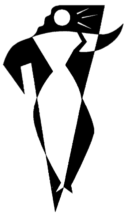

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New National Women's Health Policy

SUBMISSION

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1. Introduction

Women's Health Victoria is a statewide women's health promotion, information and advocacy service. We are a non government organisation with funding from the Victorian Department of Human Services. We work with health professionals and policy makers to influence and inform health policy and service delivery for women.

Our work at Women's Health Victoria is underpinned by a social model of health. We are committed to reducing inequities in health which arise from the social, economic and environmental determinants of health. These determinants are experienced differently by women and men. By incorporating a gendered approach to health promotion work, interventions to reduce inequality and improve health outcomes are more effective and equitable.

Women's Health Victoria's vision is for a society that takes a proactive approach to health and wellbeing, is empowering and respectful of women and girls, and takes account of the diversity of their life circumstances.

Women's Health Victoria's ways of working are guided by four principles:

1. We work within a feminist framework that incorporates a rights based approach.
2. We emphasise an understanding of all the determinants of health and illness for achieving better health outcomes.
3. We understand that the complexities involved in achieving better health outcomes for women require well-considered, forward-thinking, multi-faceted and sustainable solutions.
4. We commit to 'doing our work well', and understand that trust and credibility result from transparent and accountable behaviours and practice.

Women's Health Victoria welcomes the opportunity to be involved in consultations for the development of a new National Women's Health Policy. This is an opportunity that we have advocated for since 1997 when the last of the National Women's Health Program agreements expired.

2. Learning from history

2.1 Key dates in the Australian women's health sector

The Australian women's health sector is resourceful, committed, enduring and capable of achieving significant change toward improving the health of women. The development of a new National Women's Health Policy provides an excellent opportunity to build on this. Commonwealth leadership and support, which has largely been absent in the previous decade, is very much welcome. With this, we encourage the Minister for Health to draw on the experience and expertise that already exists within the women's health sector. This will help to ensure that the policy offers the best opportunities for health for Australian women.

In Victoria, women's health services are largely independent and are supported by the Victorian Government to focus on improving the health of Victorian women by working within a health promotion framework. Women's health services work with sectors that impact on women's health and engage the mainstream health sector to create policy, programs and services that are responsive to the needs of women. Victorian women's health services have worked toward shared goals and priorities to achieve significant outcomes.

This submission draws heavily from our positive experience of the Victorian Women's Health Program model, which was established in 1987[1]. The Program was developed in order to provide

services 'by women for women'[1]. It retains a dual strategy for women's health 'of delivering gender-specific health services whilst working to improve mainstream services'[1]. The Program has enabled women's health to progress despite the lack of support from the previous Commonwealth Government. The model of the Victorian Women's Health Program has enabled women's health services to share knowledge and capacity, to establish broad networks, and to develop high levels of expertise in the area.

When considering the direction of the new National Women's Health Policy, reflection on the history of women's health at the national and Victorian level enables us to carry the keys to success into the future, and learn from what hasn't worked so well. We understand that this formed part of the process to establish the original 1989 National Women's Health Policy and Program. To help facilitate this, we have provided a timeline of information related to relevant national and Victorian events:

2.1.1 1987 A dual strategy for women's health in Victoria
The Victorian Ministerial Women's Health Working Party produced the report *Why Women's Health: Victorian Women Respond*[2]. The report's chief recommendation was for a dual strategy, which involved the creation of a statewide network of women's health services, and 'a broader strategic approach to influencing mainstream health services'[3].

2.1.2 1988 Victorian Women's Health Program
In Victoria, the state government showed its support for women's health by funding a Victorian Women's Health Program, based on the *'Why Women's Health'* report. The program made provisions for:

- Programmatic funding for existing women's health services;
- Funding for a centrally located women's information service;
- Funding for an ethnic women's information service; and,
- Funding for one women's health service in each region by 1991/92[2].

The Victorian Women's Health Program ensured a consistent approach to women's health across the state, which included the sharing and translation of knowledge into action.

2.1.3 1989 National Women's Health Policy and Program
The National Women's Health Policy proposed a five year National Women's Health Program, with Commonwealth and states sharing the cost. The Program commenced in the 1989-90 financial year. It provided for primary health care that focused on seven priority issues and five key action areas, with the stipulation that priority was to be given to funding for innovative or special projects[3]. The Australian National Women's Health Policy and Program had international significance as the only women's health policy of its kind, making Australia a world leader in this field.

2.1.4 1989 -1997 Funding of the National Women's Health Program
The National Women's Health Program was funded and implemented over two consecutive periods, 1989-1993 and 1993-1997.

When both the National and Victorian Women's Health Program were active, progress towards women's health was achieved that would not have been possible with the programs working in isolation. The existing Victorian Women's Health Program provided the necessary infrastructure to support the implementation of a National Women's Health Program in Victoria. The funding that came through the National Women's Health Program enabled the Victorian Women's Health Program to fulfil its commitment to establish a women's health service in each of the regions of Victoria[4]. Existing levels of funding were maintained and new services emerged from previously unfunded women's networks that had been active in a number of places in Victoria.

The current configuration of women's health services funded by the Victorian Women's Health Program came into existence gradually between 1988 and 1992. The proportion of Commonwealth and Victorian Government money which went into establishing each of the services varied.

2.1.5 1997-2007 Withdrawal of Commonwealth support for women's health

The Australian Government steadily withdrew from its responsibilities for women's health. In 2004 the National Women's Health Program was not included in the draft 2004-2009 *Public Health Outcomes Funding Agreements* (PHOFAs)[5]. There was no explanation from the Commonwealth for the neglect of its responsibility and withdrawal of support for women's health. This lack of support for the National Women's Health Program put the network of women's health services across Australia at risk.

2.2 The history of Women's Health Victoria

Following the development of the Women's Health Program in Victoria the government announced the opening of tenders to run a fully funded statewide women's health information centre[5].

In 1987, Healthsharing Women, an initiative of the Victorian Women's Health Program, successfully tendered to run the fully funded statewide women's health information centre. As a statewide service, Healthsharing Women aimed to improve women's health by meeting women's needs for health information and community and professional education and support. In addition, women's needs were pursued by challenging mainstream organisations and policy makers to provide more appropriate services to meet their needs[6].

In February 1993, Healthsharing Women and another Victorian women's health information service, the Women's Health Resource Collective, decided to amalgamate to form one new organisation[i].

On 23 August 1996, Healthsharing Women's Health Resource Service officially changed its name to Women's Health Victoria. Women's Health Victoria's early work involved the development of information resources for women to fulfil an unmet need. The work also included community and professional information and support.

Since this amalgamation, Women's Health Victoria has continued to adapt and develop in response to the external environment, the needs of women, and the continued struggle for women sensitive approaches to policy, programs and services. Women's Health Victoria now focuses on influencing and informing health policy and service delivery for women.

3. Recommendations for a new national women's health policy

In response to the *Development of a New National Women's Health Policy Consultation Discussion Paper 2009*, Women's Health Victoria makes the following nine recommendations for consideration and incorporation into the new National Women's Health Policy.

These are:

1. The Commonwealth seek bipartisan support for the new National Women's Health Policy and Program.
2. A new National Women's Health Policy secures a commitment from state and territory governments for a 'joined-up' approach.
3. A new National Women's Health Policy applies a 'dual strategy' model to all states and territories.

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[i] The amalgamation discussion originally included three statewide organisations: Women in Industry: Contraception and Health, Healthsharing Women and the Women's Health Resource Collective.

4. Government mandate incorporation of gender sensitive practice into policy and service delivery.
5. A consistent model be applied to all states and territories allowing the women's health sector to be independent of government.
6. *Researching Women's Health: An Issues Paper* be revisited and the unpublished 1996 evaluation of the National Women's Health Program be made public.
7. Build knowledge and a commitment to research and knowledge translation in the new National Women's Health Policy.
8. The new National Women's Health Policy seeks to intersect with and influence other portfolio areas across government.
9. Adopt a legislative framework to ensure all policies take a gendered approach.
10. A new National Women's Health Policy focus on the five priority areas of the Australian Women's Health Network as outlined in their position paper, *Women's Health: The New National Agenda*.
11. A diversity lens forms the fifth principle to underpin the new National Women's Health Policy – replacing the life course approach.

3.1 Bipartisan commitment to women's health

Recommendation 1: The Commonwealth seek bipartisan support for the new National Women's Health Policy and Program.

The 1989 National Women's Health Policy and Program were hampered by a lack of bipartisan commitment at the Commonwealth level. This became evident in 1996 when a Liberal Government came to power, and discontinued Commonwealth support for the National Women's Health Policy and Program. The Policy was referred to as 'an initiative of the Labor Government'; overshadowing the fact that it was good practice in health promotion and an example of an innovative approach to women's health.

3.2 National and State commitment to women's health

Recommendation 2: A new National Women's Health Policy secures a commitment from state and territory governments for a 'joined-up' approach.

One of the strengths of the 1989 National Women's Health Policy and program was the joint commitment to women's health from national, state and territory governments.

We acknowledge that achieving and maintaining agreement between the Commonwealth and all states and territories is complex. However, the potential for significant benefit to Australian women can only be realised with the commitment of all stakeholders.

A shared commitment to women's health provides an opportunity to establish a consistent approach to the implementation of the National Women's Health Policy across the country.

3.3 A dual strategy approach

Recommendation 3: A new National Women's Health Policy applies a 'dual strategy' model to all states and territories

The inclusion of the 'dual strategy' approach in the 1989 National Women's Health Policy was one of its strengths. As previously discussed, the first part of the dual strategy involved the development of a network of women's health services, and the second part was to influence mainstream health to address the needs of women.

The use of a dual strategy model was confused by the inclusion of both primary care and health promotion in the description of the women's health services. This created uncertainty around interpretation of the dual strategy, which was highlighted by the varied applications of the 'women's health services' aspect of the model.

A number of state governments and women's health services across Australia interpreted the dual strategy with a primary care focus – and provided medical and other clinical services to women, together with the second element - influencing mainstream health services. Alternatively, other states focused on health promotion and influencing mainstream health services. In taking this approach, women's health services adopted a community development model, with an emphasis on working with women to build their capacity and sense of empowerment to improve their health.

Victorian women's health services took the latter approach. Rather than directly providing women sensitive medical and clinical services, Victorian women's health services incorporated this into the second aspect of the dual strategy, and worked with other primary care providers to build their capacity in the provision of women sensitive health care.

Implementation of the 'dual strategy' in Victoria has led to women's health services, in collaboration with women, focussing on the provision of health information and education[4]. The services are 'by women, for women'. They implement the dual strategy of working directly with women, and working with service providers—across the whole spectrum of service provision—to improve service responsiveness to women.

The Victorian Women's Health Program has achieved significant successes in working with women, including:

- Availability of accurate, up-to-date and appropriate information for all women;
- Increased information about women's ability to use health and related services, information and education;
- More effective decision making by women on personal health care issues; and,
- Improved awareness by women of health issues and their rights as health consumers[3].

Throughout the implementation of the Victorian Women's Health Program, funded services have adapted to the changing environment and the changing needs of women. Training, tools and resources have been responsive to changes in the health sector, as well as to women's needs.

Evidence of this adaptable way of working in health can be seen in the community response to HIV/AIDS in the 1980s, lobbying by women with breast cancer, and in the development of consumer participation in health movement in the 1990s.

In more recent times, women's health has utilised new technologies that have mainstreamed health information services e.g. Better Health Channel; HealthInsite; the telephone based Royal Women's Hospital Women's Health Information Service and Pregnancy Advisory Service; and Nurse On Call.

This adaptability has contributed to the empowerment of women to be more equal in their relationship with their doctors. In addition, women have become more active participants in their health care.

The second part of the dual strategy approach - working to improve the responsiveness of general health services to the needs of women[3], is discussed in the next section – 'gender sensitive practice'.

3.4 Gender sensitive practice

Recommendation 4: Government mandate incorporation of gender sensitive practice into policy and service delivery.

Women's health services have achieved some success in assisting general health related organisations to incorporate a gendered approach. However, in order to achieve more significant change, government policy needs to mandate incorporation of gender sensitive practice into service delivery.

Influencing and building the capacity of others to incorporate a gendered approach cannot happen without the commitment of both the Commonwealth and State Governments. They must set an example by ensuring a gendered approach to all government policy, and by including funding to state and national government departments for analysis, advice and policy development that ensures a gendered approach in all health related policy.

3.5 Independence to speak out

Recommendation 5: A consistent model is applied to all states and territories allowing the women's health sector to be independent of government.

The varying levels of independence held by the women's health sector within and between different states and territories have had an impact on progress. Because the Victorian Government has allowed statewide and regional women's health services to be specialised and independent of government (except in the Barwon South West region), their employees are not classified as public servants. This has given them the freedom to critique, advocate and lobby for change in government policy and direction and has resulted in the continued development and evolution of the women's health sector in Victoria.

There are however, different levels of autonomy in Victoria. The Barwon South West region has no independent women's health service, meaning women's health workers are employed by community health services. Even though these workers are not public servants, they have not been able to change and adapt as the other services have, and their independent autonomy to speak out on issues of relevance has been affected.

Similarly, other states have not had the same level of freedom. The placement of women's health within the government in South Australia has meant that workers are employed as public servants, thus affecting their independence and reducing their ability to be critical of government policy.

The development of a consistent approach to women's health services across all states and territories, where independence of the women's health sector is ensured, will contribute to knowledge sharing and capacity building, leading to better health outcomes for Australian women.

3.6 Putting knowledge into practice

Recommendation 6: *Researching Women's Health: An Issues Paper* is revisited and the unpublished 1996 evaluation of the National Women's Health Program be made public.

Recommendation 7: Build knowledge and a commitment to research and knowledge translation in the new National Women's Health Policy.

While operational, the 1989 National Women's Health Policy and Program enabled a state and a national network for sharing new knowledge. However, one of the problems of the Policy was the lack of clear guidelines, structures and support for converting research findings into practice.

The National Women's Health Policy and Program funded the development of *Researching Women's Health: An Issues Paper*[7], which made recommendations about the need for research to better understand the impact of the National Women's Health Policy:

> The extent to which the NWHP has, or has not, been taken into account by the bureaucracy and academic world across Australia is itself a topic for research into women's health. Such research could, among other things examine the extent and efficacy of various mechanisms for policy co-ordination, including the allocation of finance to the various bodies which fund health research [and] their policy related financial accountability[7].

The Issues Paper also recommended an extension of the collection of women's health data, and identified specific areas of gaps in knowledge within the Policy priority areas. Much of this work remains outstanding.

The evaluation of the first funded period of the 1989 National Women's Health Policy reported significant success in influencing the orientation of mainstream services beyond clinical and curative services towards health promotion and illness prevention[3]. This evaluation also found that 'on the whole, respondents supported the Program as a beginning of a long process of change'. As one respondent wrote, 'the National Women's Health Program is an excellent start'[3].

An evaluation of the second funded period—the 1996 evaluation—was conducted by the Centre for Development and Innovation in Health, but was not made public by the Commonwealth. Lessons and learnings were never shared.

In order for the National Women's Health Policy and Program to achieve success, there must be renewed commitment to women-specific services and centres of excellence. The role of statewide and regional women's health services needs to be developed and made consistent for intersectoral collaboration between the settings within which health is impacted.

3.7 Working outside the health sector

Recommendation 8: The new National Women's Health Policy seeks to intersect with and influence other portfolio areas across government.

Women's Health Victoria understands that the new National Women's Health Policy will sit within the Commonwealth health portfolio and not connect with other portfolios that also impact on the health of women. This is of serious concern. Women's Health Victoria argues that the new National Women's Health Policy must span across sectors that influence the health of Australian women.

The Australian Institute of Health and Welfare describe determinants of individual and population health as 'broad features of society, socioeconomic characteristics, health behaviours and biomedical factors which interact with each other and with individual physical and physiological makeup'[8]. These determinants involve a range of diverse and inter-related elements of life, which reside both within and outside of the health sector. As such 'policies and programs must embrace all the key sectors of society not just the health sector'[9]. The World Health Organisation (WHO) states that 'action on the social determinants of health must involve the whole of government, civil society and local communities, business, global, and international agencies'[9]. The WHO argues that while the health sector plays 'a leadership and advocacy role in the development of policies to deal with the social determinants of health', the primary action on those determinants must come from outside the health sector[9].

The new National Women's Health Policy needs to have a strong connection to other national policy documents. As it currently stands the proposed National Women's Health Policy focuses on gender,

but does not consider the other determinants of health that would sit in portfolios outside of the health sector—portfolios that have significant impact on women's health.

Lessons from the past twenty years have shown how women's health is often at the mercy of political trends and funding cuts. There were problems with the structure of the 1989 Policy. It was developed with the intent that it would make a connection with other sectors[10]. In practice, the Policy was marginalised rather than mainstreamed and lacked the clout to impact on other areas, which undermined its ability to fully achieve its goals. There is an opportunity now to work differently and to take a broader multi-sectoral approach to women's health. Whole of government recognition of gender as a social determinant of health would overcome past barriers and would help gender become a mainstream element to be considered when looking to improve health outcomes.

3.8 Apply gender and diversity lens to all public policy

Recommendation 9: Adopt a legislative framework to ensure all policies take a gendered approach

As stated in the previous section, all government policy needs to consider gender. Development and implementation of a legislative framework to ensure gender equity across government and government funded initiatives, programs and services, is required. The new National Women's Health Policy should provide a mandate for government and non-government organisations to take action towards reducing inequity.

A legislative framework to ensure equity would engage large national organisations to change current ways of working. Without a mandate, large organisations, which may know about the differences between women's and men's experience of illness and health, do not have to incorporate this knowledge into their practice.

The mandated use of a gender analysis framework would correct this. A gender analysis framework is a tool that encourages the development of policy to take account of and be responsive to gender, thereby ensuring gender equity in health and its determinants. It is predicated upon the following:

- All policies have an impact on women and men;
- Policies and programs affect women and men differently; and,
- Diversity exists between individual women and men and within groups of women and men.

The framework can help identify, understand and address equity issues for women (and for men).

The framework consists of three elements:

- Gendered data: gender disaggregated statistics can be used pro-actively in planning and are critical in gauging the extent to which women and men benefit or are affected by policy;
- Gender impact assessment: monitor new and existing policies for gender impact and use knowledge to adapt existing or proposed policies to promote gender equity in both planning and implementation; and,
- Gender awareness raising: take opportunities to build capacity and understanding of how policies and programs can cause or lead to discriminatory effects.

The Victorian Department of Human Services has an excellent tool that complements this framework: 'Gender and diversity lens for health and human services: Victorian Women's Health and Wellbeing Strategy Stage Two 2006-2010'[11].

Using a gendered analysis framework and the 'Gender and Diversity Lens' resource would assist in the identification, evaluation, modification and development of all policy and practice related to areas of women's health.

Effective models that build the premise of a gender analysis framework into them do exist and are available for scrutiny and adoption. One of these is the Gender Equality Scheme used by the United Kingdom:

Gender Equality Scheme

In the United Kingdom (UK), in April 2007, the *Equality Act 2006* enacted changes to the *Sex Discrimination Act 1975* to include a 'general duty to promote equality'. A general statutory duty was placed on public authorities, which stated that when carrying out its function the public authority shall have due regard to the need:

- Eliminate unlawful discrimination and harassment that is unlawful under the Sex Discrimination Act 1975(SDA) and in relation to employment and vocational training (including further and higher education), eliminate discrimination and harassment against transsexual individuals
- To eliminate unlawful discrimination and harassment on the grounds of sex; and,
- To promote equality of opportunity between women and men[12].

The Duty has been introduced by the UK Government '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'[12].

The Duty requires public authorities to comply with a Gender Equality Scheme (GES) in which they:

- Prepare and publish a GES document, which shows how the organisation intends to fulfil the duties, and which sets out gender equality objectives;
- Prepare the GES in consultation with employees, service users and other stake holders, including unions;
- Consider information gathered about how policies and practices affect gender equality;
- Consider the need for objectives to address the causes of any gender pay gap;
- Set out in the GES how the organisation has and intends to:
  - Gather information on the effect of its policies and practices on men and women, in employment, services and performance of its functions
  - Use the information to review the implementation of the scheme objectives
  - Assess the impact of its current and future policies and practices on gender equality
  - Consult relevant employees, service users and others (including trade unions)
  - Ensure implementation of the scheme objectives; and,
- Implement the GES and any actions for gathering and using information within the three year life of the scheme[12].

The GES is reviewed, and revised if necessary, at least every three years, with a progress report submitted annually.

Women's Health Victoria recommends an amendment to the *Sex Discrimination Act 1984* that incorporates a similar Gender Equality Duty akin to that of the United Kingdom. Statutory authority to manage this should reside with the Human Rights and Equal Opportunity Commission, along with an advisory / capacity development / monitoring and reporting role.

In an Australian context, the proposed Gender Equality Duty and Gender Equality Scheme would mean consideration of the differences between the conditions, situations, needs and priorities of women and men in all policies, planning and actions, as part of the core business and decision making of an organisation.

3.9 Priority issues for the new National Women's Health Policy

Recommendation 10: A new National Women's Health Policy focus on the five priority areas of the Australian Women's Health Network as outlined in their position paper, *Women's Health: The New National Agenda*.

While the new *National Women's Health Policy Consultation Discussion Paper* does outline leading causes of death and burden of disease, and risk factors affecting women's health, priority issues for action are not outlined.

Women's Health Victoria supports the five priority areas of the Australian Women's Health Network as outlined in their position paper, *Women's Health: The New National Agenda*[13]. These are:

- Women's economic health and wellbeing;
- Women's mental health and wellbeing;
- Prevention of violence against women;
- Women's sexual and reproductive health; and,
- Access to publicly funded health services.

3.10 Principles to underpin the new National Women's Health Policy

Recommendation 11: A diversity lens forms the fifth principle to underpin the new National Women's Health Policy – replacing the life course approach.

Women's Health Victoria generally supports four of the five principles that have been chosen to underpin the Policy:

- Gender equity in health;
- Health equity between women;
- A focus on prevention; and,
- A strong and emerging evidence base.

Women's Health Victoria has some concerns about the inclusion of a 'life course approach' as the fifth principle to underpin the new Policy, and suggests the use of a diversity lens in its place. This is discussed at the end of this section.

<u>Gender equity in health</u>
Women's health issues and needs differ from men's and Women's Health Victoria commends this recognition within the new National Women's Health Policy discussion paper. Gender equity is primarily concerned with social justice rather than debating which sex has worse health or who dies at a younger age. Power imbalance, exposure to risk factors and opportunities for good health all contribute to current gender inequities in health.

Throughout the discussion paper the sex differences between women and men are examined for an identified group of risk factors. Within this section there is a stronger emphasis on the sex differences that women experience rather than the gendered (or social) factors that contribute to ill health. Gender differences are explored in the discussion paper to a lesser degree. Women's roles, including their caring responsibilities are noted but not further investigated. This indicates the work that is still to be done to achieve gender equity within the workplace. Women's Health Victoria acknowledges that the Government has committed to addressing this, with the inclusion of paid maternity leave in the 2009 budget as one example.

Women's Health Victoria welcomes the emphasis placed on a gendered approach to health service planning and delivery to ensure gender equity in health, as well as the use of a social model of health and recognition of gender as a social determinant of health.

However, we have concern that the 'Conceptual Framework for Determinants of Health' presented in Section 5, and the underlying explanation, fail to include gender as a determinant of health. This section acknowledges the 'different roles that women and men play' and the 'importance of biological sex and gender and other social factors' to the determinants of women's health. However, the Australian Institute of Health and Welfare's conceptual framework does not include gender as a factor in any of the individual or broader health categories. The conceptual framework needs to reflect the statements made in the document regarding gender as a determinant of health by including it as one of the 'broad features of society'.

The *Development of a New National Women's Health Policy: Consultation Discussion Paper 2009* identifies gender, along with sex, as a general determinant of health, but it is not included in discussion of *social* determinants. In addition, the 'Conceptual Framework for the Determinants of Health' diagram on page 8 omits gender altogether. It is vital that gender be recognised as a social determinant of health so that a focus on the ways in which socially-constructed, and therefore changeable, gender roles, responsibilities, expectations and constraints negatively impact on women's health.

Health equality between women

Women's Health Victoria commends the identification of groups at higher risk of poorer health and wellbeing in the national Women's Health Policy:

- Aboriginal and Torres Strait Islander women
- Immigrant and refugee women
- Women from disadvantaged backgrounds
- Women from rural and remote areas
- Women with a disability including mental illness

Within the groups listed, there is an error in the language – 'women with a disability including mental illness' should read: 'women *with disabilities*, including those with mental illness'. This recognises that individuals can have multiple disabilities, and that there is more than one type of disability.

The lack of inclusion of samesex attracted women in this category is also a concern. Lesbian and samesex attracted women are known to experience significant health inequities relative to the general population. Areas where this is particularly relevant include sexual and reproductive health and mental health and wellbeing, given the impact of discrimination[14,15].

Women's Health Victoria suggests that a cultural framework specific to lesbian and samesex attracted women, be included in the social inclusion commitment of the Government and the development of the National Women's Health Policy. This framework should be similar to that proposed in section 7.3.2 (page 30) of the Discussion Paper.

Although the new National Women's Health Policy recognises that within the population of women there is significant diversity, there is an absence of analysis of the intersection of different types of diversity.

It is important to ensure that specific policies do not disadvantage or further isolate the groups identified. Recognising diversity and developing policy and programs that take this into account should be the norm as described in the Gender Equality Scheme and the Gender Analysis Framework in section 3.8 of this document.

A focus on prevention

It is entirely appropriate that the Policy principles include a focus on prevention. The importance of prevention, especially primary prevention is paramount. The focus on prevention within the discussion paper is mainly focused on the prevention of illness and disease. A greater focus on the determinants of health and the prevention of the social disadvantage that can lead to poor health is required. With much recent focus on the prevention of chronic illness, it is important that there is acknowledgment that bringing about individual behavior change alone is not sufficient to address this. The Policy must include the responsibility of government, policy makers, community and industry to participate in assisting change to achieve better population health.

The economic case for a focus on prevention is compelling. Adequate funding of prevention programs reduces mortality, morbidity and health costs. Prevention strategies can be more effective when they are sensitive to gender and reach women through key programs.

The National Preventative Health Taskforce provides an opportunity to include a gender analysis of the three key health issues of tobacco, alcohol and obesity, which would guide the development of initiatives.

Prevention often uses a 'settings approach' to target particular groups, but when doing so it is crucial to consider who is not being included. An example of this is the workplace. It has been chosen as a focus for several well funded government programs. Choosing this as a setting means that many of the most marginalised women will be missed as they are not in the paid and organised workplace. To reach women at risk, Women's Health Victoria recommends looking at non-traditional settings to better engage with those who are most marginalised.

A strong and emerging evidence base

Women's Health Victoria welcomes the priority given to this principle. A strong evidence based approach will assist in maximising the effectiveness of policies and programs and will support the allocation of resources.

Women's Health Victoria facilitates access to women's health data through the *Victorian Index of Women's Health and Wellbeing Data* (The Index)[ii]. It is a catalogue of Victorian women's health data resources which provides access to evidence to inform policy and program development in Victoria.

By facilitating the use of sex-disaggregated data, The Index assists those working in policy development, planning, research and service provision to consider women and gender, resulting in a more detailed picture of Victorian women's lives.

The breadth of data within The Index extends beyond the traditional biomedical model of health. Instead, The Index incorporates over 70 indicators of health and wellbeing relevant to a social model of health. It draws on various external reports, surveys, and other sources of quantitative data from Commonwealth and State government departments and institutes, university research departments, non-government organisations, independent research bodies and academic publications.

Women's Health Victoria recommends that the 'Victorian Index of Women's Health and Wellbeing Data' be used as a model for the development of a national database. The collection of sex disaggregated data on such a scale would assist in addressing health inequities by encouraging a gender perspective for all relevant policy and program development and review.

[ii] See The Index at: www.theindex.org.au

A lifecourse approach

Women's Health Victoria holds concerns about the adoption of a lifecourse approach as a principle that will underpin the new Policy.

As recent research has stated, the risk inherent in taking a lifecourse approach is 'that too much emphasis is laid on personal traits and characteristics and not enough on the social settings, the options and constraints, in which individuals operate'[16]. The risk of adopting a lifecourse approach over a focus on diversity is that equity issues attached to women's health will not be identified or addressed.

It is recommended that this approach not be taken and that a diversity approach be substituted in its place. Doing so would still cover most aspects of a lifecourse approach with the consideration of age, but would also allow consideration of the other social factors that influence health and wellbeing, such as Aboriginality, cultural and linguistic diversity, sexual identity, geographic location, and socioeconomic status.

Considering diversity in this context would include the varying dimensions of life that exist at different stages and not merely the deterministic development model that a lifecourse approach promotes.

4 Conclusion

In summary, Women's Health Victoria congratulates the Government on the development of a National Women's Health Policy. We acknowledge the Government's efforts to expand on the 1989 Policy and welcome this commitment as necessary for the benefit of Australian women's health. While one of the objectives of the 1989 Policy was to ensure that health services in Australia were more accessible and affordable, and acceptable and appropriate for women's needs, this was not achieved. To a large extent the reason for this was because women's health services were never in a position to influence the medical profession or able to overcome barriers that were presented to them. A commitment by the current Government to support women's health services in this is imperative.

Within this submission we have outlined our response to the consultation paper and we have made nine recommendations:

1. The Commonwealth seek bipartisan support for the new National Women's Health Policy and Program.
2. A new National Women's Health Policy secures a commitment from state and territory governments for a 'joined-up' approach.
3. A new National Women's Health Policy applies a 'dual strategy' model to all states and territories.
4. Government mandate incorporation of gender sensitive practice into policy and service delivery.
5. A consistent model is applied to all states and territories allowing the women's health sector to be independent of government.
6. *Researching Women's Health: An Issues Paper* be revisited and the unpublished 1996 evaluation of the National Women's Health Program be made public.
7. Build knowledge and a commitment to research and knowledge translation in the new National Women's Health Policy.
8. The new National Women's Health Policy seeks to intersect with and influence other portfolio areas across government.
9. Adopt a legislative framework to ensure all policies take a gendered approach.

10. A new National Women's Health Policy focus on the five priority areas of the Australian Women's Health Network as outlined in their position paper, *Women's Health: The New National Agenda.*
11. A diversity lens forms the fifth principle to underpin the new National Women's Health Policy – replacing the life course approach.

Women's Health Victoria has also responded to the principles outlined in the consultation discussion paper. We are in support of four of the five principles and have given explanation for our concern about taking a life course approach. We have also suggested inclusion of the inclusion of priority issues consistent with those proposed by the Australian Women's Health Network.

To conclude, Women's Health Victoria looks forward to development of the new National Women's Health Policy, and hopes that the recommendations made within this document, and the principles outlined by the Australian Women's Health Network, are incorporated into the final Policy.

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