee on Women and Health was a central institution in the successful formulation and implementation of the first NHWP. The Subcommittee played a key role in facilitating a co-ordinated approach to the

extensive consultation process, to community engagement and to monitoring, evaluation and review. It promoted the development and dissemination of information and provided a gendered analysis of mainstream health policies and initiatives. The Subcommittee was disbanded in 1998 and should be re-established under the new NHWP. It is recommended that members be drawn from national and State and Territory governments and relevant non-government sector groups, specifically including AWHN, Womenspeak, Aboriginal and Torres Strait Islander women, women with disabilities and CALD women representatives. The Committee's role would include responsibility for:

- developing processes for monitoring and for amending and redeveloping State and Territory women's health plans to harmonise them with the priorities and directions of the new national Policy,
- information exchange between national and State and Territory governments, between government and the non-government sector and among non-government agencies,
- providing advice on all aspects of policy development and implementation, and
- promoting collaborative intergovernmental action.

**3.6 Where not already in place, the establishment of State and Territory Women's and Men's health units, with each to have dedicated sections with specific responsibility for Aboriginal and Torres Strait Islander women's health.** The units would:

- provide leadership in pursuing a gendered approach to Aboriginal and Torres Strait Islander health in cooperation with other relevant agencies.
- oversee the implementation of policies and projects.
- work with the the AHMAC Subcommittee on Women and Health, the Commonwealth Women's and Men's Health Unit and with women's and men's health interdepartmental committees to monitor and implement progress towards a social determinants approach to health policy at all levels of government.

**3.7 Funding initiatives should be identified for agreed research priority areas, the piloting of new models of service delivery and for new and ongoing women's health services.**

**3.8 AWHN welcomes the commitment in-principle to basic funding for the Women's Health Longitudinal Study until 2016.** We recommend that the study be expanded to allow the inclusion of a new cohort of young women, now aged between 18 and 22 years, in order to obtain data about the lives and life choices of women in this age group about which very little is currently known.

# Principles Underpinning the New NWHP

## 1. Gender Analysis and Gender Equity in Health

AWHN commends the Department for its commitment to addressing gender differences in the National Women's and Men's Health Policies. As discussed above, 'gender-based discrimination is a major cause of health inequalities'<sup>21</sup>. WHO describes the complex interactions between health and gender, as follows:

Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services. These differences, in turn have clear impact on health outcomes. Evidence documenting the multiple connections between gender and health is rapidly growing<sup>22</sup>.

## 2. Health Equity Among Women

AWHN strongly supports the Department's emphasis on promoting health equity among women under the new NWHP. WHO identifies the gap between rich and poor as a key driver that determines the health of individuals<sup>9</sup>. As the Consultation Discussion Paper recognises, there are specific groups of women in Australia that are at increased risk of poor health and wellbeing, including Aboriginal and Torres Strait Islander women, immigrant and refugee women, women from disadvantaged backgrounds, including those experiencing poverty and homelessness, women living in rural and remote areas and women with disabilities, including mental illness<sup>1</sup>.

WHO argues that 'the development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health'<sup>9</sup>. AWHN agrees with WHO that remedying health inequalities that disproportionately impact on marginalised groups is a 'matter of social justice'<sup>9</sup>.

Hard, gendered evidence on health status of different groups is fundamental to effective action. For example, Aboriginal and Torres Strait Islander women have different health needs and experience different health risk factors both compared to Aboriginal and Torres Strait Islander men and compared to non-Aboriginal women. An effective National Women's Health Policy will therefore respond to differences in health experiences between women and men and between groups of women.

AWHN recommends that women experiencing economic insecurity be a priority target group for the new NWHP<sup>14</sup>. Economic insecurity interacts in complex ways with health factors and other conditions in women's lives. The well-documented relationship between socioeconomic status and health creates a 'gradient' with 'people of higher socioeconomic status generally enjoying better health and longer lives than people with a lower socioeconomic status'<sup>21 23 24 25</sup>. Women's economic insecurity is influenced, and in turn, influences, each of the other priority areas for action and is affected by many factors, including:

- inferior employment status,
- poor education,
- low income,
- inadequate superannuation,
- inadequate housing,
- homelessness,
- lack of access to resources and
- violence.

The following matrix illustrates, with brief examples, the ways in which the health and wellbeing of women in the vulnerable populations identified in the Consultation Discussion Paper can be improved in each of the priority health areas identified by AWHN.

**Priority Health Areas: Potential effects of strategies on the health and wellbeing of vulnerable populations**

|  | <b>Economic health and wellbeing</b>  | <b>Mental health and wellbeing</b>  | <b>Preventing violence against women</b>   | <b>Sexual and reproductive health</b>  | <b>Improved access to services</b>  |
|--|---|---|--|--|---|
| <b>Aboriginal &amp; Torres Strait Islander women</b> | Reduced risk of homelessness<br>Lower unemployment rates<br>Reduced discrimination in the workplace                   |   | Lower rates of violence<br>Improved access to support<br>Improved access to intervention                                 | Lower rates of sexual violence<br>Improved access to support<br>Improved access to intervention          | Improved availability of and access to culturally appropriate services<br>Improved social connectedness   |
| <b>Immigrant and refugee women</b>                   | Reduced discrimination in the workplace<br>Access to work rights  | Access to appropriate services<br>Support for dealing with previous experiences of trauma | Availability of and access to culturally-sensitive support<br>Access to support<br>Access to intervention                | Availability of and access to culturally-sensitive support<br>Access to support                          | Availability of and access to culturally-sensitive support<br>Greater number of professionals from own cultural background<br>Greater affordability |
| <b>Disadvantaged women</b>                           |   | Lower rates of mental illness<br>Access to support  | Lower rates of violence<br>Reduced dependence on carers<br>Improved access to refuges, domestic/family violence services | Lower rates of sexual violence   | Greater affordability to access services<br>Reduced cost of health supplies, medication, etc  |
| <b>Rural and remote women</b>                        | Greater employment options<br>Access to transport options<br>Balance of commitments on farms/properties               | Increased social connectedness<br>More support services                                   | Lower rates of violence  | Improved access to services<br>Improved privacy<br>Reduced cost of services<br>More appropriate services | Improved access to services<br>Improved privacy<br>Great access to women professionals  |
| <b>Women with disabilities</b>                       | Reduced discrimination in labour market<br>Reduced discrimination in workplace<br>Greater ability/flexibility to work |   | Lower rates of violence  | Lower rates of sexual violence   | Greater physical accessibility  |



It is important to note that the matrix does not illustrate the overlap between different groups of marginalised women. For example, many Aboriginal and Torres Strait Islander women live in rural or remote areas and experience high levels of economic insecurity. These multiple overlaps demonstrate the need for comprehensive, methodologically sound evidence and for a holistic, nuanced response to women's health, particularly for disadvantaged women.

There are a number of groups that are not included in the Consultation Discussion Paper that also experience higher rates of ill-health and face greater barriers to wellbeing. For example, there is increasing recognition of the ways that sexual orientation and gender identity affect health and wellbeing<sup>26</sup>. Heterosexism, including within the health sector, has many negative impacts for same-sex attracted women, including discrimination and social marginalisation, isolation, social invisibility, violence and the ongoing threat of violence and self-denial, guilt and internalised homophobia and transphobia<sup>26</sup>. Other groups whose needs are not fully explored, include young women, older women, women in prison and women sex workers.

## **AWHN RECOMMENDATIONS**

**4. That the health and wellbeing needs and experiences of vulnerable groups of women be specifically addressed in each aspect of the new NHWP.**

**5. In recognising that women with disabilities are a particularly vulnerable group with specific health and wellbeing needs, AWHN recommends that the Department takes comprehensive account of the issues raised and recommendations made by Women With Disabilities Australia (WWDA) in their submission to the NHWP.** WWDA is the peak organisation in Australia for women with disabilities and is 'run by women with disabilities for women with disabilities'<sup>27</sup>. WWDA has the expertise, knowledge and links with the community to provide an important and representative perspective on the issues faced by women with disabilities. Many AWHN members are also members of WWDA and AWHN strongly endorses the organisation's position.

### **3. A Focus on Prevention**

Primary prevention of disease, illness and disorder<sup>8</sup> is central to a social determinants approach to health. However, agencies providing preventive health services make up the smallest, least well funded sector of the Australian health system. The latest health expenditure figures available from the Australian Institute of Health and Welfare show that, in 2006-07, community health and public health combined comprised only 7 per cent of total health spending (and the community health figures include spending on administration and research). In contrast, hospital services took up 39 per cent of the health budget in that year and medical services constituted 19.1 per cent. If the Commonwealth is going to achieve its aim of moving to a more preventive health system, if unnecessary hospitalisation is to be prevented and if, indeed, women's health and the health of the Australian population is to be improved, then the community health and public health sectors must be expanded.

It is in the women's health and community health sector, that agencies, rather than focusing simply on 'disease prevention', also consider the 'basic structures of society and how they might detract [from] or contribute to health'<sup>28</sup>. These agencies largely comply with Baum's proposal of an approach that

recognises the public health importance of the continuing burden of both infectious disease and chronic disease, [but] also accepts the evidence that shifts in the pattern of disease largely reflect factors to do with the organisation of societies and the distribution of power<sup>28</sup>.

Outside these agencies, the Australian health system does not fund services or workers to provide preventive health care, outreach of any kind, community development or any form of social inclusion.

#### **Disadvantaged and Marginalised Women, Prevention and Women's Health Services**

Women's health services, like community health centres and community focused public health services play a crucial role in reaching particularly vulnerable populations. They provide a model of primary health care which most other service providers are not able to deliver and fill a crucially important primary health care gap.

Primary health care services work extensively with marginalised groups and individuals, including socially excluded women, who are often not reached by the system of medical and hospital services. Indeed, a study of Australia's women's health centres in the 1990s found that a majority of clients were disadvantaged compared with the general population. They had poorer health, were less likely to have private health insurance, had lower income and educational levels and were more likely to be from Aboriginal and Torres Strait Islander or CALD backgrounds<sup>29</sup>.

Mainstream hospital and medical services are often not responsive to women's needs, beyond providing episodic treatment for medical conditions. Prevention is low on the list of priorities for most such services, where workers are generally stretch to provide the treatment services required. Mainstream workers often lack gender and cultural competence training, and the system generally does not have the resources to foster social connection.

At present , the women-managed centres and services, along with the network of community health services (the strength and number of which varies between jurisdictions) are far too few to meet the needs of even a fraction of Australia's socially disadvantaged women, much less provide preventive primary care services to the broad population of women (and men) that would benefit from them.

### **The Work of Women's Health Centres**

Women's health services play a crucial role in integrated service modelling and in essential individual, community, professional and system capacity building. A typical women-run centre acknowledges the diversity of women and is concerned with all aspects of well-being. It works with local community groups and individuals. It provides information and referrals, liaises with other health and information services, conducts needs analyses and runs workshops and seminars on various health subjects. It is involved in developing local area health plans and contributes to State health policy. It typically aims to improve the health status of women through the provision of preventative health care, community education, consultancy and advocacy and collaborates with other agencies in the local area, often using a community development focus, where resources allow. It provides women with knowledge, skills and resources to enable them to take more responsibility over factors that adversely affect their health, encourages and support women's self help groups and provides training and consultancy for service providers, workers and volunteers. It also frequently provides training for mainstream agencies, such as other health professionals, police and members of the legal profession <sup>29 30 31 32</sup>.

The following is an example of a women's health centre that provides best practice in women's holistic health care.

### **Waminda – Best Practice in Women’s Holistic Health Care**

The work of Waminda, a publicly funded Aboriginal women’s health centre on the South Coast of New South Wales, illustrates the enormous difference between the preventive, holistic, community focused approach of a primary health care service and the approach of a primary medical service, which focuses on treatment. The two sets of agencies provide quite different services. Waminda, which has operated since the early 1980s, provides an extensive range of culture and gender appropriate health services that especially target women at risk of poor health outcomes. It was developed specifically as a response to what Aboriginal women saw as unmet needs and gaps in service provision. The service has been evaluated by OATSIH, of the Department of Health and Ageing and successfully passed risk assessment evaluation.

The principles on which Waminda is based are understanding and valuing Aboriginal culture, a holistic, family and community-as-a-whole approach, in contrast to a focus on individuals, and a respect for women’s agency and participation in decision-making. The social determinants of health inform the work of the Centre.

Primary health care programmes include a Women’s Health Program, including a health and sexual health clinic, screening services, support groups for grief and loss, physical activity groups, health promotion and information. In order to provide an incentive for women to be screened, Waminda stages Pamper Days, in which community women are invited to participate in cultural activities, designed to promote self-esteem and self-awareness. On these days, women are also offered cervical screening and sexual health support.

A domestic violence support program includes education, awareness and community development projects, healing camps, court support and various other support services. There is a drug and alcohol support program, which provides assistance in times of crisis, along with advocacy, referral, information and education, case management and early intervention projects.

A Koori Girls School Program aims to empower girls and young women and help them make informed, healthy lifestyle choices. It provides primary and secondary school education about positive relationships, promotion of cultural beliefs and traditions and a mentorship program, supported by community elders. A Koori Women’s Playgroup provides support for mothers in relation to health, welfare, housing, finances and social and emotional well-being. One of the objectives of this project is support for children through early intervention services. An early childhood nurse and a dietician are available to women, along with specialist children’s services.

A 'Koori Chicks' Binge Drinking Project provides services and programs, which focus on binge drinking and its consequences for young Koori women before and after they leave school. Education is provided and the aim is to reduce risks, using a community development and community empowerment approach. Aboriginal women and girls affected by sexual abuse are supported by a Sexual Assault Support Program, which includes information, education, referral services, transportation where necessary, court support, victim compensation and advocacy. Programs are provided both in schools and in the wider community.

A Family Support Program provides workshops for women and their children in skill development, strength building and the identification of family needs in relation to housing, finances, social and emotional wellbeing and health. A parenting program is included and the aim is to build stronger families. Waminda also supports an Aboriginal Women Artist Cooperative, aiming to promote personal growth and empowerment through art and craft, as well as the development of business and IT skills and involvement in community development projects.

Clearly, the provision of such a range of preventive health services is a valuable addition to the medical care system. Waminda has a great deal in common with other women's health services and AWHN has suggested that members showcase examples of the work done by their services in their submissions to the new NHWP. The value of these services could be the focus for discussion in the Consultation forums to be held towards the end of 2009.

The participation of women in health decision making and management also needs to be actively promoted at all levels of the system. Improving the status of women will improve the basic conditions necessary for women to speak for themselves and be heard. Local women's and community health centres provide greater opportunities for women to participate in decision-making about their own health and about health policy at the community level than are available in busy private medical practices, which are funded on a fee-for-service basis for short appointments that focus on treating illnesses. The establishment of an extensive network of women's primary health care centres, including centres controlled by Aboriginal women, will result in a huge expansion of the opportunities for women's participation in health decision-making at the local level and also promote participation at other levels of the system.

Given the valuable work done by women's health services, AWHN recommends that a new National Women's Health Program be established, to contribute towards achieving gender equity in health and equity between groups of women and to provide a wide range of holistic, preventive primary health care and community development services.

## AWHN RECOMMENDATIONS

### **6. Establishment of a new appropriately funded National Women's Health Program to give effect to the new policy.**

Outcomes based funding processes should be established for each aspect of the new Program and should include annual reporting on progress and performance against agreed key indicators under each priority area. AWHN recommends that the new Policy and Program intersect with and inform the work of the National Preventative Health Commission. The work of the Commission should be required to include explicit consideration of the social determinants of health, including gender.

#### **The new Program should provide for:**

- **establishment of a network of Aboriginal and Torres Strait Islander women controlled Health Centres within communities where the need is agreed.** Successful Waminda projects can inform policy development. These centres would be based on extensive consultation and would reflect Aboriginal women's identified priorities.
- **expansion of existing Women's Health Centres and Services to provide an appropriate response to women most at risk of poor health outcomes. Areas where new services are to be established should be selected on the basis of unmet need, with a special focus low income areas which presently are without such services.** Projects and programmes should be informed by information provided by women during the consultation processes for the NHWP. The work of these centres and services should include a focus on systematic advocacy at the State and Territory levels of government.
- **even distribution of Women's and Aboriginal and Torres Strait Islander Women's Health Services across the country.** Existing centres and agencies are providing excellent primary and preventive health services. However, the spread of centres and agencies across the country is uneven, with most women unable to access them, particularly women living in rural and remote areas. Ideally, there should be women's health centres and services and Aboriginal and Torres Strait Islander women's health services in all areas of the country, operating to provide true primary health care services.
- **workforce development.** Funding should be provided for the training of specialist women's health workers. Funding should be increased for existing training programs for Aboriginal and Torres Strait Islander women and CALD women's health workers. Gender and cultural competency should be included in all general health and medical education and training curriculums. With appropriate resourcing, women's health services and centres have the expertise to design and oversee this training.

**7. The active promotion of the participation of women in health decision making and management, including:**

- inclusion of 'women focused' and 'cultural competence' units in medical and nursing education curricula that will indirectly expand opportunities for women's participation in decision-making were in place,
- development of specialised women's units in conventional health institutions will directly improve women's opportunities to participate in decision-making and
- funding of AWHN to be able to consult more extensively with women and to channel women's views into policy-making will provide vastly increased opportunities for women's participation.

#### 4. The Translation of a Strong and Emerging Evidence Base Into Action

AWHN strongly agrees with the Department of Health and Ageing that there is a 'need for comprehensive gender-relevant evidence' to support women's health policy and initiatives<sup>1</sup>. As the Department recognises, 'an evidence based approach to improving women's health is important in order to maximise the effectiveness of policies and programs and to facilitate the allocation of cost-effective interventions'<sup>1</sup>. The importance of prioritising data collection and research in the health arena is well-established<sup>8</sup>. However, it is also of utmost importance that action be taken on the huge amount of data and evidence that we already have.

To capture the range of information relevant to the social model of health, data collection and research must have both depth and breadth and must incorporate the social determinants of health. Public health research must include investigation of 'health, disease, health services, people's lifestyles and the organisation of their societies' in order to 'describe and explain how these factors are related'<sup>28</sup>.

There is a substantial body of evidence and research on the damaging impact of poverty and violence on health, the overrepresentation of women among the poor and the high-level of violence suffered by them. Nevertheless: health departments and other agencies around Australia still collect data that is not sex disaggregated. The importance of sex-disaggregated data is fundamental to gender equity because without it, 'gender analysis of health is not possible'<sup>11</sup>.

Data collection and research must be:

- gender sensitive and sex-disaggregated
- sensitive to other social determinants of health, that is, disaggregated by economic status, housing status, ethnicity, employment status, and so on
- comprehensive
- continuous
- sensitive to barriers to women's participation in research
- diverse, recognising the strengths and weaknesses of different data collection and research methods<sup>28</sup>
- both quantitative and qualitative
- inclusive of social science research<sup>28</sup>,
- sensitive to the position of marginalised women<sup>28</sup>.

Furthermore, even where gender relevant evidence is collected, it is not always reflected in policy, as in the case of the National Mental Health Policy. The new NWHP, through the capacity building infrastructure which we recommend, will have the capacity to promote 'knowledge transfer', the development, exchange and application of knowledge and expertise for mutual benefit, between organisations,



between organisations and government and government agencies, and across government. Specialist women's health services and government agencies can play a crucial role in ensuring that evidence is collected, translated and utilised in policy and practice. Through the new infrastructure, this evidence should be disseminated to Primary Health Care policymakers, the National Prevention policymakers and the National Mental Health policymakers.

The development of a national online 'index' of data on women's health and wellbeing would be an important tool for facilitating knowledge transfer. Based on the existing Victorian Index of Women's Health and Wellbeing Data, the Index would be an online 'gateway' to health and wellbeing data on social determinants relating to health and wellbeing, which has been analysed using both gender and diversity lenses<sup>33</sup>. Within the Victorian Index, the 'breadth of gendered data...extends beyond the traditional biomedical model of health...incorporating over 70 indicators of health and wellbeing relevant to a social model of health'<sup>33</sup>. The Index in Victoria has proved to an extremely popular, effective and widely-used resource.

## **AWHN RECOMMENDATIONS**

### **8. Development of a National Index of Women's Health and Well-Being Data**

### **9. AWHN, including AWHN's Aboriginal Women's Talking Circle, be funded to provide:**

- a national women's health information clearinghouse,
- ongoing consultation with women, including Aboriginal women, women with disabilities and CALD women, Australia wide, on women's health priorities, unmet needs and gaps in services,
- a forum for the exchange of information,
- quality advice to government on the development and implementation of policy affecting women's health, based on a funded research capacity,
- advocacy on gendered, preventive and health promotion strategies and
- special projects as required.

### **10. Promote further research and understanding of health equity among women and how to translate this knowledge into health policy and programs.**

## 5. A Lifecourse Approach

It is unclear from the Consultation Discussion Paper why this is proposed as a particular approach in the new NWHP.

However, taking into account the ways in which women's health is differently affected across the lifecourse is fundamental to good health outcomes. Women have particular physical and mental health needs at different stages of life. For example, during and following pregnancy, women experience increased risk of intimate partner violence, post-natal depression and economic insecurity, due to barriers to maternal employment. Women's economic health and wellbeing is also influenced by different life stages and events such as child-rearing, caring for elderly parents, retirement and the death of a partner who had previously provided economic security<sup>34</sup>.

A lifecourse approach must recognise gender equity in health and how this may change over a time. Although, on average, women live longer than men, women's later years, in particular, are often affected by disease and disability. Women's longer lifespan can also contribute to social isolation later in life when women, who have often been carers themselves, often have few people to care for them<sup>35</sup>. Discussions of women's health should therefore focus on quality, not only length, of life.

Some women experience the same or similar problems at all stages of life: same-sex attracted women report that discrimination impairs their health across the lifespan. Health inequity among women is also an issue throughout life, since health issues at certain ages may be different for different groups of women. For example, the considerably shorter life expectancy of Aboriginal and Torres Strait Islander women, compared to non-Aboriginal women (65 years compared to 82 years respectively) means that Aboriginal and Torres Strait Islander women are experiencing life-threatening health concerns at much earlier ages<sup>36</sup>. Aboriginal and Torres Strait Islander women's health is undermined by higher infant mortality rates at almost three times the rate of the rest of the population, higher levels of morbidity and early mortality of family and other community members. Aboriginal women cite grief and grieving as a major health concern.

## Priorities of the New NWHP

AWHN has identified five key priority areas for action under the new NWHP, as published in AWHN's Position Paper<sup>3</sup>. The identification of these key areas is evidence based and derived from consultation over many years with women and women's health workers and organisations across Australia.

### Priority One: Economic Health and Wellbeing

Economic security is a fundamental women's health issue. While the relationship between gender inequity and health is complex, women's health is 'fundamentally based on women's social and economic position within the community'<sup>21</sup>. Improving economic security is crucial to promoting the health and wellbeing of Australian women and is an important way in which the new policy can build on the 1989 National Women's Health Policy.

Socioeconomic status is fundamental to women's life chances and affects all areas of health and wellbeing, including physical, mental and emotional health<sup>3</sup>. Australian women, in comparison with men, are disproportionately affected by economic disadvantage on almost every indicator of economic health and wellbeing<sup>14</sup>, including experiencing higher rates of poverty and more severe poverty<sup>37</sup>. In turn, economic insecurity compounds the health issues of women in marginalised groups, such as Aboriginal and Torres Strait Islander women, CALD women and women with disabilities.

Australian and international research has found a strong correlation between poor health and socioeconomic disadvantage<sup>9 21</sup>. International and national research has found that women with lower economic status report poorer self-assessed health status, higher rates of long-term health conditions, higher rates of tobacco consumption, lower rates of physical exercise and worse dietary habits<sup>21 23 24 25</sup>. Women who are economically insecure are also at higher risk of experiencing homelessness, poor mental health and psychological distress and marginalisation and isolation<sup>21 37 38</sup>.

Employment status is a major determinant of women's poorer economic security<sup>37</sup>. As AWHN's submission on paid maternity leave argues, women have lower and more interrupted workforce participation rates than men, do more part-time and casual work, have lower incomes even when they are employed full-time and have less superannuation<sup>14</sup>.

Women's economic health and wellbeing is important across the lifespan. For example, the characteristics of women's employment in early and middle life, such as taking time out from the workforce to care for children or other family members, has a negative impact on women's economic security during that period and also in later periods, due to reduced superannuation savings<sup>3</sup>.

Addressing women's economic insecurity, especially for those women experiencing the most insecurity, is imperative to improving women's health and wellbeing in Australia. As AWHN has argued, 'until women's economic wellbeing is seriously addressed, it will continue to compromise women's general health and wellbeing and their status in the remainder of the identified health priority areas'<sup>3</sup>.

## **AWHN RECOMMENDATIONS**

**11. The NWHP should explicitly recognise the relationship between women's health and personal economic security and develop strategies to address inequitable economic structures, such as women's pay inequity and the superannuation gap between women and men.**

## Priority Two: Mental Health and Wellbeing

Promoting mental health and wellbeing is central to women's health. On many measures, women are more likely than men to suffer poor mental health, including long-term mental or behavioural health problems and higher levels of psychological distress<sup>39</sup>. Women also experience the 'highest levels of high prevalence mental health disorders, such as depression and anxiety'<sup>40</sup>. Women's mental ill-health is also reflected in initial statistics on use of the three new items on the Medicare Benefits Scheme (MBS) that focus on access to psychiatrists, psychologists and GPs regarding mental health issues, with women accessing these items twice as often as men<sup>40</sup>. The highest level of use is among women aged 25 to 44 years<sup>40</sup>.

Mental ill-health is associated with a range of social risk factors including poverty, subjection to violence and abuse, discrimination, poor housing and housing insecurity, employment and education, all of which affect more women than men<sup>3</sup>. Gendered stereotypes, 'expectations about roles, responsibilities and power relations' and the structural and cultural gender-based divisions of labour that persist in the home, community and workforce also have a harmful effects on women's mental health<sup>41</sup>.

Women's health services and women's health researchers have played an important role in highlighting the ways in which mental health and wellbeing is affected by gender and in arguing for gender-sensitive practice. Researchers have found that viewing mental health through a gender lens reveals 'differences in the prevalence and course of illness' and differences in the 'impact of biological, psychological and social factors in the causation of illness in women and men'<sup>42</sup>. Support and treatment services need to be informed 'by a knowledge and understanding of gender differences in women and men' which can then shape women-centred approaches to mental health care<sup>42</sup>. Research also shows that 'gender neutral' approaches to treatment and care neglect women's specific needs<sup>42</sup>. Women-centred mental healthcare models emphasise the importance of contextualising health service delivery in relation to the social, cultural and economic situation of women as they receive care. The translation of gendered evidence into gender-sensitive practice is crucial in promoting positive mental health and wellbeing outcomes for women<sup>42</sup>.

Women's mental health and wellbeing is closely linked to other priority health areas. As discussed above, women with poor mental health are more likely to experience economic disadvantage, which in turn, diminishes their ability to access health services and support<sup>21 37</sup>. The Council of Australian Governments has argued that 'people with mental illness are amongst the most socially disadvantaged and economically marginalised in our communities'<sup>43</sup>. Violence is repeatedly identified as a key contributor to women's mental ill-health, with women who have experienced domestic violence being twice as likely to be diagnosed with a mental illness<sup>37</sup>, including depression, anxiety and post-traumatic stress disorder<sup>44</sup>.

Marginalised women are at particular risk of experiencing mental ill-health and often face greater barriers to accessing services<sup>37</sup>. For example, the mental health and wellbeing of women living in rural and remote areas is undermined by large gaps in service provision, which severely inhibits their ability to access timely, appropriate and affordable assistance. Issues around access are further complicated for Aboriginal and Torres Strait Islander and CALD women, who may experience language and cultural barriers, inappropriate and culturally insensitive services, difficulties navigating the complexities of the health system and may present with more complex mental health needs. The mental health and wellbeing of same-sex attracted women and their access to appropriate health care services and information is significantly inhibited by heterosexism among health professionals, including assumptions of heterosexual lifestyle, discrimination and lack of acknowledgement of significant others.

All policies addressing mental health and wellbeing must be responsive to diversity, be gender, race and culture sensitive and must recognise gender as a social determinant of health. The new National Mental Health Policy is gender blind, despite women's distinctive experience of mental ill-health and increased exposure to risk factors. Although the Policy recognises that some 'population groups [are] at heightened risk', that individuals are more vulnerable at 'certain life-stages' and that 'social exclusion, discrimination and bullying' are risk factors, the particular impact on women in each of these cases is not acknowledged. The impact of informal caring on the mental health of those providing care is identified as a 'priority direction' but it is not acknowledged that women make up the majority of informal carers and therefore caring in Australia is deeply gendered<sup>45</sup>.

The new NWHP must therefore seek to influence national policy, especially the National Mental Health Policy, so that a gender lens is applied systematically across the whole policy spectrum to understandings of prevalence and course, causation and treatment of mental illness, as well as to subsequent policies, programs, initiatives and practices.

## **AWHN RECOMMENDATIONS**

**12. Gender and diversity-sensitive research and research on women and mental health problems should be expanded by its specification as an NHMRC research priority.** The mental health needs of women and the impact and prevalence of gender on mental health should be researched in detail<sup>35</sup>. In particular, there is a need for research that targets marginalised women, including Aboriginal and Torres Strait Islander women, women with disabilities, CALD women, low income women and women from rural and remote regions.

**13. Incorporate evidence-based understanding of the impacts of gender and diversity on mental health needs and outcomes and translate into practice across all mental health policies and sectors.**

**14. Gender and diversity-sensitive practice should be promoted across all government services and funded organisations concerned with mental health.**

**15. A gender lens should be applied to the recommendations of the Senate Committee on Mental Health, released April, 2006. The review of the recommendations should be conducted by an expert or expert panel, after which implementation should be facilitated.**

### **Priority Three: Preventing Violence Against Women**

The experience of violence has a major impact on the health and wellbeing of Australian women and, in turn, on their families and communities. The high prevalence of violence against women in Australia is well documented<sup>46 47 48</sup>. Violence is embedded in gender inequality and is directly linked to poor health outcomes for women and children. One in three Australian women experience violence, along with a large proportion of their children. Campaigns to reduce violence against women and children must operate across the full range of public policy areas, addressing the wide and varied factors, the social determinants, that cumulatively produce gender inequity and violence against women.

As AWHN argues in its submission to the National Council to Reduce Violence Against Women and Children, violence is enormously detrimental to women's physical, mental, sexual and reproductive health and wellbeing<sup>49</sup>. It leads to increased risk of death, including homicide and suicide, to higher rates of mental illness, including depression, to higher levels of chronic pain, physical injuries, psychosomatic disorders, post-traumatic stress disorder, sexually transmitted infections and other negative reproductive health outcomes.<sup>49 50 51</sup> The effects of violence can persist for many years after the abuse had stopped and the more severe the abuse, the greater the detrimental effect on health, with multiple episodes having a cumulative impact. These patterns are recognised in the National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021<sup>52</sup>.

Violence against women is a contributing factor in women's economic insecurity and experience of homelessness. For example, financial abuse, which involves restricting women's access to household resources, has been identified as a 'key aspect' of women's experience of poverty<sup>37</sup>. Impaired mental and physical health undermines women's ability to participate in the paid workforce. Lack of economic security and fear of homelessness are also factors in many women's decisions to stay in violent relationships<sup>52</sup>.

Evidence shows that low status is one of the fundamental causal factors underpinning violence against women and, in turn, violence has a particularly deleterious impact on marginalised women, so that violence both results from and serves to reinforce and perpetuate inequality and inequity<sup>49</sup>. Statistics illustrate that women in disadvantaged groups are at increased risk of experiencing violence, particularly Aboriginal and Torres Strait Islander women, women with disabilities, CALD women and young women<sup>53</sup>: Women from marginalised groups also typically face greater barriers to accessing appropriate support services.



In light of the multiple damaging effects of violence on women's health and wellbeing, WHO has identified the health sector as a crucial arena within which to address violence prevention, alongside human rights and legal frameworks. Violence against women must be addressed as a top health priority.

#### **AWHN RECOMMENDATIONS**

**16. Establishment of a permanent Council for the Prevention of Violence against Women and Children to provide** ongoing comprehensive action with the aim of systematically reducing violence against women and children.

**17. Recognition of the health impacts of violence against women, within all national health policies,** including the new NWHP, the National Men's Health Policy, the National Mental Health Policy and sexual and reproductive health policies, and in other national policy areas, such as education, housing and child protection.

**18. Expand the capacity of existing women's health centres and services, community health centres and community services to provide, at the local level, both violence prevention strategies and support services for those who have suffered/are suffering from the impact of different forms of violence.**

## Priority Four: Sexual and Reproductive Health

Sexual and reproductive health is a crucially important health and wellbeing issue for women, which impacts on their health across the lifespan<sup>3</sup>.

The Consultation Discussion Paper identifies a range of sexual and reproductive health issues that affect women, including antenatal and postnatal depression, cervical cancer, endometriosis, menopause symptoms, ovarian cancer and chlamydia<sup>1</sup>. Australia needs a national sexual and reproductive health strategy which incorporates gendered analysis to recognise and address the ways gender factors adversely affect women's sexual and reproductive health.

For example, sexual and reproductive health is affected by women's experiences of violence, including being coerced into unwanted sex<sup>54</sup>. Sexual violence is associated with a range of health concerns, including the risk of unwanted pregnancy and sexually transmitted infection, as well as psychological distress and longer-term mental health problems<sup>55</sup>. Young women are particularly vulnerable to sexual violence<sup>56</sup>. Australian research on young people's sexual activity and health has found links between binge-drinking and unwanted sex<sup>56</sup> and experience of sexual violence<sup>57</sup>, low rates of contraception use including emergency contraception<sup>57</sup> and poor knowledge of sexually transmitted infections (STIs) including the most common infections, such as chlamydia, gonorrhoea, herpes simplex virus and genital warts<sup>56</sup>. The intersections between young women's vulnerability to unwanted sex and sexual violence, excessive alcohol consumption, risk of unplanned pregnancy and STIs highlight an urgent need for better education around sexual and reproductive health aimed at young people, including respectful, equal relationships, and the early identification and treatment of STIs to promote positive health outcomes, especially for young women.

The importance of applying a diversity lens to issues of sexual health is highlighted by the recurrent assumption that same-sex attracted women are not vulnerable to STIs, a misconception that has clearly has adverse affects for the sexual health of same-sex attracted women.

Lack of access to appropriate services affects women's sexual and reproductive health and impairs women's control over their reproductive health. For example, many Australian women lack access to public abortion services or other sexual and reproductive health services, particularly those living in rural and remote areas<sup>54</sup>. Rural and remote women also face higher costs for services, a limited range or choice of services and concerns about confidentiality (concerns that affect not only sexual and reproductive health but all health priority areas for rural and remote women).

Access to contraception is a crucial factor in heterosexual women's sexual and reproductive health. Availability and choice of contraceptive methods has greatly improved over the last 15 years. However, women still experience a range of difficulties in relation to contraception, including cost, the logistics of accessing contraception (such as barriers of access to doctors), inadequate or confusing advice from health professionals, inconsistent or disrupted supply (e.g. typically only three cycles are distributed at once), side effects (e.g. depression, mood swings), parental views on contraception and/or sexual activity and conflicting information or misinformation. Women bear the primary responsibility for contraception.

As with each of the other health priorities, women's sexual and reproductive health is affected by factors both within and outside the health sector, including Medicare, the role of general practitioners and pharmacists and social attitudes. Strategies to improve women's health must therefore be multidimensional and must include interventions within each of these spheres. This approach is reflected in the points of action identified by the Public Health Association of Australia (PHAA) to tackle STIs, which include:

- Promotion of respectful, equitable, non-violent relationships
- Provision of consistent, high quality, comprehensive relationships and sexual health education across Australian schools
- Promotion and provision of a full range of affordable contraceptives, emphasising the role of condoms and safe sex practices in reducing STIs
- Investment in comprehensive sexual and reproductive health services, and
- Reduction of binge-drinking among young people<sup>57</sup>.

Access to safe, affordable and legal abortion, both medical and surgical, is also fundamental to women's sexual and reproductive health. Currently, abortion remains in the criminal code of four States (New South Wales, Queensland, South Australia and Tasmania) and the Northern Territory, creating a risk of both consumers and providers being charged with a criminal activity, as in Queensland at the present time.

The illegal status of abortion inhibits women's access to termination services, reduces support services and information for making informed decisions about unplanned and/or unwanted pregnancy and abortion and contributes to the continuing social stigma around women's decisions to have abortions. Giving women opportunities and support to make free, informed decisions regarding unplanned and unwanted pregnancies leads to the best outcomes for women. The legalisation of abortion in all States and Territories must be a priority and must be accompanied by the establishment and maintenance of 'a coordinated system of pregnancy support services...for women who are dealing with an unplanned and/or unwanted pregnancy' and 'accessible, affordable, and timely services...throughout [Australia]

for women seeking abortion'<sup>58</sup>. These services must be tailored to meet the specific needs of marginalised women and women living outside the major cities.

## **AWHN RECOMMENDATIONS**

**19. AWHN recommends that in developing the new NWHP, the Department of Health and Ageing reviews the current Medicare and PBS arrangements which control and often restrict women's access to contraception.** The role of general practitioners as 'gate-keepers' for contraception and the provision of emergency contraception through pharmacists should also be analysed, questioned and evaluated. The rebate for surgical abortion should be examined to ensure that out of pocket expenses do not constitute a barrier to service use.

**20. The new NWHP should facilitate the dissemination of information about access to and correct use of contraception** through education and social-marketing, including through the National Schools Curriculum. These channels should also be used to promote shared responsibility in relation to contraception.

**21. AWHN supports the call for a National Sexual and Reproductive Health Strategy.** Such a strategy will facilitate a comprehensive and systematic approach to sexual and reproductive health at all levels of government, in non-government agencies, in research organisations and among service providers<sup>57</sup>. AWHN supports the holistic, preventive, strongly evidence based strategy, carefully worked out by experts in Sexual Health and Family Planning Australia (SH&FPA) and the Public Health Association of Australia in 2008<sup>57</sup>.

**22. AWHN calls for the removal of abortion from the criminal codes of all remaining Australian States and Territories.**

**23. AWHN calls upon the Commonwealth government to take steps to ensure that medical abortion is available to women in all jurisdictions of the country.**

## **Priority Five: Improving Access to Publicly-Funded and Financially-Accessible Health Services**

### **Access to Holistic Preventive Health Services**

One of the aims of funding separate women's health services in 1989 was not only to fill gaps in service provision but to experiment with new, women-friendly approaches to women's health, based on input and feedback from women in local communities, many of them marginalised in different ways. The best practice approaches thereby developed within to provide a model for mainstream service provision.

The women's health sector has been able to influence the mainstream in certain critical areas, for example, in raising awareness of the health impacts of violence against women, successfully campaigning in two States and one Territory for the reform of abortion laws, influencing law reform regarding sexual assault, the establishment of the Aboriginal Birthing Centres and the development of national quality standards for women's health services, to name just a few.

Overall, however, the impact of the 1989 National Women's Health Policy and Program on mainstream services and policies within and between States and Territories has been patchy and it has been restricted by low levels of funding. There has been no obligation for the mainstream to be gender responsive and there are few conduits through which information can flow directly between these sectors of the health system providing very different services. At present, most medical services are offered in the private sector on a fee-for-service basis. This system encourages volume in service provision, as is widely recognised in most European countries and in Canada. It does not, however, encourage the provision of preventive services: practitioners are not currently paid to produce the kinds of preventive, holistic outreach health services that are required as part of a population health and social determinants approach.

Given the current health system structure, one option to increase women's access to real primary health care services would be to provide financial incentives for hospitals and private practitioners to broaden the mix of services they produce. However, to date, evaluations of the additional funding that has been channelled through the Divisions of General Practice have not been positive<sup>59</sup>. Moreover, the hospital and medical services systems are already stretched to full capacity providing treatment services. The fact that the focus is on individual treatment rather than population health or the social determinants of health is in line with the education that practitioners and workers have received but this, along with time pressures limits systemwide capacity to optimise health outcomes.

A second option, and the one recommended by AWHN, as discussed above, is to put in place an extensive network of comprehensive, publicly funded, public sector

primary health care services, including specialised women's health services, capable of immediately employing a gendered, preventive approach. As discussed in each of the preceding priority areas, inadequate access to preventive and holistic health services is a major impediment to women's (and men's) achievement of positive health and wellbeing outcomes.

### **Access to Conventional Hospital and Medical Services**

Access to timely, affordable, appropriate and high quality hospital and medical services is critical to women's health and is essential to ensure the early treatment of disease, a secondary prevention measure<sup>3</sup>. However, women face a range of obstacles to accessing appropriate and affordable services. Current barriers include limited access to bulk-billing practitioners in many parts of Australia, shortages of accessible women-specific health services, such as the dearth of sexual and reproductive health services away from major cities, shortages of women medical practitioners and waiting times, particularly for specialists. Other obstacles include lack of gender and cultural competence, lack of sensitivity and understanding about the specific health care needs of certain groups of women, such as same sex attracted women, refugee women, women with disabilities and older women<sup>3</sup>. Women's access to health services is also affected by lack of transport options, especially for low income women, including outer suburban, rural and remote areas, lack of gender sensitivity in the design of some diagnostic tests and treatments and gender bias in medical research and training which preferences the male body<sup>3</sup>.

In light of women's relative socioeconomic disadvantage, ensuring the affordability of medical and diagnostic services, medications and treatments is crucial to promoting women's health and wellbeing. Approximately 54 percent of women do not have private health insurance, thereby reducing the services they can access<sup>60</sup>. Increasing user charges have a serious impact on access<sup>61</sup>. 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<sup>62</sup>. Other studies conducted in New South Wales in 2003 show that private patients were using the vast bulk of non-emergency, elective surgery, crowding out those without private insurance<sup>63</sup>.

Comparative research undertaken in 2007 suggests a slight improvement in access over 2003 but shows that serious access barriers remain. In the year prior to the study, user charges were given as the reason for 13 per cent of Australians not 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. 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<sup>64</sup>.

User charges, then, prevent Australian women (and men) on low incomes from using conventional medical services, a finding consistent with major international studies. The gap between the fee charged by health care providers and the Medicare rebate is a financial barrier, especially in relation to specialist services and expensive diagnostic services, where the gap can run to hundreds of dollars. Financial barriers are exacerbated for all groups of marginalised women, as reflected in the unacceptably low levels of access to culturally appropriate health care services for Aboriginal and Torres Strait Islander women, cultural minorities and certain ethnic groups, particularly in remote communities.

As is well-known, lack of timely access to treatment services results in higher levels of serious illness. The unfairness of a national policy of user charges that impacts most heavily on the poorest citizens strikes home when we remember that low income people suffer the most ill health at the best of times. The irrationality of it in terms of high unnecessary expenditure is underlined when we consider that the AIHW has estimated that 9 per cent of Australia's hospital admissions are avoidable, a disproportionate number coming from the most disadvantaged areas, as we would expect<sup>65</sup>.

## **AWHN RECOMMENDATIONS**

### **24. Measures are needed to encourage the health system to be more responsive to the needs of women. Specifically:**

**24.1 In the interests of access and equity, user charges should be eliminated for medical services, through the mandatory use of bulk billing,** following the model set by Canadian Medicare. More generous safety net provisions should be put in place for pharmaceutical goods to ensure affordability. A national, publicly funded, salaried dental service should be implemented forthwith to ensure that low to middle income earners have access to services.

### **24.2 New specialised women's health units in public sector health institutions should be established to include:**

- birthing centres in public hospitals,
- women's health units in community health centres,

- designated women's health units in each of the 31 GP Super Clinics, especially since these clinics are to be located in high need and underserviced areas and
- the expansion of community health centres, providing comprehensive, prevention oriented, gendered, primary health care (as well as primary medical care, where appropriate) which places priority on the health needs of those most at risk of avoidable health inequities.

**24.3 Review of medical and nursing education:** to determine, with a view to reform, the extent to which educational curricula include specialised components on gender and cultural competence, on the social determinants of health (as well as a medical and biological perspective) and on the health (as well as illness treatment) of those groups in the community at greatest risk of poor health outcomes.

**24.4 The establishment of a permanent Health and Hospitals Reform Commission, with equal representation of women and proportional representation of Aboriginal and Torres Strait Islander women, women with disabilities, CALD women and women from rural and remote communities, mandated to advise on, among other things,**

- how the conventional medical care system can be reoriented to include a focus on the social determinants of health, including gender, and how service provision can be altered accordingly,
- how primary health care systems, rather than primary medical care systems, can be strengthened,
- how health services for Aboriginal and Torres Strait Islander women can be improved,
- how health services for women generally can be improved and
- how services for those groups most at risk of poor health outcomes can be improved.



## Conclusion

The new NWHP has the potential to change the lives of women across Australia. Improving women's health and wellbeing will require action across many areas, both inside and outside the health system. Priorities must be economic health and wellbeing, mental health and wellbeing, preventing violence against women, sexual and reproductive health and improving access to publicly-funded and financially-accessible health services. A foundation has been put in place by the first National Women's Health Policy, 1989, which made Australia a world leader in women's health and the social health perspective. However, this foundation now needs to be strengthened and expanded. The opportunity is present for Australia to again take an international leadership role in developing appropriate women's health strategies based on the social determinants of health, which are now widely accepted in OECD countries.

AWHN appreciates the opportunity to be part of this important consultation process and would be willing to be involved in the development and implementation of the policy in the future. AWHN looks forward to a new National Women's Health Policy that reflects the experiences, voices and recommendations of women, women's health organisations and service providers, draws on national and international evidence and best-practice and provides a strong framework for the progression of women's health in Australia.

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