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

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Comments on ANPHA's Stakeholder Engagement Strategy, Consultation Draft.

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ABOUT THE AUSTRALIAN WOMEN'S HEALTH NETWORK (AWHN).

AWHN is a peak advocacy organisation that provides a national voice on women's health, based on informed consultation with members. It maintains that women's health is a key social and political issue which must be kept on political agendas at all times. It coordinates the sharing of information, skills and resources to empower members and maximise their effectiveness. It promotes informed and effective participation of women in all decision making which affects their health and well-being.

Through the application of a social view of health, it provides a woman-centred analysis of different models of health and medical care and research. It argues that to improve women's health and the health of the population at large, the social determinants of health outcomes must be an integral consideration in all policy debates.

AWHN aims to foster the development and expansion of women's health services and other comprehensive, community-based primary health care services, such as Aboriginal community controlled health services and community health centres. It advocates extensive collaboration and partnership between agencies on issues affecting women's health, particularly at the local level.

A coalition of organisations, AWHN aims to promote equity within the health system and equitable access to services for all women, in particular those women disadvantaged by race, class, education, age, poverty, sexuality, disability, geographical location, cultural isolation and language.

Currently, AWHN has 95 organisational members and 119 individual members, a membership that allows it to engage with women across a broad range of health and well-being issues. Through member organisations, especially women's health centres and services, it reaches smaller, often poorly represented groups, including women who are socially excluded and marginalised.

INTRODUCTION

The Australian Women's Health Network welcomes the opportunity to comment ANPHA's draft Stakeholder Engagement Strategy.

We strongly endorse ANPHA's vision of a healthy Australian society in which "the promotion of health is embraced by every sector, valued by every individual and includes everybody". We are very pleased to see that the importance of comprehensive engagement with a range of stakeholders is recognised and that a key objective is to be a catalyst for strategic partnerships.

We would like to focus our comments around ANPHA's aim of "achieving a healthy Australian society where the promotion of health is embraced by every sector". Certainly, it is important to engage with governments, industry groups, health service agencies, NGOs and a full range of relevant agencies. However, this engagement must be informed by a social determinants of health perspective, which should be foundational in all discussions, documents and considerations. Currently, a social determinants perspective is largely invisible in our general health system and in debates about health policy reform. A social determinants view is absolutely essential to the success of any efforts to reduce obesity, tobacco use and harmful alcohol consumption. In addition, a social determinants perspective draws attention to the structural barriers institutionalised within the health system that work against improved population health.

THE FOUNDATIONAL IMPORTANCE OF A SOCIAL HEALTH PERSPECTIVE.

AWHN has promoted a social health perspective for four decades, articulating such a view even before the World Health Organisation's 1978 pronouncements. Stephanie Bell, Director of the Central Australian Aboriginal Congress, captured the essence of the social health perspective nicely in 2001 when she wrote that

> *a person's physical health is like a frozen moment taken from the social and economic environment.*

International research shows that health outcomes emerge from complex interactions between social, economic, cultural, environmental and biomedical factors, rather than arising from biological determinants alone. Biomedical processes therefore need to be understood in their social context. As has been argued, 'there is a close interplay between social and biological factors, which means that biology must be problematised' (Hammarstrom 1999:243). A treatment focus alone is unnecessarily narrow and misses a great deal that is critical for optimal human health.

Yet despite an impressive and growing body of international evidence and despite the repeated arguments mounted by NGOs, the vast bulk of Australia's health dollars are spent on hospital and medical services. The Australian women's health movement, the Aboriginal health movement, the new public health movement and health promotion communities have all argued for the provision of a more comprehensive, community based, preventive health sector, in other words, a very much stronger primary health care system to operate beside the primary medical care system. International evidence demonstrates that where countries have

made substantial investments in primary, community-based health care to complement medical and hospital services, health outcomes are improved. In this respect, AWHN is very sorry that ANPHA's Draft Engagement Strategy does not specifically identify the non-government community-based women's health sector as an important stakeholder.

THE IMPACT OF ECONOMIC INEQUALITY.

If improved population health is to be taken seriously and if effective health promotion strategies are to be put in place, the relationship between poverty and other social and economic factors and inferior health outcomes must be recognised. Recent research suggests that levels of inequality, material and social, can explain the social gradient in health outcomes. Countries with the largest gaps between rich and poor experience more mental illness, more drug and alcohol-related problems, more obesity, higher rates of teenage pregnancy, poorer educational performance and literacy scores and higher rates of homicide (Wilkinson and Pickett 2009).

Inequality works to undermine health, it is suggested, by increasing stress right across society. Stress, medical research shows, produces a range of diseases and behavioural problems. In heavily unequal societies, the rich fear the poor and the poor suffer from status anxiety and shame, making everyone's health poorer than it would otherwise be. More equal societies enjoy higher levels of trust and lower levels of stress. Low status, low levels of respect and feelings of low self-esteem, rather than material deprivation per se, contribute more to poor health and help explain the social gradient (Wilkinson and Pickett 2009). The arguments of Australian Aboriginal people, for example, who point to the devastating health consequences of colonisation and racism are corroborated by these findings.

THE IMPORTANCE OF EMPLOYING A GENDER LENS.

Women in Australia, as everywhere, are over-represented amongst the poor, thus highlighting the need for a gender lens to be applied to all health promotion strategies.[1] Australia's gender pay gap, for example, contributes to economic insecurity, increasing the number of low-income families, especially female-headed families, with a negative impact on health, including the health of children. It also contributes to financial vulnerability for women, especially women in retirement. The effects of the pay gap are exacerbated by socially prescribed caring responsibilities, which reduce the workforce participation rates of women, whether they be mothers, daughters, friends or neighbours.

Violence is another major 'cause of the causes' of poor health, and one that particularly affects women. While the underpinnings of violence are complex, there is wide agreement that intimate partner violence, in particular, is firmly embedded in gender inequality. Violence is detrimental to women's health in many ways. A major WHO study found that violence had a negative impact on women's physical, sexual, reproductive, psychological and behavioural health, as well as having fatal consequences in cases of AIDS-related mortality, maternal mortality, homicide and suicide (Krug et al. 2002).

[1] This is not generally the case for Aboriginal women, who point out that they often have better jobs and higher education levels than Aboriginal men.

Post-traumatic stress disorder (PTSD) is more prevalent among women who have experienced violence, along with neurological disorders as a result of head injuries and attempted strangulation. Women who have experienced violence have more sexually transmitted and urinary tract infections, more migraine headaches, more chronic pain and poorer reproductive health outcomes (Coker 2005:1; Taft et al. 2003). Moreover, studies show that the health consequences of abuse can persist for years, even throughout life, and that the more severe the abuse, the greater is the detrimental impact on health, with multiple episodes having a cumulative impact.

Workplace conditions are other factors that can give rise, directly and indirectly, to poor health outcomes. Discrimination or harassment in the workplace, for example, might lead to anxiety, depression and other mental health problems and economic insecurity—all closely associated with reduced life chances and poorer health. The Canadian Women's Health Strategy (Health Canada 1999) identified 12 key social determinants of women's health: income and social status; employment status; education; social environment, including social support and social exclusion; physical environment, including access to food, housing, transport, clean air and the like; healthy child development; personal health practices and coping skills; access to health services; social support networks; biology and genetic endowment; gender; and culture. Indeed, each of these categories is an umbrella for more specific determinants.

GENDER APPLIES TO MEN'S HEALTH AS WELL AS WOMEN'S HEALTH, NOT TO FORGET CHILDREN'S HEALTH.

While the Australian women's health movement has championed a social view of health and illness, it is cognisant that this perspective is equally relevant to men's health. Gender, as one of the social determinants, helps shape the conditions of men's lives, just as it does those of women. Male gender roles might work to undermine health by encouraging physical risk taking and, perhaps, the denial of emotions, physical discomfort and pain. The expectations held about what is required of breadwinners, as another example, might induce men to work in stressful, dangerous occupations or to work unhealthily long hours. Risk-taking behaviour can have untoward effects on the health of both men and women, particularly in relation to sexual activity. We might not be able to tell for sure whether women suffer more morbidity than men (Broom 1991:47–52), but a social health perspective tells us for certain that many men and women suffer high levels of avoidable ill health as a consequence of the constraints and requirements of masculine and feminine gender roles.

Similarly, it is very important to consider social and cultural factors and factors relating to the position that particular people find themselves in such as experiencing a disability in any plan to improve population health. Research shows that people will not use health services if they are not culturally appropriate. Plans to improve population health should be especially sensitive to the position of those who are most disadvantaged, including Aboriginal Australians and those with disabilities.

AWHN argues that ANPHA has a key role to play in putting the health impact of social determinants on all Australian policy agendas.

STRATEGIES TO IMPROVE POPULATION HEALTH INFORMED BY A SOCIAL DETERMINANTS PERSPECTIVE.

The impact of social, economic and cultural health determinants points to the need for comprehensive and collaborative strategies that address the root causes of ill-health and aim to prevent illness and injury. Evidence shows that successful interventions are multifaceted and collaborative. It is recognised that lifestyle behaviours, such as in activity and alcohol abuse, depend heavily upon factors in the environments in which people live and work.

The work of ANPHA, in engaging with a range of stakeholders with the purpose of modifying pernicious environmental factors is to be applauded.

However, changes must also take place at the level of service delivery. The Ottawa Charter for Health Promotion proposed that action needs to be taken in the areas of personal skill development, building healthy public policy and strengthening community action as well as creating supportive environments and reorienting health services. Providing information and enhancing life skills increases the opportunities for people to exercise more control over their own lives and lifestyles.

We note that inV1:17 of the draft Stakeholder Engagement Strategy that ANPHA envisages "reshaping consumer demand towards healthy living choices" is one of its goals. Research shows that it is very difficult to reshape so-called consumer demand and while providing information in traditional social marketing programs is important, we know that such initiatives have a limited impact on health outcomes and on people’s so called "lifestyle choices". Individuals need opportunities to be able to exercise effective health choices. They need to be supported in a variety of ways if they are to have the capacity take responsibility for their behaviours. The mobilisation towards health of the communities in which we all live is one aspect of this support. This is where community-based health services play a very important role.

THE COMMUNITY-BASED HEALTH SECTOR, INCLUDING WOMEN'S HEALTH SECTOR.

The Australian women's health sector, although it is small, provides a remarkable model for the provision of collaborative, community-based preventive health care. The sector firmly adheres to a social view of health. Female run centres and services, including women's health centres, refuges and various agencies providing support for women who have experienced assault, substance abuse and the like offer avenues for extensive individual and community participation in health decision-making, including participation by disadvantaged and marginalised women.

Primary prevention undertakings are tailored to meet local needs. Self-help is supported, health literacy is promoted and group programs are developed. Support and referral services and community development projects are part of everyday practice, along with interaction and collaboration with local service providers. There is frequently extensive collaboration with other health providers, including general practitioners, local government, recreation services, education institutions and local businesses. Ideally, if a network of such services were to be spread evenly across Australia, the result would be the empowerment of individuals and communities through effective participation in a wide range of health projects, broadly conceived. Community-based Aboriginal health services, along with those

community health centres that have been preserved since the 1970s, are also informed by a social health perspective and offer a similarly comprehensive range of services and community development projects.

The Australian Women's Health Network recommends that ANPHA promote the value of Australia's existing community-based health sector. ANPHA is also well placed to foster strategic partnerships between this sector and other important stakeholders. In particular, collaboration between Medicare Locals and local hospital networks and the community-based health sector could be fostered and encouraged.

To return to the impact of the medical care system on health outcomes, as presently structured, the Australian system presents a number of crucially important structural barriers to improved population health. These include serious access barriers to conventional treatment services, as well as high access barriers to preventive health and support services. Population health outcomes can only be optimised if these structural barriers are addressed and removed.

STRUCTURAL BARRIERS TO IMPROVED POPULATION HEALTH

Australia exhibits a number of entrenched structural barriers that impede full access to hospital and medical treatment. These include (but are not limited to) the fee-for-service system of doctor remuneration, the Australian preference for small medical practices, increasing user charges and imbalance in the geographical spread of services. Financial barriers also inhibit access to allied health services, including dentistry, physiotherapy, dietary advice and the like. Moreover, there is still excessive emphasis on a medical model of care in medical, nursing and other health professional education with insufficient emphasis on training to increase awareness of prevention and of cultural, sexuality and gender differences. If the health system is to be re-oriented towards health, as suggested by the Ottawa Charter, health professional education systems must be reformed to incorporate a population health perspective as a fundamental building block.

Fee-For-Service Medical Services

Although Medicare is a type of national health insurance system, it provides only partial coverage against the cost of medical services outside hospitals. Australian user charges—that part of the cost of a service paid for by the user—have been allowed to increase steadily since 1984 and are now among the highest in the world (Schoen et al. 2010:2327). There is a large international literature showing that user charges constitute a serious financial barrier to access, especially for low-income people (reviewed in Gray 2004:65–77). In 2009, 22 per cent of Australians went without care because of cost, 21 per cent paid user charges of $1000 or more and 8 per cent reported being unable to pay medical bills or having serious problems paying (The Commonwealth Fund 2010). Moreover, the cost of accessing the services of allied health professionals, including dieticians, physiotherapists, psychologists, counsellors, podiatrists, dentists, midwives and alternative therapists, is beyond the financial capacity of a great many Australians and is especially difficult for low-income people, especially women.

These structural impediments mean that those lower down the social gradient are often missed by conventional medical systems, bringing to mind 'the inverse care law' coined by Welsh doctor, Julian Tudor Hart, some 40 years ago. 'The availability of good medical care', Hart argued, 'tends to vary inversely with the need of the population served' in systems where market forces are allowed to operate (Hart 1971:405).

Some people are deterred from accessing services because health professionals are not trained in cultural or gender competence and are not trained to understand the health problems faced by those with non-heterosexual orientations. Aboriginal people report experiencing racism when using mainstream services, while people from backgrounds other than Anglo-Australian often find that the circumstances of their lives are misunderstood. For similar reasons, GLBTQ (gay, lesbian, bisexual, transgender and questioning) people identify the production of appropriate health services as a top priority.

The inverse-care law also operates strongly in relation to residents of rural and remote areas, where services of all types are in short supply, despite evidence that rural people suffer poorer health than people living in metropolitan areas.[2] If we were to take the optimisation of population health seriously, reforms would be implemented to modify and, in an ideal world, eventually eliminate, all of these structural barriers.

Australian health policy has failed to deal with the overt barriers that impact adversely on access to hospital and medical treatment, at least partly because the social determinants of health outcomes are not recognised widely enough. These fundamental shortcomings must be addressed as a preliminary step towards improving population health. The provision of up-to-date and apposite research is needed to inform policy processes.[3] In addition to the problems of access to conventional medical care, to optimise health outcomes, structural changes are needed to strengthen the primary health care system.

Structural Barriers to a Stronger Primary Health Care System

The important barriers weighing against the development of a more comprehensive healthcare system include cultural factors, financial forces and the stake that powerful groups have in preserving the system as it stands. Ideas about what is appropriate and necessary in a health system take a long time to change. The century-old idea that a health system provides hospital and medical services and not much else is taking a long time to fade. Because there are so few comprehensive primary healthcare centres in Australia, most people have no experience of the kind of care they could be offered and are probably unfamiliar with what is done in other countries in the name of holistic primary health care. What we do know, however, as the experience of women's health centres clearly demonstrates, is that when people have an opportunity to access such services, they are prepared to line up for hours or wait many weeks to do so.

[2] We do not have geographical access problems of such magnitude in education because educators do not operate as private business entrepreneurs.

[3] It is instructive that the best evidence we have about access to services is not produced in Australia but rather emanates from overseas work. We cannot begin to optimise health outcomes without Australian evidence as a basis for appropriate political and policy action

The fee-for-service method of payment works against the provision of comprehensive, preventive, primary health care.[4] It operates as an economic incentive for doctors to see as many patients as possible, as quickly as possible, producing high turnover, curative medicine. It discourages the longer appointments necessary for thorough check-ups, for the management of complex and chronic conditions and to engage in primary prevention work. Internationally, fee-for-service remuneration has come under heavy criticism. One OECD assessment argues that it gives physicians 'full discretion' over the level and mix of services and creates incentives 'to expand the volume and price of the services they provide' (OECD 2003). Policy in a number of European countries is moving away from fee-for-service towards other forms of payment. Fee-for-service has been replaced completely with contract and salaried payment in New Zealand. Recent research shows that the percentage of New Zealanders who go without care because of cost has fallen since 2004 when this change came into operation (Schoen et al. 2010:2327).

In the 1970s, government members and committed bureaucrats 'talked up' the value of comprehensive primary health care, whereas in the twenty-first century, most health debate focuses on hospitals and their waiting lists. Despite acknowledgement of the importance of preventive health care in recent health documents, there is not enough Australian-based evidence that demonstrates the value of comprehensive, community-based health care. A preference for solo or small group practice, supported by the financing system, is another structural barrier to comprehensive, primary health care. When women talk about gaps in services, they have in mind such services as prevention advice, counselling and support which are in such short supply under present Australian arrangements and which are so crucially important for improved health outcomes. Evidence from overseas shows that teams of health professionals are necessary to deliver an integrated and comprehensive range of preventive, educational, counselling, caring and social advocacy services, alongside conventional medical services. Australia's National Health and Hospitals Reform Commission acknowledged this body of overseas evidence. It also shows that the sharing of ideas and the collegiality that comes with teamwork is beneficial to providers and clients alike. Health teams have been introduced in some European countries and in New Zealand and Canada.

Finance, of course, is a key factor militating against greater investment in strong primary health care and presents Australian governments with a circular dilemma. Hospital and medical costs have increased faster than other prices for decades and, even for the Commonwealth, which controls most of the Finance in the Australian Federation, they are a large budget item. Under these circumstances, it is difficult for governments to find new money to invest in new prevention oriented services. Yet the only effective way to control hospital and medical cost increases is to improve population health. Under the circumstances, delaying investment in comprehensive primary health care ensures the continuation of a destructive spiral: low spending on primary health care results in avoidable illness and unnecessary hospitalisation, which leads to unnecessarily high expenditure on hospital and medical services which, in turn, manifests in low spending on primary health care.

The National Health and Hospitals Reform Commission drew attention to this quandary, commenting on the lack of any nationally coordinated mechanism to deliver preventive

[4] There is a distinct contrast between primary health care and primary medical care. Whereas primary health care focuses on the provision of a comprehensive range of community based services, including prevention, primary medical care is mainly concerned with the delivery of conventional treatment services to individuals.

health care. In relation to chronic disease, it argued that Australia spends less than 2 per cent of the health budget on ‘a problem which consumes a major proportion of health expenditure’ (Commonwealth of Australia 2009c:51). Meanwhile, highly expensive practices are not only maintained but are expanding. For example, Australian rates of Caesarean section are high by international standards and growing (although they are defended by certain groups of professionals). Indeed, all the English-speaking industrialised countries have high rates, except for New Zealand, which, since the important reforms of the 1990s expanding the roles and responsibilities of midwives, is now placed about the middle. The OECD country with by far the lowest caesarean section rate is the Netherlands, where medicalisation has always been lower than anywhere else and where approximately one-third of babies are born at home (OECD 2011).

In the longer term, the mainstream Australian health system must embed ‘prevention and early intervention into every aspect’ of practice, as recommended in 2009 by the NHHRC (Commonwealth of Australia 2009c:95). In order to move towards the achievement of this goal, ANPHA has a key role to play which includes promotion of awareness of a social health perspective and recognition of structural changes that need to take place to remove obstacles to both treatment and to preventive health care.

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