



Women's Health:

Australian
Women's
Health
Network

The New National Agenda

Discussion paper | July 2007

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Foreword

The Australian Women's Health Network is pleased to present this discussion paper, 'Women's Health: The New National Agenda'.

In 1989 when Australia launched its first National Women's Health Policy we led the world in describing and developing solutions to the health needs and issues of women. This innovative and progressive policy established a vision for improving the health of all Australian women through targeted strategies. It also committed the federal, state and territory governments in Australia to allocate funds towards implementing those strategies.

Since then, many other developed and developing countries have followed Australia's lead and developed their own women's health plans. However in Australia, there is concern that women's health has slowly disappeared as a policy priority on the national agenda.

With the changing and increasingly demanding roles of Australian women, we believe it is more important than ever before that the health needs of women are framed as an integral part of our national health policy—not as a special interest group or as a subset of reproductive health issues.

The fields of health research, health care and health funding are highly contested and constantly evolving. Within this discourse, it is vital that the voices and concerns of women are raised, including the voices of women's health organisations and the myriad other groups dealing with women's health outcomes on a daily basis.

At the 2005 National Women's Health Conference, it was agreed that significant effort was required to bring women's health back onto the national health policy agenda before our next conference in 2010. This discussion paper, and our upcoming summit in Canberra (September 2007), represent part of that effort.

The Australian Women's Health Network is seeking input and collaboration from all stakeholders in women's health and wellbeing—including governments, professional associations, community organisations and individual women—in further developing our vision for a forward looking women's health policy of which we can all be proud.

Australian Women's Health Network

July 2007

About the AWHN

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 and operates as a women's health advocacy, information and lobbying organisation, working with government policy makers and other agencies to improve the health and wellbeing of Australian women.

AWHN has affiliated networks in all states and territories of Australia. Both the state/territory groups and the umbrella national organisation represent a wide cross section of women, and organisations representing specific groups of women. As health is interpreted in a broad social context, women from a range of interest groups take up AWHN membership. The organisation cuts across political, economic, social and ethnic barriers. Women's health networks frequently consult with other organisations representing women and work together to address major issues facing women.

The broad aims of AWHN are:

- 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 our objects and philosophy.

AWHN is funded from membership fees and does not receive government funding.

Acknowledgments

Chris Black, Author of *Women's Health: The New National Agenda*, on behalf of AWHN

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Executive summary

The purpose of this discussion paper is to propose a new national agenda for women's health in Australia. It does so by outlining the key arguments for making women's health a priority of governments, health professionals and the broader community and proposes a framework and process through which this can be achieved.

Section 2 describes 'why women's health matters' and how women's experience of life (and health) differs from that of men. It underscores the fact that improving the health of all women will have a marked impact on the health of the broader community.

Section 3 provides a summary of the development and achievements of Australia's first National Women's Health Policy, widely acknowledged as a world leading best practice example of how to approach women's health. It notes that the framework and commitments of that first policy still have great relevance and currency today, and provide a strong base for the development of a new policy.

In **Section 4**, statistics compiled for the Australian Government's publication, *Women in Australia 2007*, are used to demonstrate some of the key social, economic and health issues facing women today. These statistics highlight achievements that have been made over recent decades, as well as continuing inequities and differences that demonstrate the need for a coordinated and holistic approach to women's health and wellbeing.

Section 5 outlines the differences between 'gender' and 'sex' and how each impacts on women's health experiences and outcomes. It also shows how gender mainstreaming and gender analysis have been used by international bodies and other national governments to maximise the effectiveness of investment in health services.

Section 6 proposes several key criteria to be used in the development of a new national women's health policy, namely:

- using a social model of health
- incorporating a diversity analysis to ensure that the needs of all groups in the community, including Indigenous women, are taken into account
- developing priority areas for women's health (outlined in Section 7)
- the benefits of adopting a gendered approach to the already agreed national health priorities
- using an inclusive and accountable process for further development and implementation of the new women's health policy.

Section 7 outlines the suggested priority areas for new national policy. This is likely to be a contested area as there are always calls for different aspects of health to be prioritised. However we have suggested that, as a starting point, the following are considered as priorities in the first iteration of the new national women's health policy:

- women's economic health and wellbeing
- women's mental health and wellbeing
- preventing violence against women (in all its forms)
- women's sexual and reproductive health
- improving women's access to publicly funded health services.

Within these priority areas, critical issues such as improving Indigenous health and life expectancy, health care for our rapidly ageing population, and addressing the harms of health issues such as obesity and drug and alcohol abuse can all be incorporated.

The paper poses questions around the choice of these priority areas, and what sort of indicators and performance measurements should be used in each case.

Finally, the appendices contain some background information about international developments in women's health policy, a more detailed record of the way in which the first National Women's Health Policy was developed, and an overview of how women's health policy and programs are now approached through the government-negotiated Commonwealth/state/territory Public Health Outcomes Framework Agreements (PHOFAs).

All aspects of this paper, including the calls for action on pages 17–18, will be discussed at the AWHN Summit in Canberra in September 2007. Suggestions for improvements and additions are welcomed from all stakeholders, and expressions of support will be sought from organisations involved with improving women's health and wellbeing.

This paper represents the start of a new national women's health policy framework, and a process for delivering on that goal.

Understanding why women's health matters

Women are different from men and experience life differently, both in sickness and in health. Throughout their lives, from childhood to old age, women will have different health experiences and outcomes based on both biological factors and gender roles.

As well as the obvious anatomical differences, these include genetic, hormonal, psychological and social factors. In responding to women's health issues it is important that these differences are recognised and acknowledged, without overshadowing or dismissing the commonalities women share with men. Similarly, many aspects of men's health could be improved by considering their gendered roles in society.

There are some conditions that affect more women than men such as arthritis, major depression, osteoporosis, eating disorders and the health impacts of family violence. There are also some conditions that affect women differently than they affect men. Heart attacks and HIV/AIDS are two of the more serious conditions that doctors sometimes overlook in women because the signs and symptoms look different than they do in men.

In addition, there are some conditions related to reproductive health that will only affect women, such as pregnancy, childbirth and menopause. However women's reproductive health issues represent just some of their health concerns. As will be detailed throughout this paper, there are many other health issues related to their productive roles (as workers, carers, active community members, etc) and their gendered roles that are just as critical to address.

Better outcomes in women's health and wellbeing have benefits for the individuals and their families, and for the broader community. Flow on benefits are extensive and include greater participation and productivity by women in the paid and unpaid workforce, and less demand for high cost health services to be funded by government.

As highlighted in the South Australian Women's Health Policy¹, 'women are the majority of health consumers, the majority of health service providers and the majority of carers. Improving the health of **all women** will improve the health of the whole community.'

These better health outcomes can only be reached by having a health policy that is approached from a gendered and whole of government perspective—one which responds to the broad range of economic, social and cultural factors that impact on health outcomes for women.



“Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Women’s health involves their emotional, social and physical wellbeing and is determined by the social, political and economic context of their lives, as well as by biology.” (Para. 89)

**UN Platform for Action
Beijing, 1995**

3

Building on the first Australian National Women's Health Policy

In Australia we are lucky enough to already have a strong framework for addressing women's health that could be used to build a refreshed and strengthened vision for the future. Australia's *National Women's Health Policy*², adopted in 1989, led the world in delivering a health policy that responded to the specific needs and issues facing women. It was very progressive in adopting a social model of health that went beyond the dominant biomedical model of health and acknowledged that social, environmental, economic, biological and gender factors all influenced health outcomes.

This paradigm shift from a biomedical to a social model of health was influenced by new thinking at the national and international level (through the World Health Organization and other bodies) and driven by women's health organisations and advocates. It also reflected the significant involvement of women and women's organisations in the extensive consultation processes that were undertaken by government.

The *National Women's Health Policy* (NWHP) was developed following calls for action at the 1985 National Women's Health Conference. In response, a commitment was made by the Commonwealth Government to pursue a national approach and consultation occurred with more than one million Australian women. The policy provided both a framework and action plan to improve the health of women in Australia to the year 2000. Its focus was on those women considered most at risk, and to encourage the health system to be more responsive to the needs of women.

Unfortunately the specific issues so important to Indigenous women's health were left to one side because a separate inquiry into the health of Indigenous people was being undertaken around the same time.

Principles underlying the *National Women's Health Policy* were:

- an understanding of health within a social context, as emphasised by the World Health Organization and endorsed by the Australian Government, recognising that:
 - health is determined by a broad range of social, environmental, economic and biological factors
 - differences in health status and health outcomes are linked to gender, age, socioeconomic status, ethnicity, disability, location and environment
 - health promotion, disease prevention, equity of access to appropriate and affordable services, and strengthening the primary health care system are necessary, along with high quality illness treatment services
 - information, consultation and community development are important elements of the health process

- the need to encompass all of a woman's lifespan, and reflect women's various roles in Australian society, not just their reproductive role
- the need to promote greater participation by women in decision making about health services and health policy, as both consumers and providers
- recognising women's rights, as health care consumers, to be treated with dignity in an environment which provides for privacy, informed consent and confidentiality
- acknowledging that informed decisions about health and health care require accessible information which is appropriately targeted for different socioeconomic, educational and cultural groups
- the importance of using accurate data and research concerning women's health, women's views about health, and strategies which most effectively address women's health needs.

The Australian Government and all state and territory governments became signatories to the policy and committed funding to establish the National Women's Health Program. In the first four years of the program, it was agreed to tackle seven priority health issues for women:

- reproductive health and sexuality
- health of ageing women
- women's emotional and mental health needs
- violence against women
- occupational health and safety
- the health needs of women as carers
- the health effects of sex role stereotyping on women.

In implementing the policy, there were five key action areas identified as necessary within the health care system to improve women's health, and to be delivered through the Commonwealth–state agreed *National Women's Health Program*. These were:

- improvements in health services for women, based on a dual approach which meant the provision of more women's health services, and complementary improvements to existing general health services
- provision of health information for women, in both the prevention and treatment of health problems
- research and data collection on women's health (which led to the establishment of the Longitudinal Women's Health Study)
- women's participation in decision making on health, at government and community levels, and as consumers of health services
- training of health care providers, at both undergraduate and postgraduate levels, around women's health care needs.

A review of the first four year program led to it being renewed for a further four years (1993–97). Another evaluation in 1997 (unpublished) concluded that the program had been highly effectively and highly valued by the women who used its services. However with the introduction of the new Public Health Outcomes Framework Agreements (PHOFAs) in 1997, the specific focus on women's health policy at the national level was lost (see Appendix B for details on history of the policy and current arrangements).

On a more positive note, in reviewing the 1989 NWHP today, it is clear that many of its goals and principles remain highly relevant in 2007 and beyond.

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Current status of women in Australia

Many Australian women are undoubtedly experiencing higher levels of economic prosperity, educational attainment and good health than in previous decades, and certainly in comparison to women in developing countries. However there are still many women living in poverty, trapped in under-employment or low income occupations and experiencing poor health outcomes. The following statistics are compiled from the Australian Government's *Women in Australia 2007* report, and represent some of the key social, economic and health issues faced by women.

Population — *women live longer than men*

- As at June 2006 women comprised 50.2 per cent of the population (N=10,348,070).
- On average, Indigenous women die much younger, with the life expectancy of Indigenous women 64.8 compared to 83.3 years for non-Indigenous women.
- Women on average live 4.8 years longer than men, and by the age of 85 years, women outnumber men two to one.

Economic security — *women are less economically secure*

- In December 2006 nearly 58 per cent of women were in the paid labour force (compared with 72 per cent of men).
- Between November 1996 and November 2006, full-time ordinary time earnings for women increased by 18.8 per cent in real terms.
- However at the end of 2006 the ratio of female to male full-time earnings was 0.84, representing a gender earnings gap of 16 per cent.
- Women's average weekly full-time earnings are \$941 compared to \$1125 for men (a gap of \$184 per week). Average earnings for all women (including part-time) was \$666 per week.
- Women are less likely than men to have superannuation, and women have lower superannuation balances than men across all age groups, particularly those women working part-time or not in the labour force.
- As at June 2004, there were nearly 2.6 million women in receipt of income support payments (compared to 1.8 million men) with Age Pension, Parenting Payments and Partner Allowances being predominantly paid to women.

Women as mothers and carers— *women maintain the primary caring role*

- In 2005 the fertility rate was 1.81 babies per woman, the highest rate since 1995.
- Women are continuing to delay childbearing with the greatest fertility rates now in the 30–34 year range (for Indigenous women the greatest fertility rates are for women under 30 years).
- Women continue to do the majority of housework and child care.
- More women than men care for the elderly and people with a disability.
- The majority of one-parent families (83 per cent) were headed by single mothers.

Violence against women— *a costly problem in all communities*

- Research by VicHealth showed that domestic violence is the leading contributor to death, disability and illness in Victorian women under the age of 45 years.
- A 2004 survey found that one in ten Australian women had experienced physical and/or sexual harm during the previous 12 months.
- Indigenous women are around three times more likely to experience physical violence or sexual assault than non-Indigenous women.
- In 2002–03 it was estimated that domestic violence cost the Australian economy \$8 billion each year.
- While the 2005 ABS Personal Safety Survey showed a decrease in the reporting rate of violence for all women, there was an increase in reports from women aged 45 years and over.
- Rates of reporting to police remain low, with more than 80 per cent of sexual assaults and 66 per cent of physical violence not being reported.
- In 2003–04, 75 per cent of female homicides were at the hands of their partner or another family member.

Women's health outcomes— *divergent issues and outcomes*

- Based on self-reporting surveys, the majority of women report being healthy but nearly twice as many Indigenous people report only fair or poor health.
- However nearly 4 in 5 women suffer from at least one long term ill-health condition, with women experiencing higher prevalence asthma, hypertensive disease, chronic sinusitis and arthritis than men.
- Women are less likely to report alcohol and drug problems than men, but 1.5 times more likely to report anxiety-related and mood (affective) problems.
- Women are 1.5 times more likely to report high levels of psychological distress than men, but lower rates of low level distress.
- Heart diseases, stroke, dementia and breast cancer are the leading causes of death for women.

- Breast cancer continues to be the most common type of cancer in women. It is projected that the incidence of breast cancer will increase over the next five years to nearly 15,000 women, yet the survival rates for both breast cancer and cervical cancer are improving.
- Data indicated that the greatest health risk factor for women is inadequate fruit and vegetable consumption, followed by excess weight and lack of physical activity.
- Since 1995, nearly twice as many women engaged in risky levels of alcohol consumption, while smoking rates remain relatively stable.
- More young women are engaging in early sexual intercourse, with nearly one quarter of year 10 girls reporting involvement in sexual intercourse.
- Chlamydia is the most frequently reported sexually transmitted infection, with an increase of more than 400 per cent over the last decade. (It is thought that genital warts and genital herpes are more common, but these are not notifiable diseases).
- In 2003 there were 84,218 reported induced abortions, with the highest incidence in the 20–24 age group (21,826), and the lowest in girls under 15 years (306) and women over 44 years (498).
- Around 95 per cent of women at risk of unplanned pregnancy reported using some form of contraception, however sexually active school age girls were less likely to report using a condom than were a similar cohort in 1997.

Gender as one of the social determinants of health

5.1 Gender vs. sex differences

Over the past few decades, there has been growing evidence of the relationship between gender and health, and an improved understanding of gender as an important determinant of health and wellbeing. Although the importance of gender to health outcomes is now widely accepted in many contexts, this concept remains absent from both policies and practices in many health settings, and is still often confused with sex differences.

The World Health Organization provides the following definition:

Gender is used to describe those characteristics of women and men which are socially constructed, while sex refers to those which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles⁴.

An example of these gender based behaviours is the increasing uptake of smoking among young women since smoking became 'acceptable' for women in the second half of the 20th century⁵, with the resultant increase in the incidence of lung cancer among this group. There is also a strong link between smoking and socio-economic status, which again requires some gender-based analysis given the high levels of women-headed low income households.

As outlined in the *1989 National Women's Health Policy* and many subsequent women's health plans both in Australia and internationally, it is important that gender is included as one of the many interactive factors that contribute to an individual's health status. Internationally, G8 leaders have made a particular call for a 'gender-sensitive response' and to ensure that 'greater attention and appropriate resources are allocated [to] the needs of women and girls.' Other leaders in the health area have gone so far as to say that 'the single most important issue on the face of the planet is gender equality'.⁶

It is equally important that processes for incorporating knowledge and awareness of gender issues are built into both the mainstream health service system and women-specific health services.

This process of ensuring that women's health issues are not marginalised outside the mainstream health system is often referred to as 'gender mainstreaming'.

5.2 Gender mainstreaming

Gender mainstreaming is the process of assessing the implications for women and men of any planned action, including legislation, policies or programs with the ultimate goal of achieving gender equality. It is a strategy for making women's—as well as



'Gender relations are present at every part of the health and disease pathway, and so gender needs to be considered at every stage of health promotion, disease prevention, health care and palliative care.'

**Dr Robert Hall,
Director Public
Health and Chief
Health Officer,
Victoria³**

men’s—concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programs.

The aim of gender mainstreaming is to ensure that any inequality and discrimination in the allocation of resources and benefits or in access to services is identified and addressed⁷.

Other benefits of adopting a gender perspective in health policy, as identified by the World Health Organization European Region⁸, include that it:

- recognises the need for the full participation of women and men in decision-making
- gives equal weight to the knowledge, values and experiences of women and men
- ensures that both women and men identify their health needs and priorities, and acknowledges that certain health problems are unique to, or have more serious implications, for men and women
- leads to a better understanding of the causes of ill-health
- results in more effective interventions to improve health
- contributes to the attainment of greater equity in health and health care.

This approach has been embraced by international bodies such as the World Health Organization, the United Nations, and the Commonwealth Heads of Government, and is supported by women’s health advocates—as long as it is complemented by the continued provision of a sustainable women’s health service system.

The Canadian Government has taken this gendered approach to policies and programs even further by developing and mandating the use of ‘gender-based analysis’ as a tool for assessing the effects of gender on health and healthcare⁹.

Gender analysis in health often highlights how inequalities disadvantage women’s health, the constraints women face in attaining optimal health and ways to address and overcome these constraints¹⁰.

Such a tool can be used to help distinguish the differences between women and men, the nature of their social relationships, their different social realities, life expectations and economic circumstances.

Using this approach, it is possible to identify a range of health issues that affect women only, some that are more common in women than men, and special conditions that are related directly to gender roles¹¹:

| Some health issues that affect women only | Some health issues more common in women | Special conditions related to gender roles |
|--|---|---|
| <ul style="list-style-type: none"> ■ menstruation ■ pregnancy ■ complications of pregnancy ■ menopause ■ gynaecological cancers | <ul style="list-style-type: none"> ■ breast cancer ■ heart disease ■ osteoporosis ■ depression ■ hypertension ■ arthritis | <ul style="list-style-type: none"> ■ sexual abuse ■ domestic violence ■ effects of prostitution ■ anorexia/bulimia nervosa ■ conditions related to poverty, particularly in older women or as a result of women’s role as carers |

Similarly for men, there is a range of health issues that only affect them (such as prostate cancer), that are more common to men (alcohol use, lung cancer, pulmonary disease, hearing loss) and that are related to gender roles (stress related to overwork, lack of social connectedness, suicide).

A formal gender analysis tool would help to ensure that health interventions are more effectively targeted at important health issues for women and can also inform the development of a new national women’s health agenda.

A new national women's health policy

We are rapidly heading toward the year 2009 which will mark the 20th anniversary of the first National Women's Health Policy and Program. This is also the year in which the current Public Health Outcomes Framework Agreements (PHOFAs) are due to expire.

Therefore the next two years represent an excellent opportunity for all stakeholders to review the achievements of women's health initiatives to date, and work collaboratively to develop a new way forward for national policy addressing women's health and wellbeing.

The following criteria are proposed as a starting point for the development of a new and effective national women's health policy for all Australian women:

- 1 That it is based on the **social model of health** outlined in the 1989 Women's Health Policy, and incorporates a specific focus on gender as one of the social determinants of health. (See Section 5.1)
- 2 That it includes a **diversity analysis** that considers factors such as Aboriginality, ethnicity, geographic isolation, work/family responsibilities, level of ability, and sexual orientation. (See Section 5.2)
- 3 That **women's health priority areas**, based on consultation and further analysis of current health indicators, are specified (See Section 6) with an initial set of priorities suggested as:
 - women's economic health and wellbeing
 - women's mental health and wellbeing
 - prevention of violence against women
 - women's sexual and reproductive health
 - access to publicly funded health services.
- 4 That a gendered approach is incorporated into **the agreed national health priorities**. (See Section 5.3)
- 5 That the policy is developed and implemented through an **inclusive and accountable process**, in collaboration with all stakeholders and in a transparent manner. (See Section 5.4)

6

Q. Are there other criteria that should be used as a starting point? If so, what are they?

6.1 Social model of health

As outlined in the principles for the first National Women's Health Policy (Section 2), a social model of health is considered essential in order to deal with women's health and wellbeing in a comprehensive and coordinated framework.

In a social model of health, importance is placed on understanding and reflecting the broader environment in which a woman lives—her family, community, workplace—and her ability to access health care services and other service systems. As explained in the NSW Women's Health Outcomes Framework¹², use of the social health model:

'demonstrates that a broad range of environmental, socioeconomic, psychological, and biological factors impact on health and that, to large extent, it is the settings, conditions and experiences of every day life that determine good or poor health outcomes for women at all ages.'

The Canadian Women's Health Strategy developed a list of 12 social determinants for their framework¹³, including gender:

- income and social status
- employment status
- education
- social environment (including social support and social exclusion)
- physical environment (including access to food, housing and transport)
- healthy child development
- personal health practices and coping skills
- health services
- social support networks
- biology and genetic endowment
- gender
- culture.

A health determinants approach such as this could be used to identify appropriate responses both within the mainstream health care system and within specialist women's health services. It could also be used to identify and respond more appropriately to specific men's health priorities.

6.2 Diversity of women

It must also be recognised that within the diversity of women that make up the Australian population, there are some that face even greater disadvantage. These include:

- Indigenous women
- women in rural and remote areas
- women of culturally and linguistically diverse backgrounds, including refugees
- women with disabilities
- women as carers (both of children and elderly relatives)
- lesbians, bi-sexual women, transgender and intersex people
- women in prison or detention.

In response to the specific health needs of these groups, it is proposed that in addition to a gender analysis framework, a diversity analysis is overlaid that considers factors such as race, ethnicity, geographic isolation, work/family responsibilities, level of ability, and sexual orientation.

6.3 Starting with a gendered approach to the national health priorities

As a starting point to a new gendered approach to health policy and service delivery, governments and service providers should ensure that the agreed National Health Priorities¹⁴ (set by the Commonwealth and state/territory governments) are considered from a gendered perspective. Currently national priorities are identified as:

- asthma
- cardiovascular disease
- cancer
- diabetes mellitus
- injuries and poisoning (including suicide)
- mental health problems
- arthritis and musculo-skeletal problems.

These priority areas account for 75 per cent of the national burden of disease and are critical in directing health funding for research and service provision. Many of these diseases and conditions have differential rates for men and women and contain gendered perspectives that should be acknowledged and addressed within a women's health policy, and within broader health frameworks such as the National Mental Health Plan.

As a starting point for implementing a gender-based analysis of all health policy, these National Health Priorities should be subjected to a gender analysis to ensure that existing approaches are most effectively targeting and treating women and men. The Victorian Gendered Data Directory developed by Women's Health Victoria (released in July 2004) could be used as the basis for a national directory to present data sources for a wide range of health indicators.

6.4 An inclusive and accountable process

One of the greatest successes of the first National Women's Health Policy was its foundation in consultation and collaboration between policy makers, service providers, advocacy groups, and women as health consumers.

It is considered essential that the new policy is both developed and implemented through similarly consultative and collaborative processes. In order to achieve this, it is proposed that the following principles and commitments drive work around the development of a new policy and its agreed priority areas:

- that Commonwealth, state and territory governments be asked to provide leadership and commit to supporting the development of this policy, through involvement of their health ministers and ministers for women's affairs
- that the process of developing a new national women's health policy is adequately resourced—to allow for consultations, development and distribution of background

materials, and involvement of all stakeholders (including women identified in the diversity framework)

- that a women's health and gendered health section be established within the Department of Health and Ageing to support the development and implementation of women's health priority initiatives
- a national peak body for women's health should be funded, with key functions to include: advice to government on the development and implementation of policy affecting women's health, advocacy for women's health, provision of a forum for the exchange of information relating to women's health and capacity to undertake action research and special projects as required
- that outcomes based funding processes be established for each aspect of the new policy, including annual reports on progress and performance against agreed key indicators under each of the priority areas
- that state and territory women's health plans be developed in line with the National Women's Health Policy priorities and directions, with appropriate advisory and reporting mechanisms established at the state/territory level
- that the National Women's Health Policy be actively linked with other national health priority areas (including the National Mental Health Plan, the National Health and Medical Research Council agenda, and the National Health Priorities)
- that improving women's health and wellbeing is promoted at cabinet level as a critical factor in other relevant national policy areas (such as welfare reform, taxation and superannuation policy, industrial relations, Indigenous affairs, foreign affairs policy, etc.)
- that a clear evaluation and development framework be devised to ensure transparent and rigorous evaluation of the policy, with a commitment to evaluation processes being undertaken in a timely manner and ongoing development occurring to ensure the policy remains timely and relevant.

Key women's health priority areas

It is proposed that the new national women's health policy identify a number of priority areas for action. These should be agreed on through the consultation process to be established under the new framework. As a starting point, the following five key women's health priority areas are proposed for discussion, based on evidence of current health and wellbeing outcomes and recent consultations by the Australian Women's Health Network:

- women's economic health and wellbeing
- women's mental health and wellbeing
- prevention of violence against women
- women's sexual and reproductive health
- access to publicly funded health services.

In addition to funding programs and initiatives in these priority areas, there should also be a commitment to fund further research in each of these priority areas to continue the development of evidence-based health policy, particularly research evaluating the translation of evidence into practice.

Key elements to be considered in the development of strategies for each of these priority areas are outlined below.

7.1 Women's economic health and wellbeing

A person's economic health and wellbeing has a major impact on their life chances, including their health outcomes. Unfortunately women continue to experience disadvantage on virtually every indicator of economic health and wellbeing, including their ability financially support themselves through a longer life span than men and more years of disability. The reality of women's lives means that they typically:

- spend less time in the paid workforce
- need to take more time out from work to care for children and other family members
- face reduced job security through part-time and casual work
- are clustered in low income occupations
- have fewer savings, including significantly lower superannuation savings.

Many studies have provided evidence of the link between socioeconomic status and health status, with those from lower socioeconomic backgrounds having higher rates of mortality and morbidity.

7

Q. Are there other priority areas that should be included? If so, what are they?

Q. What are the specific economic health and wellbeing indicators and performance measurements that should be included in the new national women's health policy?

The statistics provided in Section 3 outlined some of the key areas where women's economic security is compromised. These and other issues acting as barriers to women's greater economic health and wellbeing need to be addressed through:

- eliminating gender pay gaps
- developing more family friendly workplace conditions (including introduction of a universal paid maternity leave scheme)
- greater levels of secure part time and casual employment
- removing inequities in retirement savings and superannuation schemes
- ensuring that sole-parent households (which are predominantly headed by women) have adequate child care and other supports to enable them to undertake education, training and employment.

A good place to start for eliminating gender pay gaps would be in the health care sector, where women medical graduates earn only 89.1 per cent of male earnings¹⁵ and hold less than 30 per cent of specialist medical practitioner positions¹⁶. In contrast, women make up 99 per cent of dental assistants and over 90 per cent of all nursing positions¹⁷.

Until women's economic wellbeing is seriously addressed, it will continue to compromise their general health and wellbeing and their status in the remainder of the identified health priority areas.

7.2 Women's mental health and wellbeing

Mental health and mental illness are determined by multiple and interacting social, psychological and biological factors. Indicators of risk include poverty, low levels of education, poor housing and social exclusion. Women as a group experience high levels of all these risk factors. There is also a direct link between women's mental health and their experiences of significant levels of violence.

Socially constructed gender roles, when interacting with biological differences, have been found to contribute to mental health problems and health seeking behaviours. They also have a strong influence on responses provided by the health sector¹⁸.

Mental health problems and illnesses include short term anxiety and depression (more commonly reported by women) as well as a range of longer term conditions. Women more commonly report very high levels of psychological distress and higher levels of psychiatric disabling conditions than men¹⁹.

Dementia is a major health problem for older women. Largely as a result of an ageing population, it is projected that by 2016 dementia may take over as the greatest cause of ill health for women in Victoria²⁰.

Women are also more prone to depressive disorders, with population studies showing that women are twice as likely as men to experience depression²¹. Depression is the most prevalent health problem among women and is likely to be accompanied by other psychological disorders. The following data from Women's Health Victoria's Depression Gender Impact Assessment highlight the severity of the illness²²:

- ten to fifteen per cent of women suffer a major depressive episode shortly after childbirth
- one in four women and one in six men in Australia will experience depression at some time in their lives

- women with depression are significantly more likely to be prescribed anti-depressant drugs than men with the same diagnosis
- despite women being diagnosed with depression at a higher rate, it is not necessarily the case that depression in women is well recognised by doctors, family and friends.

Despite these overwhelming statistics, it is concerning that there is no gender analysis or response within the current National Mental Health Plan.

With mental health attracting significant new funding by the Commonwealth government in recent years, it is important that state contributions and future policy directions take into account the gendered nature of mental and emotional health so that more appropriate services and responses are provided.

7.3 Preventing violence against women

Violence has been found to be the leading contributor to death, disability and illness in Victorian women aged 15 to 44, being responsible for more of the disease burden than many commonly accepted preventable risk factors such as high blood pressure, smoking and obesity.²³

While this study by VicHealth was conducted in Victoria, it is widely considered to be indicative of the scope and size of the problem in other parts of Australia, with women in Indigenous communities considered to face even higher levels of violence.

This report also found broad consensus internationally that intimate partner violence is best addressed in the context of human rights, legal and health frameworks and through the development of multi-level strategies across sectors.

As well as the high personal costs of experiencing violence, Access Economics has undertaken a study on the economic and social costs of family violence, and estimate that it costs the Australian economy around \$8 billion per year²⁴. With one in four women affected by intimate partner violence, the health costs are already enormous. Family violence is also the leading cause of family homelessness in Australia, with half of the people using homelessness services being parents with children²⁵. And most importantly, family violence is to a large degree preventable.

Other forms of violence such as sexual assault, carer abuse, pornography, and trafficking of women for sex are also preventable with adequate commitment and resources.

As part of the Prime Minister's Partnerships Against Domestic Violence (PADV) initiative, there was a wide range of research and demonstration projects undertaken across Australia. However what is now needed is an integrated prevention and crisis response program, comprehensively funded to adequately address the unacceptably high levels of family violence occurring throughout all communities. While the existing women's refuge crisis service system remains overwhelmed with demand, and lacks adequate resources to undertake comprehensive prevention and education strategies at the local community level, there is little hope that future generations of women will experience any better outcomes when it comes to physical, sexual and emotional abuse.

Women's health services are already working in a range of ways to prevent violence against women²⁶. Current and recent initiatives in primary prevention, early intervention for those at risk, and intervention for victims and survivors of violence have been undertaken in the following areas:

Q. What are the specific mental health and wellbeing indicators and performance measurements that should be included in the new national women's health policy?

Q. What are the specific indicators and performance measurements around reducing violence against women that should be included in the new national women's health policy?

- research, monitoring and evaluation
- organisational development
- community strengthening
- communications/social marketing
- advocacy
- legislative and policy reform.

However it is clear that the current responses need additional resources and greater commitment from all parts of the community, including coordinated government effort, if the unacceptably high levels of violence against women are to be adequately addressed.

7.4 Women's sexual and reproductive health

Sexual and reproductive health is a fundamental issue for all women, affecting them at every life stage. It affects women's control over their own bodies, through access to safe and appropriate health services and information, and remains a central priority of women and the women's health movement.

The development of a national reproductive and sexual health policy, along with funded programs, is critical for women in this environment. Currently Australia has unacceptably high levels of sexual and reproductive ill-health, demonstrated by the following statistics compiled by the Public Health Association of Australia²⁷:

- higher rates of early sexual activity among young people have increased the risk of unplanned pregnancy and sexually transmissible infections
- high rates of sexual violence (19.1 per cent of women and 5.5 per cent of men have experienced sexual violence of some kind)
- increasing rates of Chlamydia and newly acquired HIV infections
- inadequate access to safe and effective contraceptive education and methods
- unacceptably high levels of teenage pregnancy compared to other developed countries (18.4 births per 1000 women aged 15–19 years)
- high estimated abortion rates (19.7 per 1000 females aged 15–44 years in Australia) compared with other countries (eg Germany 7.7, The Netherlands 8.7 and Finland 10.9)
- high rates of infertility (1 in 6 couples).

Many of the problems associated with these statistics are compounded by the failure to address sexual and reproductive health policies and programs in Australia in a coordinated and consistent manner.

Currently there are significant differences in the legislation of various states and territories (including the inclusion of termination services in the criminal codes of several jurisdictions), and a high level of variability and inconsistency in the sexual health and sexuality education provided to young people across the country.

In the absence of improved sexual and reproductive health information and services, we are putting the future health and fertility of all young people at risk.

The development of a new women's health policy requires a more coordinated approach to reproductive and sexual health policy within government structures.

Q. What are the specific sexual and reproductive indicators and performance measurements that should be included in the new national women's health policy?

7.5 Improving women's access to publicly funded health services

It is widely acknowledged that access to appropriate and high quality health services are critical in both prevention and early treatment of disease and illness.

As outlined above, women use health services in a way which is different to men and experience a range of health problems that are driven by either biological or gender-based differences. While all health services are required to ensure that they provide non-discriminatory services and access to women, it is clear that there are still a range of barriers encountered, many of which are entrenched within the health system.

Some of the existing and continuing barriers faced by women in accessing appropriate and affordable health care services include:

- an expressed preference for treatment by female doctors cannot always be met, due to the under-representation of women in general practice and across all specialist areas
- the relative socioeconomic disadvantage of many women means they are unable to afford private health insurance or high out-of-pocket costs for medications or treatment
- particular barriers for women in rural and remote areas, with doctor shortages only exacerbating an existing lack of women-specific health services²⁸
- women use services more throughout a longer span of their lives, and when they are well (e.g. contraception and pregnancy)
- the unacceptably low levels of access to culturally appropriate health care services for Indigenous women, particularly in remote communities
- lack of gender sensitivity in the design of some diagnostic tests and treatments (such as coronary heart disease)²⁹
- problems of gender bias in medical research and curricula³⁰, where the male body is still treated as the 'norm' for trials and teaching purposes
- lack of sensitivity and understanding about the specific health care needs of lesbian women, including failure to screen for and diagnose reproductive health problems³¹. This is also the case for women with disabilities who often experience the treatment of their disability rather than as women, including for their reproductive health needs.

While many parts of the mainstream health service system provide excellent access and services to women, there are still many improvements required.

Since the first National Women's Health Policy, there has been a concerted effort to fund and support women's health services, as a complementary specialist service system alongside the mainstream health services. This 'dual track' approach has allowed the development of a strong network of women's health services across the country, contributing to improved primary health care and health education for women.

It is critical that this dual track approach is maintained and the knowledge and expertise of the women's health service system is incorporated into future strategies to achieve better health outcomes for Australian women, their families and communities.

Q. What are the specific indicators and performance measurements around improving access to publicly funded health services for women that should be included in the new national women's health policy?

International developments in women's health policy

1975 marked a turning point in the approach towards women's health, with the United Nations International Women's Year conference in Mexico establishing the move towards an equity model, rather than a traditional welfare/poverty approach, to women's health.

UNIFEM (United Nations Development Fund for Women) was established in 1984 to recognise the importance of gender equality in international development projects including many health initiatives, with the General Assembly instructing UNIFEM to "ensure women's involvement in mainstream activities".

In 1995 the landmark UN World Conference on Women (Beijing) officially adopted "gender mainstreaming" — i.e. the application of gender perspectives to all legal and social norms and standards, policy development, research, planning, advocacy, development, implementation and monitoring.

The Beijing Platform for Action that resulted from this conference has helped drive women's health policy over the last decade, including an emphasis on health as a basic human right and the importance of women to be free from violence in order to maximise their health outcomes. A key statement from the conference was:

Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

1995 also marked the formal adoption of a 'gender and development' approach by the Commonwealth Heads of Government in Auckland which recognised that many inequalities were created by society, and therefore need to be rectified by society³². It also recognised that both men and women needed to be involved in developing solutions to these gender based inequalities.

The UN Beijing +5 Women's Conference (2000) further strengthened the concept of gender mainstreaming in its resolutions. By adopting the Beijing Platform for Action, governments throughout the world—including Australia—effectively committed to effective integration of a gender perspective throughout all their policies, programs and service delivery. Their performance in delivering in each of these areas is subject to regular reviews, and Australia's performance is reliant on reporting by both federal and state/territory governments.

Women's health policy in Australia (1985–2007)³³

APPENDIX B

Development of the National Women's Health Policy 1989

The International Decade for Women, which ran from 1976 to 1985, raised many issues of particular concern to women across Australia, including their health status and the appropriateness of existing health care responses.

Following a national conference in 1985, the Australian Government agreed on the need for a specific focus on women's health. After an intensive development phase involving consultations with over one million women across Australia, the National Women's Health Policy (NWHP) was officially launched in April 1989. It was signed off by Commonwealth, state and territory ministers and subsequently endorsed by both Liberal and Labor governments.

The goals of the policy were to improve the health and wellbeing of all women in Australia, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of women. The central premise of the NWHP is a social view of health, which recognises that social and environmental factors, as well as knowledge, attitudes and behaviours of individuals, determine the health of populations and of individuals. The NWHP received acclaim throughout the world as a far-reaching, forward-thinking response to the health needs of women.

The National Women's Health Program, a bilateral Commonwealth–state/territory program, was established to implement the NWHP. Both levels of government provided matched dollar for dollar funding for the program. The huge success of the policy across Australia was largely due to this commitment of funding to implement its key platforms.

From the late 1980s through the 1990s the National Women's Health Program was responsible for funding an extensive network of women's health services and initiatives throughout Australia. In line with the NWHP, the focus of the program services and projects was on achieving equitable outcomes for women by addressing the social determinants and conditions that affect health, particularly for women in most need. In adopting an 'upstream' (early intervention/prevention) approach, the program was in many ways ahead of its time.

The subsequent very successful national HIV/AIDS strategy built upon learnings from the women's health program. More recently, evidence based population health promotion strategies are replicating the community capacity building approach taken in the women's health program. There is a growing body of evidence to support this approach as a means to reduce the risk factors and strengthen the protective factors underlying morbidity and mortality.

1997/98 to 1998/99 Public Health Outcomes Funding Agreements (PHOFAs)

In 1997, the National Women's Health Program, Alternative Birthing Program and the Female Genital Mutilation Education and Prevention Program were all incorporated under the new Public Health Outcomes Funding Agreements (PHOFAs). These agreements were developed between the federal government and the state/territory governments. They effectively 'broad-banded' the previous specific purpose programs, giving states and territories greater flexibility regarding the use of federal funding.

The first PHOFA between the Commonwealth and the states/territories operated from 1997/98 to 1998/99. The stated aim was to improve *'the health and wellbeing of Australians through the enhanced delivery of public health activities and more flexible funding arrangements within the spirit of nationally agreed policies and strategies'*. *The agreements were 'seen as part of a continuing development process to achieve shared public health objectives.'*

Under the first PHOFAs, it was stated that the Commonwealth and the states/territories would *'continue their commitment to implement agreed national strategies'*, including the National Women's Health Policy. However this was somewhat undermined by the abolition of the Australian Health Ministers' Advisory Committee's (AHMAC) Subcommittee on Women and Health.

The agreements specified few performance measures, with those that were included being regarded as part of jurisdictional effort, but not intended to limit it.

1999/00 to 2003/04 PHOFA Agreement

The 1999/00 to 2003/04 PHOFAs between the Commonwealth and the states/territories continued to cover agreed outcomes for a range of public health initiatives. These were delivered under the following eight 'broadbanded' funding categories:

- HIV/AIDS
- women's health
- alternative birthing
- education on female genital mutilation
- breast screening
- cervical screening
- childhood immunisation
- illegal drugs

In line with the overall goal, *'to improve the health and wellbeing of all women in Australia, with a focus on those most at risk, by improving the responsiveness of the health system to women's health needs, particularly those most at risk of poor health and wellbeing outcomes'* the agreements specified five outcomes:

- 1 Health departments maintain community based services for women, based on national health policies, principles and specific strategies in place to target at risk female populations.

- 2 Health departments foster partnerships/collaborative programs between gender specific health services and mainstream services based on national health policies or principles as they relate to women.
- 3 Health departments encourage midwife based birthing services to be established in the publicly funded health care system and for Indigenous women.
- 4 Health departments work with communities to develop and implement information resources and programs to prevent occurrence of female genital mutilation and to minimise harm to those at risk or subjected to female genital mutilation.
- 5 Health departments take steps to decrease the proportion of Aboriginal and Torres Strait Islander newborns with birth weight <2500g, per 1000 live births.

In a review of the early years of the PHOFAs (1999–00 to 2001–02) it was found that there were both positive and negative aspects with regards to its women's health component. There was seen to be a need for women's health programs to be more directly linked to national health outcome trends and for the reporting and performance frameworks around women's health to be reviewed.

A better approach may be to identify an agreed set of common objectives ... for nationally relevant health issues (eg antenatal care, smoking, interventions in the early lifecourse of women to address issues such as chronic disease prevention and avoidable pregnancy; lifecourse interventions targeting low SES women) which could be incorporated into broader (than current) outcome categories.

The review also pointed to need for national level strategic guidance for women's health and family planning, suggesting that the National Public Health Partnership could develop a much stronger role in this regard. *'The performance indicators highlight that an investment is required by both levels of government in this area.'*

The review recommended that: *'an investment in the development of priorities and better indicators [for women's health] is urgently required by both levels of government in this area.'*

The 2004/05 to 2008/09 PHOFAs

Contrary to the recommendations of the review and its call for a strengthening of the national role with regard to women's health, the initial draft of the 2004/05 to 2008/09 PHOFAs left out any mention of the National Women's Health Program and only included a single indicator from the previous agreements—that relating to low birthweight Aboriginal babies.

The National Women's Health Program, the Alternative Birthing Program and the National Education Program on Female Genital Mutilation had effectively disappeared from the national agenda. However, after considerable lobbying by AWHN, by state and territory governments and others with an interest in women's health issues, the final Agreements were reworded to include an indicator relating to 'availability/access to community based health services for women, including at-risk female populations'. This change committed jurisdictions to maintaining some focus on women's health. Concerns from stakeholders regarding the inclusion of this indicator within a broader category labelled 'health risk factors' fell on deaf ears.

Current approaches to women's health by jurisdiction

In addition to their reporting requirements against specific women's health initiatives under the PHOFAs, state and territory governments continue to develop a range of women's health policies and programs to respond to the needs of women in their own jurisdictions. The following table provides a list of current initiatives and emerging priorities of each jurisdiction.

| Jurisdiction | Approach and Initiatives |
|------------------------------|--|
| Commonwealth | Some women's health program areas remain jointly funded under the Public Health Outcomes Framework Agreements (PHOFAs). The term of the current Agreement is 2004–05 to 2008–09. |
| Victoria | Victorian Women's Health and Wellbeing Strategy (2006-2010) |
| New South Wales | Strategic Framework to Advance the Health of Women (2000). Currently developing a NSW Women's Health Strategic Implementation Plan (due for completion in January 2008) |
| Queensland | No specific current women's policy/strategy, however Queensland Health funds 11 women's health services through their PHOFA. |
| South Australia | South Australian Women's Health Policy (commenced 2005) |
| Western Australia | Domestic Violence initiative currently being developed. |
| Tasmania | Women's Health Program |
| Northern Territory | Women's Health Strategy |
| Australian Capital Territory | ACT Women's Plan and ACT Government Health Action Plan (2002) include commitments to address women's health. |

Major milestones in women's health in Australia

| | |
|-----------|--|
| 1896 | Queen Victoria Memorial Hospital founded in Melbourne (one of three hospitals in the world founded, managed and run by women, for women) |
| 1914 | First baby health centre opened |
| 1920s/30s | Growth of maternal and infant health programs |
| 1970s | Family planning program established |
| 1973 | Women set up health centres, refuges and crisis centres in all states and Territories. Some were later funded under the Commonwealth Community Health Program. |
| 1975 | 'United Nations International Year of Women' (followed by UN Decade for Women 1976-1985) First National Women's Health Conference, held in Brisbane. Medibank introduced (Australia's first universal health insurance scheme) |
| 1983 | Medicare scheme introduced (revised from Medibank) |
| 1985 | Second Women's Health Conference passes the resolution: <i>'That a National Policy on Women's Health be developed consistent with the World Health Organisation Global Strategy for Towards Health for All by the Year 2000'</i> . |
| 1986 | Consultation with over one million women on the national women's health agenda |
| 1987 | Appointment of a special adviser to the health minister to coordinate development of a health policy for women |
| 1988 | Launch of discussion paper <i>'Women's Health: a Framework for Change'</i> (Feb, 1988) |
| 1989 | National Women's Health Policy endorsed by all health ministers, and National Women's Health Program launched |
| 1991 | Breastscreen Australia and national cervical screening program established |
| 1993 | Second National Women's Health Program commenced |
| 1997 | National Public Health Partnership launched, with women's health program funding broadbanded into the Public Health Outcomes Framework Agreements (PHOFAs) between Commonwealth and state/territory governments |
| 1999 | Second PHOFAs included the National Women's Health Program, Alternative Birthing Program, and Female Genital Mutilation Education and Prevention Program |
| 2001 | National Women's Health Conference calls for 'a renewed national women's health policy and program'. |
| 2003 | Third PHOFA further broadbands funding to include three 'overarching public health priority categories' to incorporate women's health priorities. |
| 2005 | National Women's Health Conference agrees on the critical need to redevelop the national women's health policy and program. |

Sources: Baum F (2002)³⁴, Commonwealth Government (1993)³⁵ and www.qwmc.org.au.

“Well behaved women rarely make history.”
Laurel Thatcher Ulrich (1938–)

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