



Australian Government
Department of Health and Ageing



DEVELOPMENT OF A
**NEW NATIONAL
WOMEN'S HEALTH POLICY**
CONSULTATION DISCUSSION PAPER 2009

Development of A New National Women's Health Policy – Consultation Discussion Paper 2009

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INTRODUCTION BY THE MINISTER FOR HEALTH AND AGEING

The health of Australian women is important. Women take on a myriad of responsibilities, as mothers, grandmothers, sisters, daughters, wives and partners. Many combine paid work and raising families in an increasingly busy society. Often it is the women in households who have the main responsibility for looking after the health of other family members.

Despite many improvements in women's health – Australian women's life expectancy is amongst the highest in the world – not all women in Australia have benefited equally. We need a new approach to improving the health and wellbeing of all women in Australia, especially those with the highest risk of poor health. By improving the health of all Australian women we will improve the health of the whole community.

This is why the Government made an election commitment to developing a new National Australian Women's Health Policy. It has been twenty years since the first *National Women's Health Policy: Advancing Women's Health in Australia* was released and it's time to revisit the issues and concerns Australian women have about their health.

The purpose of the new National Women's Health Policy is to improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health; encourage the health system to be more responsive to the needs of women; actively promote the participation of women in health decision making and management; and to promote health equity among women.

In line with international developments and the Government's social inclusion agenda, the new National Women's Health Policy will emphasise prevention, health inequalities and the social determinants of those inequalities. The Policy will address the needs of all women, including those of Aboriginal and Torres Strait Islander descent; immigrant and refugee women; women from disadvantaged backgrounds, including women experiencing homelessness; women from rural and remote areas; and women with a disability, including mental illness.

The consultation process for the new Women's Health Policy is underway. On 16 December 2008 I released the paper: *Developing a Women's Health Policy for Australia: setting the scene*. This paper identified areas of concern for women's health issues across the life course, the principles which might underpin the policy and how the community might be involved.

This paper takes a further step forward by setting out some of the health issues for Australian women that a policy might address. During 2008 there will be consultations with consumers, the community, health service providers, key women's groups and state and territory governments in all states and territories. Women's health organisations and women themselves may like to make submissions on what they think the policy should encompass.

More information on the development of Australia's new National Women's Health Policy can be found on www.health.gov.au/womenshealthpolicy.



Nicola Roxon
Minister for Health and Ageing

DEVELOPMENT OF A
**NEW NATIONAL
WOMEN'S HEALTH POLICY**
CONSULTATION DISCUSSION PAPER 2009

1. Introduction

In 2007, the Australian Government made an election commitment to develop a new National Women's Health Policy in recognition of the fact that it has been 20 years since the last Australian women's health policy has been developed. It is time for the health issues and concerns of Australian women to be reconsidered.

The women's policy will recognise gender as a basic determinant of health, which gives rise to different health outcomes and different needs for women and men.

In line with international developments and the Australian Government's social inclusion agenda, the policy will emphasise prevention, health inequalities and the social determinants of those inequalities. The women's policy will address the needs of:

- Aboriginal and Torres Strait Islander women;
- immigrant and refugee women;
- women from disadvantaged backgrounds, including women experiencing homelessness;
- women from rural and remote areas; and
- women with a disability, including mental illness.

The purpose of the new National Women's Health Policy is to:

- improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health;
- encourage the health system to be more responsive to the needs of women;
- actively promote the participation of women in health decision making and management; and
- promote health equity among women.

2. Purpose of the Consultation Discussion Paper

This Consultation Discussion Paper has been developed to provide background information and promote discussion about the National Women's Health Policy and important health issues for women. The paper provides an overview of Australian women's health, and discusses some key determinants of health, sex and gender and other social determinants of health. It then discusses some of the health inequities experienced by disadvantaged and vulnerable groups of Australian women.

The Australian Government will undertake consultations with consumers, the community, health service providers, key women's groups and state and territory governments, to make sure that the new National Women's Health Policy meets the varied needs of Australian women of all ages and from diverse backgrounds and locations. The views of stakeholders and interested persons will help to shape the development of the policy.

3. Why do we need a new National Women's Health Policy?

3.1 WOMEN'S HEALTH IS IMPORTANT

Good health ('complete physical, mental and social wellbeing and not merely the absence of disease and infirmity'¹) is fundamental to women's wellbeing and enjoyment of life. Improving the health and wellbeing of all women will improve the health and wellbeing of families and whole communities, through the caring, nurturing and educative roles that women perform on a daily basis.

Other benefits of improved health for women include greater participation and productivity in paid and unpaid occupations.² Increased productivity and participation by women is crucial to the Australian economy, given the ageing of the population.³ Access Economics has estimated that an increase in women's participation could increase national output by around \$100 billion by 2040.⁴

As women are the majority of health consumers in Australia, improved health for women would also reduce demand for high cost health services that need to be funded by government.⁵

3.2 HEALTH INEQUALITIES

Life expectancy for Australian women is one of the highest in the world (83.7 years in 2005–07).⁶ However, while the average life expectancy of Australian women continues to rise, significant health inequalities exist between different groups of Australian women.

In addition, while Australian women have a higher life expectancy than men (79.0 years in 2005–07), there are sex and gender differences in the types and prevalence of conditions experienced.⁷

It is clear that addressing these health inequalities will require new approaches to provide a basis for focussed and coordinated action and to make a real difference.

As many of the factors that contribute to poor health are preventable, a new National Women's Health Policy has the potential to improve the health and wellbeing of all Australian women.

4. Overview of Australian Women's Health

4.1 LEADING CAUSES OF DEATH AND BURDEN OF DISEASE

Table 1 below sets out the leading causes of female death and burden of disease (years of 'healthy life' lost due to disease or injury⁸) in Australia. Ischaemic (coronary) heart disease, stroke, dementia, cancer of the trachea, lung and breast, and anxiety and depression are the leading causes of death and burden of disease.

1 World Health Organization 1946. Preamble to the Constitution of the World Health Organization.

2 Australian Women's Health Network, *Women's Health: The new national agenda*, AWHN Position Paper March 2008, AWHN, Available at <www.awhn.org.au>

3 Commonwealth Government Office for Women. 2007 *Women in Australia 2007*, Commonwealth of Australia, Canberra

4 Access Economics. 2006 Meeting Australia's ageing challenge: the importance of women's workforce participation. House of Representative Standing Committee on Family and Human Services Inquiry into Balancing Work and Family

5 Australian Women's Health Network, *Women's Health: The new national agenda*, AWHN Position Paper March 2008, AWHN, Available at <www.awhn.org.au>

6 ABS. 2008. *Deaths, Australia, 2007*. ABS, Canberra. Cat no. 3302.0

7 *ibid*

8 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*. AIHW, Canberra

Table 1. Females – leading causes of death (2006)⁹ and burden of disease (2003)¹⁰

	Cause of death*	Burden of disease
1	Ischaemic heart disease – angina, blocked arteries of the heart and heart attacks (16.6%)	Anxiety and depression (10%)
2	Stroke (10.7%)	Ischaemic heart disease (8.9%)
3	Dementia and Alzheimer’s (6.9%)	Stroke (5.1%)
4	Trachea and lung cancer (4.1%)	Type 2 diabetes (4.9%)
5	Breast cancer (4.0%)	Dementia (4.8%)
6	Chronic lower respiratory diseases – asthma, bronchitis and emphysema (3.8%)	Breast cancer (4.8%)
7	Diabetes (2.8%)	Chronic obstructive pulmonary disease – of the lungs (3.0%)
8	Heart failure (2.7%)	Lung cancer (2.7%)
9	Diseases of the kidney and urinary system (2.7%)	Asthma (2.7%)
10	Colon and rectum cancer (2.6%)	Colorectal cancer (2.3%)

*65,183 Australian females died in 2006

Changes in the leading causes of death with increasing age reflect the ageing process and longer exposure to risk factors. As set out in Table 2, for girls and young women, injury and poisoning are the major causes of death. Among women in the 25–84 age groups, cancer is the leading cause of death, and for women aged 85 and over, cardiovascular disease is the leading cause.

Asthma is the leading contributor to burden of disease for the 0–14 age group, anxiety and depression in the 15–44 age group, breast cancer in the 45–64 group, and ischaemic heart disease in the 65 and over group.

Table 2: Females by age: leading causes of death (2006)¹¹ and burden of disease (2003)¹²

Years	Cause of death	Years	Burden of disease
1–14	Injury and poisoning (28.6%)	0–14	Asthma (17.0% of burden)
15–24	Injury and poisoning (56.1%)	15–24	Anxiety and depression (31.8%)
25–44	Cancer – all neoplasms* (35.5%)	25–44	Anxiety and depression (24.4%)
45–64	Cancer – all neoplasms (57.5%)	45–64	Breast cancer (10.7%)
65–84	Cancer – all neoplasms (33.7%)	65–74	Ischaemic heart disease (11.4%)
85+	Cardiovascular disease** (49.4%)	75+	Ischaemic heart disease (18.7%)

*tumours

**includes ischaemic (coronary) heart disease and stroke

9 ABS. 2008. *Causes of Death, Australia, 2006*. ABS, Canberra. Cat. No. 3303.0.

10 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*. AIHW, Canberra

11 AIHW Mortality FAQs National Mortality Database. 2006 <http://www.aihw.gov.au/mortality/data/faqs.cfm>

12 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.



4.2 RISK FACTORS

Begg et al (2007) identified a group of health risk factors which explained one third of Australia's total health loss in 2003.¹³ These tend to be more prevalent among disadvantaged and vulnerable groups of women (as outlined at Section 5.2.2). According to Begg et al, significant gains can be made through achievable changes in exposure to a limited number of well established health risks.¹⁴

Overweight and obesity, physical inactivity, poor diet, alcohol misuse and tobacco smoking are key determinants of preventable diseases such as coronary heart disease, stroke, Type 2 diabetes, and cancer (including breast cancer and cervical cancer) and other major risk factors such as high blood pressure and high blood cholesterol. Table 3 sets out the relationship between selected chronic conditions and their determinants.

Table 3 Selected chronic conditions and their determinants^{15, 16}

	Excess body weight	Physical inactivity	Poor diet and nutrition	Alcohol misuse	Tobacco smoking	High blood pressure	High blood cholesterol
Coronary heart disease	✓	✓	✓	✓	✓	✓	✓
Stroke	✓	✓	✓	✓	✓	✓	✓
Type 2 diabetes	✓	✓	✓	✓			
Depression	✓	✓		✓			
Lung cancer					✓		
Colorectal cancer	✓	✓	✓	✓			
Osteoarthritis	✓	✓					
Osteoporosis		✓	✓	✓	✓		
Asthma					✓		

13 Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

14 Ibid

15 AIHW. 2005. *Risk Factors*. <http://www.aihw.gov.au/nhpa/riskfactors/index.cfm>

16 AIHW 2008 Indicators for chronic diseases and their determinants 2008 AIHW cat. no. PHE 75

Intimate partner/family violence against women is also a major risk factor leading to illness, injury and premature death. The risk factors are briefly outlined below, along with risk behaviours in young women:

- **Overweight/obesity** – nearly half of Australian women are overweight or obese, and high body mass was the leading risk factor (along with high blood pressure) identified as contributing to the burden of disease in Australian women in 2003.^{17,18} The Australian Longitudinal Study on Women's Health (ALSWH) has also found that obesity is now the primary cause of chronic illness in women, with the risk of developing a range of diseases increasing as excess weight increases.¹⁹ Notably, the lifetime risk of developing Type 2 diabetes in women of normal weight is 17.1 per cent but increases to 35.4 per cent in overweight women and 74.7 per cent for very obese women.²⁰ Depression and anxiety are also known to increase in women who are overweight and decrease upon weight loss.^{21,22}
 - Of considerable concern is the accelerating rate of weight increase of younger Australian women. According to ALSWH, 'Unless there is a significant reduction in the rate of weight increase in the younger cohort, they will have a much higher prevalence of obesity and overweight when they reach 45 years of age.'²³ The younger cohort is now 30–35 years.
 - At the Australian Health Ministers' Council meeting in April 2008, obesity was endorsed as a National Health Priority Area to help tackle the significant health burden that obesity places on the Australian community.
- **High blood pressure**^{24,25} – is experienced by 27 per cent of Australian women (aged 25 years and over) and was identified by Begg et al as the equal leading risk factor contributing to the burden of disease in Australian women. It is a major risk factor for coronary heart disease, heart failure and stroke. Lifestyle (non biomedical) causes of high blood pressure include being overweight, physical inactivity, alcohol consumption, high intake of saturated fat and salt, and low intake of fruit and vegetables. The risk of heart attack and stroke increases threefold in people who smoke tobacco and have high blood pressure.
- **Physical inactivity** – about one third of Australian women do not exercise,²⁶ which is a major contributor to being overweight or obese. A lack of regular physical activity was the third highest risk factor identified as contributing to the total burden of disease in Australian women in 2003.²⁷ It is a major risk factor for all of the National Health Priority Areas except asthma. Increasing physical activity not only assists with weight loss but also reduces stress, anxiety and depression.²⁸

17 ABS 2006. *National Health Survey: Summary of Results 2004-05* Cat. No. 4364. Canberra: ABS.

18 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

19 Adamson L. Brown W. Byles J. 2007. *Women's weight: Findings from the ALSWH*. Department of Health and Ageing.

20 Venkat Narayan K et al. 2006. Presentation – *Scientific Sessions of the ADA*, June 2006.

21 Wadden et al 2006. Comparison of psychosocial status in treatment-seeking women with class III vs. class I-II obesity. *Obesity (Silver Spring)*, 14(Suppl 2), pp90S-98S.

22 Bradshaw A, Katzer L, Horwath CC, et al. 2004 'A randomised trial of three non-dieting programs for overweight women'(abstract), *Asia Pacific Journal of Clinical Nutrition*, vol 13(Suppl), 2004, page S43.

23 Adamson L. Brown W. Byles J. 2007. *Women's weight: Findings from the ALSWH*. Department of Health and Ageing. pp5-6.

24 AIHW. 2005. *Risk Factors*. <http://www.aihw.gov.au/riskfactors/index.cfm>

25 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

26 ABS 2006. *National Health Survey: Summary of Results 2004-05* op. cit.

27 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

28 Stear S. 2003, Health and fitness series-1. The importance of physical activity for health. *Journal of Family Health Care*, Vol 13, Issue 1, 2003, pp10-13.

- **Poor diet** – in Australia 40 per cent of women do not eat enough fruit and over 80 per cent of women do not eat enough vegetables.²⁹ While Begg et al (2007) found low fruit and vegetable consumption to be the seventh highest risk factor,³⁰ the over consumption of foods with high fat and sugar contents is also significantly driving the level of weight increase in Australian women and contributing to heart disease and cancer.
- **High blood cholesterol**^{31,32} – a major risk factor for coronary heart disease experienced by 51 per cent of Australian women (25 years and over). It is the equal fourth highest risk factor identified by Begg et al as contributing to the total burden of disease in Australian women. Saturated fat in the diet is the major lifestyle risk factor for high blood cholesterol.
- **Tobacco smoking** – the equal fourth highest risk factor identified as contributing to the total burden of disease in Australian women in 2003.³³ While tobacco smoking has declined over time, 15.2 per cent of females aged 14 and over continue to smoke daily.³⁴ Tobacco smoking is a major risk factor for asthma, coronary heart disease, stroke, lung cancer and osteoporosis, and has serious implications for women's reproductive health, including higher rates of:^{35,36}
 - cervical cancer;
 - premenstrual tension, irregular periods, heavy periods and severe period pain;
 - decreased fertility; and
 - earlier onset of menopause (up to 4 years earlier).
- **Intimate partner/family violence against women** – was the sixth highest behavioural risk factor identified by Begg et al and, according to the Australian Bureau of Statistics, at least one in 17 women in Australia is assaulted each year.³⁷ Violence against women can significantly impact on the physical and psychological health of women in both the short and long term,³⁸ and result in:^{39,40}
 - premature death and injury;
 - anxiety and depression, post traumatic stress disorder, and being suicidal;
 - illicit and licit drug use (for example tobacco, alcohol, tranquillisers, and anti-depressants); and
 - sexually transmitted diseases, unplanned pregnancy, termination or miscarriage.

29 ABS 2006. *National Health Survey: Summary of Results 2004-05* op. cit

30 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

31 AIHW. 2005. *Risk Factors*. <http://www.aihw.gov.au/riskfactors/index.cfm>

32 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

33 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

34 AIHW 2008 *Australia's Health 2008* Cat no AUS 99 Canberra p132

35 Mishra G et al 2000. Cigarette smoking, menstrual symptoms and miscarriage among young women ANZJPH 24(4). 413-20

36 *Women and smoking*. A report of the US Surgeon General. 2001.

37 Australian Bureau of Statistics *Personal Safety Survey Australia 2005* Cat No. 4906.0 Canberra

38 Australian Domestic and Family Violence Clearing House. 2003. *Routine Screening for Domestic Violence in Health Services*

39 Department of Human Services Victoria, 2004. *The health costs of violence*, Measuring the burden of disease caused by intimate partner violence, A summary of findings, Victorian Health Promotion Foundation.

40 Australian Domestic and Family Violence Clearing House. 2003. *Routine Screening for Domestic violence in Health Services*

- **Excessive alcohol consumption** was identified as the equal eleventh highest risk factor overall but the fifth highest for women in the 0–44 age group.⁴¹ It contributes to road traffic accidents, cirrhosis of the liver, stroke, inflammatory heart disease, hypertension, falls, suicide, self inflicted injuries, drowning and cancers, such as of the mouth and liver.⁴² A 2007 study of 70,000 women found that three or more alcoholic drinks a day increased the risk of breast cancer by 30 per cent – similar to the increased breast cancer risk from smoking a packet of cigarettes or more a day.⁴³ Women who drink three alcoholic drinks a day for 10 years also have an increased risk of brain damage.⁴⁴ *The 2007 National Drug Strategy Household Survey* indicated that females in the 14–19 to 40–49 years age groups were more likely than males to drink alcohol at risky or high risk levels for long term harm, with the gap being widest between teenage males and females.⁴⁵
- **Risk behaviours in young women** – young women are engaging in a range of health risk behaviours, such as:
 - smoking – more females in the 12–19 years age groups are smoking than males and female teenagers are more likely to be daily smokers than male teenagers;^{46, 47}
 - alcohol – in 2007 higher proportions of females than males in the 12–19 years age group drank daily and weekly and higher proportions of females in the 16–17 and 18–19 years age groups drank alcohol less than weekly. More than 15 per cent of females aged 16–17 years drank alcohol weekly;⁴⁸
 - inconsistent use of contraception, including condoms as a protection against sexually transmissible infections such as chlamydia;⁴⁹ and
 - self harm – young females account for the majority of hospitalisations for intentional self harm (70 per cent), mainly due to self poisoning. In the last 10 years, self harm requiring hospitalisation among young women increased by 51 per cent.^{50, 51}

41 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

42 ibid

43 Li Y. Baer D. Friedman GD., Udaltsova N. Shim V. Klatsky AL. Wine, liquor, beer and risk of breast cancer in a large population European Journal of Cancer – 17 December 2008 (10.1016/j.ejca.2008.11.001)

44 <http://www.arbias.org.au/hangover-for-life/a-checklist-are-you-at-risk.html>

45 AIHW 2008. *2007 National Drug Strategy Household Survey First Results* p23

46 AIHW 2008. *Australia's Health 2008* op cit p 133

47 AIHW 2008. *2007 National Drug Strategy Household Survey* p15

48 AIHW 2008. *2007 National Drug Strategy Household Survey First Results* Canberra Cat no PHE 98 p21

49 Sexual and Reproductive Health Strategy Reference Group of the Public Health Association of Australia Women's Health Special Interest Group, Sexual Health & Family Planning Australia and the Australian Reproductive Health Alliance, 2008. *Time for a national sexual & reproductive health strategy for Australia Background Paper*.

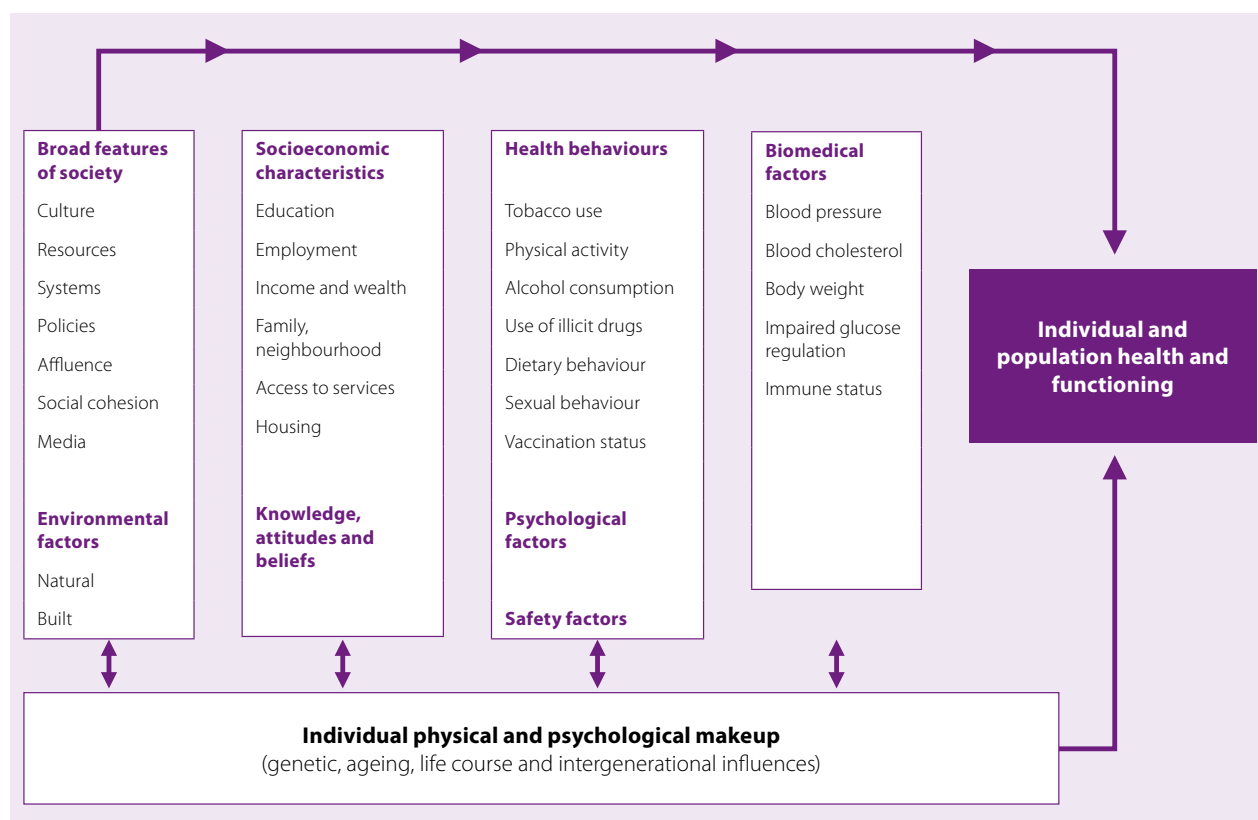
50 Eldridge D 2008 *Injury among young Australians*. AIHW Bulletin Series no 60 cat no AUS 102 Canberra

51 AIHW 2007 *Young Australians: their health and wellbeing 2007* AIHW cat. no. PHE 87

5. Determinants of Health⁵²

In *Australia's Health (2008)*, the Australian Institute of Health and Welfare (AIHW) describes the 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 psychological makeup.⁵³ These include the different roles that women and men play in the community and sex-specific biological predispositions. The AIHW has produced the following framework for understanding the determinants of health.

Conceptual Framework for the Determinants of Health⁵⁴



The figure illustrates how the broad features of society, including culture, economic and power systems, social policies, politics, affluence and social cohesion, impact upon socioeconomic circumstances and social and physical environments. These then influence people's health behaviours, their psychological states and factors relating to safety. All of these contributors may then influence biomedical factors, producing further health effects. The elements within the boxes interact with each other and with individual physical and psychological makeup, such as genetics, ageing, the influence of life course and intergenerational influences.

The following discussion highlights the importance of biological sex and gender and other social factors as determinants of women's health.

⁵² Australian Women's Health Network. <http://www.awhn.org.au/content/view/49/59/>

⁵³ AIHW 2008 *Australia's Health 2008* op cit

⁵⁴ AIHW 2008 *Australia's Health 2008* op cit.

5.1 SEX AND GENDER AS DETERMINANTS OF HEALTH

In 2002 the World Health Organization (WHO) released the Madrid Statement, stating:⁵⁵

To achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities.

The word 'gender' is used to define those characteristics of women and men that are socially constructed, while 'sex' refers to those that 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 roles.

Women and men have different life and health experiences due to biological, psychological, 'economic, social, political and cultural attributes and opportunities associated with being male and female'.⁵⁶ These differences can impact on health status: some conditions, such as endometriosis, affect only women; others, such as depression, are more prevalent in women; and some conditions, such as heart disease, may be managed and experienced differently by women.

The Madrid Statement recognised that the factors that determine health and ill health are different for men and women. It argued that mainstreaming gender in health is the most effective strategy for achieving gender equity. Such a strategy, if comprehensively implemented, would promote the integration of gender concerns into the development and monitoring of policies and services with the aim of ensuring that women and men achieve optimal health outcomes.

Initiatives specifically targeting either women or men or equality between them are considered to be necessary and complementary to a mainstreaming strategy. The objective of such gender specific initiatives is to create optimal outcomes for women and men by compensating for historical and social disadvantage that prevent men and women from operating on a level playing field.⁵⁷

The principle of gendered analysis is integral to a population health approach, which focuses on improving the health of sub-groups of the population, rather than individuals.⁵⁸ Both men and women need health policies that target specific and unique needs. Gender based analysis is used to identify health issues and health behaviours that are of particular concern for men and women. Such analyses have been carried out in countries such as Canada and the United Kingdom and in Australia, for example, by Victoria and New South Wales.

5.1.1 Sexual and reproductive health

Conditions relating to women's sexual and reproductive health, which only women experience, or in the case of chlamydia, which can have a more serious impact on women, include:

- **Antenatal and postnatal depression** – affects an estimated 15 per cent of Australian women during pregnancy and early parenthood.⁵⁹
- **Cervical cancer** – incidence and mortality rates have declined by 48 per cent and 53 per cent respectively since the National Cervical Screening Program was introduced in 1991,⁶⁰ however, these rates remain significantly higher in Aboriginal and Torres Strait Islander women.⁶¹

55 World Health Organization, 2001 Madrid Statement Mainstreaming gender equity in health: the need to move forward.

56 Beijing Declaration and Platform for Action, Fourth World Conference on Women (1995)

57 Health Canada, *Health Canada's Gender-based Analysis Policy*, Publications Health Canada, Canada 2000, at <http://www.hc-sc.gc.ca/hl-vs/women-femmes/gender-sexe/policy-politique-eng.php>

58 *ibid*

59 www.beyondblue.org.au

60 AIHW. 2008. *Cervical screening in Australia 2005-2006*. <http://www.aihw.gov.au/publications/can/csa05-06/csa05-06.pdf>

61 AIHW 2007. *Cervical Screening in Australia 2004-2005*. Canberra: AIHW p33

- **Chlamydia** – the most frequently reported sexually transmitted infection, which can lead to infertility. The National Notifiable Disease Surveillance System shows that the number of reported female cases has more than tripled between 2000 (10,109 female cases) to 2008 (34,761 female cases).⁶²
- **Endometriosis**⁶³ – affects an estimated one in ten females of reproductive age and up to 30 per cent of women with infertility. It has no known cure and on average takes 7 to 12 years to diagnose.
- **Gestational diabetes** – diagnosed in 5-12 per cent of pregnant women, who then have a 50 per cent risk of developing Type 2 diabetes within five years, and is lifestyle related.⁶⁴
- **Menopause symptoms** – changed periods, hot flushes, depression and sleeping difficulties can significantly impact on women's lives. The menopause brings about shifts in weight distribution to the abdomen associated with the development of cardiovascular disease and Type 2 diabetes.⁶⁵
- **Ovarian cancer** – more than 1,200 new cases of ovarian cancer in Australian women were diagnosed in 2005⁶⁶ and 60 per cent of women diagnosed with ovarian cancer in 1998–2004 died within five years of diagnosis.⁶⁷
- **Polycystic Ovary Syndrome** – up to 10 per cent of women and 30 per cent of obese women⁶⁸ have this condition, which is associated with an increased risk of diabetes, cardiovascular disease⁶⁹ and mental health issues.⁷⁰

5.1.2 Differences in the leading causes of death and burden of disease

The leading causes of death and burden of disease in Australia demonstrate that there are differences in the types and prevalence of conditions experienced by women and men, for example:⁷¹

- **Anxiety and depression** – the first or second leading causes of burden of disease for females in the age groups spanning 0–64 years, and females experience more than double the burden of males in each of these groups. The Australian Longitudinal Study on Women's Health has found that the most common claim on the Pharmaceutical Benefits Scheme for the youngest cohort, 30–35 years, is for antidepressants.⁷²
- **Asthma** – the leading cause of burden of disease in the 0–14 age group for both females and males, but asthma remains the fourth highest cause for women aged 15–44 years (while it drops out of the top 10 for males).
- **Breast cancer** – the fifth highest cause of death and a major cause of burden of disease in the 15–74 age groups (the leading cause in the 45–64 years age group) but is far less commonly experienced by males.

62 Carnie J Dr Chlamydia Forum http://www.health.vic.gov.au/vwhp/downloads/forum/john_carnie.pdf

63 jeanhailes.org.au

64 Di Cianni G, Volpe L, Lencioni C, Miccoli R, Cuccuru I. 2003. Prevalence and risk factors for gestational diabetes assessed by universal screening. *Diabetes Research and Clinical Practice*. 62:2

<http://www.mayoclinic.com/health/belly-fat/WO00128>

66 AIHW 2008 Cancer in Australia: An overview 2008 AIHW cat. no. CAN 42

67 AIHW 2008 Cancer survival and prevalence in Australia: Cancers diagnosed from 1982-2004 cat. no. CAN 38

68 Norman, R.J., Wu, R., & Stankiewicz, M.T. (2004). MJA Practice Essentials – Endocrinology 4: Polycystic ovary syndrome. *Medical Journal of Australia*, 180, 132-137.

69 Meyer, C., McGrath, B.P., Teede, H.J. (2005) The effects of medical therapy on insulin resistance and the cardiovascular system in polycystic ovary syndrome. *J Endocrinology & Metabolism*, 90(10) 5711-6.

70 Coffey S, Mason H. 2003. The effect of polycystic ovary syndrome on health-related quality of life. *Gynecology Endocrinology*, 17, 379-386.

71 Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

72 ALSWH 2007 *Use and costs of medications and other health care resources: Findings from the Australian Longitudinal Study on Women's Health* Department of Health and Ageing

- **Cardiovascular disease** (including coronary heart disease and stroke) – contributes to over 50 per cent of all female deaths, and women are 10 per cent more likely to suffer from it than men.^{73, 74}
- **Dementia and Alzheimer’s disease** – the third ranked cause of death in females (eighth for males) and the fifth ranked contributor to the burden of disease in females but does not appear in the top 10 for males.
- **Migraine** – the second highest contributor to the burden of disease in the 15–44 year age group but does not appear in the top 10 for males.
- **Osteoarthritis** – the seventh most frequently managed problem by general practitioners in Australia in 2003–04. Nearly 10 per cent of female respondents in the 2004–05 National Health Survey reported osteoarthritis, compared with 6.1 per cent of males.⁷⁵
- **Osteoporosis** – In the 2004–05 National Health Survey, 14 per cent of females aged 60–69, 22 per cent of female respondents aged 70–79 and 29 per cent of females aged 80 and over, reported osteoporosis compared to 2 per cent, 5 per cent and 5 per cent of males in the three age groups respectively.⁷⁶

5.1.3 Differences in risk factors

There are also gender differences in risk behaviours and in the approaches needed to effectively address them. For example, being overweight or obese is the equal leading risk factor for Australian females, identified by Begg et al (2007), but tobacco smoking is the leading risk behaviour for males.⁷⁷ Alcohol does not feature as prominently as a risk factor for women as it does for men, and intimate partner/family violence has significantly more health consequences for women than men.

Effective prevention strategies need to address, for example: why young women’s weight is escalating; women’s understanding of body image and diet; their attitudes to exercise; why teenage girls start smoking; how women are coping with the increasing stress of modern life, including work and caring responsibilities inside and outside the home; and the additional hardships faced by women at risk.⁷⁸

More sex and gender related research needs to be carried out to enable effective prevention strategies to be developed. Notably, a recent study found that teenage girls who smoke had a significantly increased risk of becoming overweight in adulthood, and those who smoke more than 10 cigarettes a day were most at risk, especially for abdominal obesity. Perhaps this information could be effectively used as a deterrent.⁷⁹

The outline below of some of the sex and gender differences in relation to smoking makes it clear that a gender neutral approach to prevention and quitting may not achieve optimal outcomes for Australian women.

73 ABS 2008 *Causes of Death 2006* 3303.0

74 AIHW 2008 *Australia’s Health 2008* op cit p183.

75 AIHW 2008 *Arthritis and osteoporosis in Australia 2008*. cat. no. PHE 108

76 AIHW 2008 *Arthritis and osteoporosis in Australia 2008*. cat. no. PHE 108

77 Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*.

78 Baker P. The sex war is over. Gender sensitivity: the new public sector duty in healthcare. Improving the health of Men and Women. UK Gender and Health Partnership

79 Suoma E. Saarni, Kirsi H. Pietiläinen, Suvi Kantonen, Aila Rissanen, Jaakko Kaprio Association of Smoking in Adolescence With Abdominal Obesity in Adulthood: A Follow- Up Study of 5 Birth Cohorts of Finnish Twins 1 *American Journal of Public Health*, 10.2105/AJPH.2007.123851



TOBACCO SMOKING^{80, 81, 82, 83}

Tobacco smoking is a leading risk factor for diseases such as heart disease, stroke and lung cancer. While the QUIT campaign in Australia has had considerable success, smoking is still a significant issue for women at risk, and more females in the 12–19 years age group are smoking than males. Further success could be achieved by addressing the sex and gender differences in the reasons women start and stay smoking, and the health impact of smoking. For example, research suggests:

- women tend to smoke for different reasons to men, such as, in response to stress and depression and to avoid weight gain;
- in relation to heart disease, the risk for women who smoke (compared to non smoking women) is higher than for men who smoke (compared to non smoking men);
- the risk of dying of a heart attack for women who smoke is three times higher than for an ex smoker. The risk is even higher for women smokers, who are taking oral contraceptives, and are 35 years or over;
- at the same level of smoking, women have a higher risk of lung cancer than men;
- women may experience higher exposure to environmental tobacco smoke;
- nicotine replacement therapy may be less effective for women, who may suffer more from withdrawal symptoms; and
- women of childbearing age who attempt to quit smoking have a higher success rate if they do so during or just after the menstrual cycle.

Women's experience of heart disease also demonstrates how important sex and gender are to effective prevention, diagnosis, treatment, and overall health outcomes. A gender neutral approach may lead to poorly targeted prevention campaigns, misdiagnosis, and inadequate treatment for women.

⁸⁰ Health Canada 2003 *Exploring concepts of Gender and Health*

⁸¹ UK Equal Opportunities Commission 2007 Sectoral Guidance for England: Health gender equality duty

⁸² Payne S Dr. Practical implications. Lung Cancer. Gender sensitivity: the new public sector duty in healthcare. Improving the health of Men and Women. UK Gender and Health Partnership

⁸³ Baker P. The sex war is over. Gender sensitivity: the new public sector duty in healthcare. Improving the health of Men and Women. UK Gender and Health Partnership

HEART DISEASE^{84, 85, 86, 87}

Coronary heart disease (CHD) is the leading cause of death of Australian women and kills around 11,000 women a year. Any successful prevention campaign would need to address key gendered issues in relation to heart disease, including the perception that it is a male disease and that breast cancer is of more concern for women.

- **Women are not aware that CHD is the leading cause of death** – a 2008 Heart Foundation National Newspan Survey found that 70 per cent of women did not know that coronary heart disease is the leading cause of death of Australian women. The majority of women believed that breast cancer is the leading cause of death for women even though heart disease is responsible for more than four times the number of Australian women's deaths than breast cancer.
- **Women are not aware of key risk factors** – the same Newspan survey found that while women recognised that smoking and obesity are key risk factors, few women recognised that high blood pressure, high cholesterol and diabetes were leading risk factors for heart disease. Women may also not be aware that diabetes is a greater risk factor for women than men and that the risk of heart disease significantly rises after menopause.
- **Women and health professionals may not be aware of sex and gender differences in the symptoms of heart disease and heart attack** – which is crucial to prevention and which are likely to be related to anatomical differences (for example women have smaller coronary artery lumens) and psychosocial differences (for example depressed patients report more episodes of angina and more intense angina pain, and women have significantly higher rates of depression than men). Differences which may lead to inadequate treatment and which may be partly responsible for women being more likely to die after myocardial infarction (heart attack) than men, include:
 - around 70 per cent of women initially present with angina (compared to 30 per cent of men, who present more often with myocardial infarction) and women are more likely to first present with atypical angina that makes diagnosis difficult;
 - during an infarction, chest pain is the most common symptom but women experience more nausea, vomiting, neck and back pain than men; and
 - women are more likely to suffer 'silent' infarction (without symptoms).

Both sex and gender are significant determinants of health, and health outcomes are the result of a complex interaction between the two and the broader social determinants outlined in the next section.

84 Baker P. The sex war is over. Gender sensitivity: the new public sector duty in healthcare. Improving the health of Men and Women. UK Gender and Health Partnership

85 Doyal L Payne S Cameron A 2003 Promoting gender equality in health University of Bristol. Equal Opportunities Commission

86 Health Canada. 2003. *Exploring concepts of gender and health*

87 <http://www.heartfoundation.org.au/SiteCollectionDocuments/HF%20Go%20Red.pdf>

5.2 SOCIAL DETERMINANTS OF HEALTH⁸⁸

'The social determinants of health are the circumstances in which people are born, grow up, live, work and age and the systems in place to deal with illness', which are all shaped by wider societal factors.⁸⁹

Health inequities, 'the avoidable inequalities in health between groups of people within countries and between countries',⁹⁰ are shaped by the social and economic conditions in which people live their lives. The World Health Organization (WHO) Commission on Social Determinants of Health, in its report *Closing the Gap in a generation: health equity through action on the social determinants of health*⁹¹ found that while the 'poorest of the poor' have high levels of illness and early death, ill health is not confined only to the worst off. Rather, in all countries at all levels of income, 'health and illness follow a social gradient: the lower the socioeconomic position, the worse the health'.⁹²

Health inequalities are not only shaped by unequal distributions of material resources. Social inclusion and a sense of control over life circumstances are crucially important for the development of human potential and health.⁹³ People need to feel that they have at least some level of control over their lives, their jobs, their housing and their environments.

Moreover, different groups have different opportunities to participate, and therefore to experience some level of control, in political, economic, social and cultural structures and relationships. Groups that may face barriers to participation include low socio-economic groups and minority groups, such as Aboriginal and Torres Strait Islander people. Non-participation generally gives rise to further adverse circumstances, such as low educational achievement and lower levels of service use, including health service use.⁹⁴ Typically, so-called behavioural health risks factors, such as smoking, poor diet and low levels of physical activity are firmly embedded in social exclusion and marginalisation.

Education is one of the central measures of socioeconomic status and a crucial determinant of health, employment and income. According to *Australia's Health*, higher levels of education provide better employment opportunities and higher income, and can provide the knowledge and skills necessary to access health services and to live a healthy lifestyle.⁹⁵

While the national Year 12 completion rate for Australian females was 81 per cent in 2006, the completion rate was only:

- 66 per cent for socioeconomically disadvantaged females (in the bottom 25 per cent of post codes in 2006);⁹⁶
- 44 per cent for Aboriginal and Torres Strait Islander females in 2005;⁹⁷ and
- 61 per cent for females in remote areas (23 per cent in the Northern Territory) in 2006.⁹⁸

88 Australian Women's Health Network. <http://www.awhn.org.au/content/view/49/59/>

89 World Health Organization. Commission on the Social Determinants of Health. 2008 Key Concepts Geneva: WHO. http://www.who.int/social_determinants/final_report/key_concepts/en/index.html

90 WHO CSDH. 2008 *Key Concepts*. op cit

91 WHO. CSDH. 2008 *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva:WHO.

92 ibid

93 Marmot, M. *The status syndrome: how your social standing affects your health and life expectancy*, Bloomsbury, London, 2004.

94 Hayes M, Gray A, Edwards B. 2008. *Social Inclusion: Origins, concepts and key themes*. AIFS, Canberra

95 AIHW 2008 *Australia's Health 2008* op cit. p126

96 Simon Marginson. 2008. *Trends and Issues in Australia Higher Education Participation* The University of Melbourne Forum on Higher Education and Social Inclusion July 2008

97 AIHW. 2007 *Aboriginal and Torres Strait Islander Health Performance Framework report 2006*, AIHW, Canberra. AIHW cat. no. IHW 20

98 Simon Marginson. 2008. *Trends and Issues in Australia Higher Education Participation* The University of Melbourne Forum on Higher Education and Social Inclusion July 2008

The Australian Women's Longitudinal Health Study found that women with a university degree had the lowest body weights and body mass index (BMI) throughout the study period compared to women with no formal qualifications, who had the highest weights and BMI.⁹⁹

Income and Employment: According to *Australia's Health*, higher levels of income and wealth are associated with better health status, are generally derived from higher skilled employment and education, and provide better access to healthy food, health care and housing.¹⁰⁰

Australian women continue to experience economic disadvantage at higher rates than men.

In Australia, as elsewhere, people's economic circumstances are generated by the main roles they play, including their paid and unpaid work.

- Australian women vastly outnumber men as recipients of income support payments;¹⁰¹
- Australian women who work outside the home are 'concentrated in low-paid, low-skilled sectors of the labour market, often under part-time and casual working arrangements';¹⁰²
- Women continue to undertake the majority of unpaid work, such as housework and child care, and this can limit the ability to access secure, high quality and well paid jobs.^{103, 104, 105}

Changes in the adverse conditions of people's lives are necessary to reduce health risks and avoidable health inequalities. It is the adverse social and economic circumstances of people's lives that lead to high levels of stress and unhealthy behaviours that then lead to high rates of disease and injury.¹⁰⁶

5.2.1 Social inclusion agenda

The Australian Government has committed to addressing the social exclusion of disadvantaged Australians – 'the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas'.¹⁰⁷

The Australian Social Inclusion Board, supported by the Social Inclusion Unit (in the Department of the Prime Minister and Cabinet) has been established to ensure that 'all Australians... [are] able to play a full role in Australian life, in economic, social, psychological and political terms'.¹⁰⁸ Six priorities have been identified:

- addressing the incidence and needs of jobless families with children;
- delivering effective support to children at greatest risk of long term disadvantage;
- focusing on particular locations, neighbourhoods and communities to ensure programs and services are getting to the right places;

99 Adamson L, Brown W, Byles J, Choienta C, Dobson A, Fitzgerald D, Hockey R, Loxton D, Powers J, Spallek M, Waters B & Watson M. *Women's weight: Findings from the Australian Longitudinal Study on Women's Health*. Report prepared for Commonwealth Government Department of Health & Ageing, June 2007. (Report 137)

100 AIHW 2008 *Australia's Health 2008* op cit. p128

101 Australian Women's Health Network 2008, pp 10-11.

102 Women and Work Research Group, Faculty of Business & Economics, University of Sydney, 2008 Submission, *Down and Out with Work Choices: The Impact of Work Choices on the Work and Lives of Women in Low Paid Employment*. A report to the Office of Industrial Relations, June 2007, p. 8.

103 Craig L, Sawrikar P 2007 *Housework and divorce: the division of domestic labour and relationship breakdown in Australia*. The Melbourne Institute of Applied Economic and Social Research.

104 Charlesworth s, Macdonald F 2007 *Hard Labour? Pregnancy, Discrimination and Workplace Rights. A Report to the Workplace Rights Advocate*. Centre for Applied Research, RMIT University, October 2007, p37

105 ABS. 2008. *Australian Social Trends 2008*. ABS, Canberra. Cat no 4102.0

106 Marmot M. 2005. Social determinants of health inequalities. *Lancet*; 365: 1099-1104

107 Levitas R, Pantazis C, Fahmy E, Gordon D, Lloyd E, Patsios D. 2007. *The multi dimensional analysis of social exclusion* Bristol

108 An Australian Social Inclusion Agenda 2007 ALP http://labor.com.au/download/now/071122_social_inclusion.pdfhttp://labor.com.au/download/now/071122_social_inclusion.pdf

- addressing the incidence of homelessness;
- employment for people living with a disability or mental illness; and
- closing the gap for Aboriginal and Torres Strait Islander Australians.

The WHO report, *Closing the Gap in a generation: health equity through action on the social determinants of health* argues that putting health inequalities right is a matter of social justice and is an urgent 'ethical imperative'.¹⁰⁹

An understanding of the social determinants of health is crucial to the design and implementation of policies and programs intended to reduce avoidable health inequalities. Indeed, as the AIHW argues, the social determinants of health are 'the crux of disease prevention and health promotion'.¹¹⁰

The new National Women's Health Policy will form part of the Government's broader social inclusion agenda by addressing the health inequalities which exist between different groups of Australian women. Social exclusion is associated with high levels of risk behaviours, such as obesity and tobacco smoking, and much worse health outcomes, but good health enables women to be socially included and fully participate in community life.¹¹¹

5.2.2 Major inequalities in the health of Australian women

Major inequalities in the health status of Australian women exist in relation to the groups of women outlined below. There is a degree of overlap between these groups as, for example, a substantial number of Aboriginal or Torres Strait Islander women live in rural and remote areas and socioeconomic disadvantage plays a significant role in the health status of all of the groups.

A detailed examination of mortality in Australia found that there is 'considerable scope for reduction in inequalities, especially those between Aboriginal and Torres Strait Islander peoples and other Australians, between males and females, and between low and high socioeconomic groups'.¹¹²

5.2.2.1 Aboriginal and Torres Strait Islander women

Aboriginal and Torres Strait Islander women experience poorer health across almost all health areas compared to non-Indigenous women, particularly in remote areas, and life expectancy at birth is estimated to be 17 years less than for non-Indigenous women.¹¹³ Compared to non-Indigenous women, Aboriginal and Torres Strait Islander women have, for example:

- higher rates of mental health conditions, and hospitalisation and mortality for those conditions;^{114, 115}
- hospitalisation as the victims of assault at a rate 33 times higher;¹¹⁶
- a higher proportion of deaths due to disadvantage, particularly for circulatory diseases, diabetes and kidney diseases;¹¹⁷

109 WHO. CSDH. 2008 *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. op cit

110 AIHW, *Australia's Health 2008* op cit p109

111 Social Inclusion Unit, PM&C 2008 *Social Inclusion – Origins, concepts and key themes*

112 Ring, I.T. O'Brien, J.F. 2007, 'Our hearts and minds – what would it take for Australia to become the healthiest country in the world?' *Medical Journal of Australia* 187 (8):860-865.

113 ABS, AIHW 2008. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* AIHW cat. no. IHW 21; ABS cat.no. 4704.0

114 ibid

115 Australian Health Ministers' Advisory Council 2006. *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*. Canberra:AHMAC.

116 ABS, AIHW 2008. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* op cit

117 Australian Health Ministers' Advisory Council 2006 op. cit.

- more than double the rate of cervical cancer between 2000-04 and more than four times the death rate for this cancer;^{118, 119} and
- higher rates of chlamydia and hepatitis C, particularly in the 15 to 35 age groups of Aboriginal and Torres Strait Islander women.¹²⁰

Overweight and obesity and tobacco smoking are the most important risk factors contributing to the burden of disease in Aboriginal and Torres Strait Islander women.¹²¹ In 2004–05, 34 per cent of Aboriginal and Torres Strait Islander women were obese, double the rate of non-Indigenous women, and over half of Aboriginal and Torres Strait Islander women reported their level of physical activity as ‘sedentary’ compared to a third of non-Indigenous women.¹²² In addition, 49 per cent were current daily smokers, more than twice the rate of non-Indigenous women, and 52 per cent of Aboriginal and Torres Strait Islander mothers reported smoking while pregnant compared to 16 per cent of non-Indigenous women.^{123, 124}

While Aboriginal and Torres Strait Islander status is not collected for cervical screening, it is known that Aboriginal and Torres Strait Islander women access breast cancer screening less than non-Indigenous women, although rates of Aboriginal and Torres Strait Islander participation have increased over time.¹²⁵ Participation in the National Bowel Screening Program between 2006–08 was estimated at 17 per cent of those invited – less than half the participation rate for non-Indigenous people (38.6 per cent).¹²⁶

Social inclusion

The health and wellbeing of Aboriginal and Torres Strait Islander peoples is a high priority for the Australian Government. Factors which impact on the social inclusion and health and wellbeing of Aboriginal and Torres Strait Islander women include: lower levels of education, income and housing security; dispossession; racism; marginalisation; sexual abuse; removal of family members or themselves; and community and family violence.¹²⁷

The Australian Government is committed to closing the gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians by tackling disadvantage and improving the health of Aboriginal and Torres Strait Islander women. In 2008, the Council of Australian Governments announced initiatives for Aboriginal and Torres Strait Islander Australians worth \$4.6 billion across early childhood development, health, housing, economic development and remote service delivery.

The higher level of risk factors, burden of disease, earlier onset and lower survival rates experienced by Aboriginal and Torres Strait Islander women highlights the potential for significant health gains through improved prevention, early detection and treatment.

Section 7.3.2 outlines a Cultural Respect Framework which could assist health policy makers and service providers more effectively address health issues for Aboriginal and Torres Strait Islander women.

118 AIHW 2008 *Australia's Health 2008*. op. cit.

119 AIHW 2008. *Cervical screening in Australia 2005-2006*. Cancer series no. 41 Cat. No. CAN 36. Canberra AIHW.

120 ABS, AIHW 2008. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. op. cit.

121 Vos T, Barker B, Stanley L, Lopez AD. 2007. *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003*, University of Queensland.

122 ABS, 2006, *National Aboriginal and Torres Strait Islander Health Survey 2004–05*, ABS Cat. No. 4715.0. Canberra.

123 *ibid*

124 AIHW Grayson N, Laws P Sullivan EA. 2006 *Smoking and Pregnancy* cat. no. PER 33

125 AIHW *Australia's Health 2008*. p476 op. cit.

126 National Bowel Cancer Screening Program monitoring report 2008

127 AIHW, 2008, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Population*. AIHW, Canberra. Cat no. IHW14

5.2.2.2 Immigrant and refugee women

The health status of women arriving in Australia, from some 224 countries, is based on a number of factors including birthplace, age, socioeconomic status, and fluency in English.¹²⁸ Upon arrival, many migrant women, due to government selection and self selection processes, enjoy health that is better than that of the Australian population.¹²⁹ Over time, however, their health resembles that of the host population, illustrating the way social and physical environments can reshape health.¹³⁰

Women from diverse cultural and linguistic backgrounds, around 16 per cent of the total Australian population,¹³¹ have varied risk profiles for the development of disease. Some groups may be at higher risk due to genetic predispositions to developing certain diseases, as well as other lifestyle risk factors.¹³² The adoption of Western diets and lifestyles and changed environments can accelerate the development of diseases and conditions in some groups.

Vitamin D deficiency in immigrant women provides a good example of how changed environments can impact adversely on health status. Studies have found vitamin D deficiency in more than one in three Australian women in summer, and one in two in winter, but women with darker skin, such as those from Eastern and sub Saharan African countries, are at particular risk.¹³³ Women with darker skin may need six times more sun exposure per day than women with fair skin but may not be able to generate enough vitamin D when moving to cities such as Melbourne, where there is less sunlight than in their previous country of residence.¹³⁴ Muslim women who practise veiling are also at high risk of vitamin D deficiency.

Vitamin D deficiency is linked to a range of problems including rickets, osteoporosis, depression, immunity and autoimmunity disorders (such as multiple sclerosis), thyroid disorders, obesity, type 2 diabetes and breast cancer.¹³⁵

In some cases, cultural practices and beliefs can increase risk of poor health outcomes:

- in some immigrant populations, great importance is placed on food and food has a unique place in connection with social customs and hospitality. Among Pacific Island populations, for example, larger body sizes are traditionally associated with high status, power, authority and wealth;¹³⁶
- women born in Asia report lower rates of regular Pap smear testing and higher rates of hospitalisation for cervical cancer;¹³⁷
- in a study of physical activity among Muslim women, barriers to participation included a lack of women-only venues, prioritisation of family duties and absence of Arabic-speaking and culturally appropriate physical activity classes;¹³⁸
- restrictions regarding movement in public spaces, for example, needing a chaperone, not being allowed to drive, being financially dependent;

128 Australian Institute of Health and Welfare 2002, *Australian health inequalities 1: Birthplace*. Bulletin Issue 2, AIHW: Canberra.

129 AIHW 2008 *Australia's Health* op. cit. p91

130 AIHW 2008 *Australia's Health* op. cit. p91

131 ABS 2006 *Migration Australia: 2006–07*. Cat no. 3412.0

132 AIHW 2008 *Australia's Health* op. cit. p91

133 Ebeling PR MJA 2005; 183 (1): 4-5

134 www.monashdivision.com.au/resources/imit/Osteoporosis_information_sheet_july08.rtf – American Society of Clinical Oncology

135 Ebeling PR MJA 2005; 183 (1): 4-5

136 Colagiuri, R. Thomas, M., and Buckley, A. 2007, *Preventing Type 2 Diabetes in Culturally and Linguistically Diverse Communities in NSW*. NSW Department of Health: Sydney.

137 Australian Bureau of Statistics 2004, *Australian Social Trends 2004*. ABS Cat. No. 4102.0. ABS: Canberra.

138 National Health and Medical Research Council, 2005, *Cultural Competency in Health: A guide for policy, partnerships and participation*. NHMRC: Canberra

- restrictions on education and employment for women, which puts them in a highly dependent position when living in a culture where they may not know the language, the legal system or their rights, may have limited family and social networks and do not know how to access appropriate health services; and
- imperatives for women to see female health workers, where necessary with the involvement of a female interpreter.¹³⁹

Many migrant women experience a double disadvantage due to lower levels of English proficiency than male migrants, which impacts on the ability to access health related knowledge, health services, and more broadly, education, employment and income.¹⁴⁰

The practice of female genital mutilation (FGM) remains a concern, with reports of increasing demand for services since FGM prevention programs commenced in 1995–96, due to changing demographics, regional settlement and new cultural groups taking up residency in Australia.

Additionally, refugees may face particular health challenges and often have little or no family support. Common health issues relate to:¹⁴¹

- mental health (for example, anxiety, depression and post traumatic stress disorder);
- dental health;
- nutritional deficiencies;
- infectious and communicable disease; and
- chronic disease.

Many health problems relate to the deprivation associated with the refugee experience. Further, the country of origin for many refugees is likely to have been poor.¹⁴² Other health problems relate to concentration in poorly paid jobs, racism and emotional and mental stresses arising from low socio-economic status, the immigration experience and language barriers.

In order to address the health issues faced by women from culturally and linguistically diverse communities, health services and preventive programs and strategies need to take account of the diversity of backgrounds and need to be culturally appropriate.

Section 7.3.2 suggests that a cultural respect framework or tool could be developed to assist health policy makers and program managers more effectively address health issues for immigrant and refugee women.

5.2.2.3 Women from disadvantaged backgrounds, including women experiencing homelessness

Social and economic disadvantage, for example, lower levels of income and education, unemployment, limited access to services and inadequate housing, is directly associated with reduced life expectancy, premature mortality, injury and disease incidence and prevalence, and biological and behavioural risk factors.¹⁴³

A recent study showed a 32 per cent greater burden of disease for the most disadvantaged population compared with the least disadvantaged, due to higher rates of burden for most causes, particularly mental health disorders, suicide, self-harm and cardiovascular disease.¹⁴⁴ In 2000–02, women living in the most disadvantaged areas had a 29 per cent higher death rate from coronary heart disease than those living in the most advantaged areas.¹⁴⁵

¹³⁹ Ibid

¹⁴⁰ Perspectives on Migrants, 2007 Cat. No. 3416.0

¹⁴¹ Victorian Dept of Human Services 2005. *Refugee Health Wellbeing Action Plan 2005–2008*. Melbourne.

¹⁴² Ibid

¹⁴³ AIHW 2008. *Australia's Health 2008*. op. cit. p65

¹⁴⁴ Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez A.D. 2007. *The Burden of Disease and Injury in Australia 2003*. p6

¹⁴⁵ AIHW 2006. *Australia's Health 2006* 2006. Canberra: AIHW.

Socioeconomically disadvantaged women are more likely to have a higher rate of health risk factors, such as being overweight or obese, having fewer or no daily serves of fruit, smoking tobacco, and being exposed to violence.^{146, 147}

Women from disadvantaged backgrounds report a greater use of doctors and hospital outpatient services, but are less likely to use preventive health services.¹⁴⁸ Participation in national preventive health screening programs for breast, cervical and bowel cancer, tends to be lowest for the most disadvantaged women.^{149, 150}

Women who are homeless

Women who are homeless are among the most socially and economically disadvantaged in Australia. It is estimated that around 46,000 women were homeless in Australia in 2006 including people without access to safe, secure and adequate housing, such as those living on the streets, squatting, staying with friends and family, or in boarding houses and supported accommodation with no usual address.^{151, 152}

Homelessness has flow on effects to health and welfare and 'adequate housing is essential for decent health, education, employment and community safety outcomes'.¹⁵³

Women who are homeless have higher rates of chronic health problems, and infectious and sexually transmitted diseases.¹⁵⁴ Research also suggests that there is a clear link between homelessness and mental illness and problematic substance use, with these problems more prevalent in the homeless population than in the general population¹⁵⁵ and for many, actually developing after a person becomes homeless.¹⁵⁶

People who are homeless are less likely than other Australians to use preventive and routine health care but are higher users of hospital emergency services, which often become the main point of access to health care.¹⁵⁷ However, many people who are homeless do not attend any health service when needed.¹⁵⁸

The Australian Government's White Paper on Homelessness, a key part of its social inclusion agenda, was released in 2008 and provides a national action plan to address homelessness to 2020. The National Women's Health Policy can play a role in ensuring that poor health does not become a causal factor in homelessness and in ensuring that the poor health of women who are homeless is addressed.

146 AIHW 2008. *Australia's Health 2008*. op. cit.

147 Mouzos, J. and Makkai, T. 2004. *Women's Experiences of Male Violence*, Australian Institute of Criminology, Research and Public Policy Series, Number 56, p 28.

148 Australian Institute of Health and Welfare 2004. *Australia's Health 2004*. Canberra: AIHW.

149 AIHW 2008. *Australia's Health 2008*. op. cit. p476

150 AIHW 2008. National Bowel Cancer Screening Program 18 month monitoring report

151 ABS (2008) *Australian Census Analytic Program Counting the Homeless Australia 2006* Cat No. 2050.0

152 Supported Accommodation Assistance Program Act 1994. http://www.austlii.edu.au/au/legis/cth/consol_act/saaa1994359/s4.html

153 AIHW *Australia's Welfare 2007*. AIHW cat. no. AUS 93p209

154 Green Paper on Homelessness: Which Way Home p24

155 Lunn 2007; St Vincent's Mental Health Service & Craze Lateral Solutions 2006; Teesson et al. 2000 as cited in AIHW 2007. *Australia's Welfare 2007*. 30 October 2008.

156 AIHW 2007 *Australia's Welfare 2007*. op cit

157 Fulde G The homeless and the emergency department: a special relationship *MJA* 2003; 179 (11/12): 651-652

158 Council to Homeless Persons http://www.chp.org.au/parity/articles/results.chtml?filename_num=00249

5.2.2.4 Women living in rural or remote areas

Women in rural and remote areas have poorer health than women living in urban areas, including higher rates of diabetes, arthritis, high blood pressure and asthma (in inner regional areas).¹⁵⁹

Diabetes is a large contributor to excess deaths among women in rural and remote areas, who are significantly more likely to report diabetes than women in major cities,¹⁶⁰ as is lung cancer for females under 65 years.¹⁶¹ For young women in rural and remote areas, the death rate is three to four times higher than in major cities.

Other preventable cancers, such as melanoma and cervical cancer, also have significantly higher incidence rates in women living in rural and remote areas than those in the cities.^{162, 163}

Women in remote areas of Australia participate in bowel cancer and cervical screening at lower levels than in other areas, and in breast cancer screening at lower levels in very remote areas.^{164, 165} However, women in rural and outer regional areas participate in breast cancer screening at a higher rate than women living in other areas.¹⁶⁶ The higher participation rates in rural and remote regions reflect the success of BreastScreen Australia mobile screening units. Mobile screening units allow easier access to breast screening services for women living outside major cities.

They also have higher levels of risk factors such as being overweight or obese, smoking tobacco and lower consumption of fruit and low fat milk.¹⁶⁷

Higher death rates than expected are also experienced by women living in regional and remote areas compared to women living in major cities, and the death rate rises with increasing remoteness.¹⁶⁸

Analysis suggests that higher death rates and poorer health outcomes in regional and remote areas are likely to be the result of factors such as greater socioeconomic disadvantage (lower levels of education and poorer access to work, particularly skilled work), poorer access to health services, higher levels of personal health risk factors, and environmental issues linked to road travel and occupation.^{169, 170}

5.2.2.5 Women who have a disability including mental illness

Australian women with a disability, that is 'having...impairments, activity limitations or participation restrictions that have lasted, or are likely to last, for at least six months and that restrict everyday activities', are a diverse group, with varying disabilities and health needs.¹⁷¹

In 2003, 20.1 per cent of Australian females had a disability, with the majority being under 65 years.¹⁷² Disease, illness or hereditary factors were the leading known causes of female disability in 2003, while accident and injury were the leading causes for males.

159 AIHW 2008. *Rural, regional and remote health: indicators of health status and determinants of health*. Rural Health Series no. 9. Cat. no. PHE 97. Canberra: AIHW.

160 AIHW 2008 *Rural, regional and remote health: indicators of health status and determinants of health* op cit. p7, 119

161 AIHW, 2007, *Rural, Regional and Remote Health: a Study on Mortality (2nd edition)*. Rural Health Series no. 8. Canberra, p. 29.

162 AIHW 2008. *Australia's Health 2008* op. cit. p83

163 AIHW 2008. *Rural, regional and remote health: indicators of health status and determinants of health*. op.cit. p23

164 AIHW 2008. *Australia's Health 2008*. op. cit. p476

165 AIHW 2008. National Bowel Cancer Screening Program 18 month monitoring report.

166 Australian Institute of Health and Welfare 2008. BreastScreen Australia monitoring report 2004–2005. Cancer series no. 42. Cat. no. CAN 37. Canberra: AIHW.

167 AIHW 2008. *Rural, regional and remote health: indicators of health status and determinants of health*. op.cit. p 92, p111, p115, p125

168 *ibid* p61

169 AIHW 2005 *Rural, regional and remote health: indicators of health* AIHW cat. no. PHE 59

170 AIHW 2006 *Rural, regional and remote health: mortality trends 1992-2003* AIHW cat. no. PHE 71

171 ABS (2004) *Disability, Ageing and Carers, Australia: Summary of Findings, 2003* 4430.0

172 *ibid*

In 2003, around 1 in 20 Australians had a psychiatric disability (5.8 per cent of females) and anxiety and depression were the leading causes of burden of disease in females (10 per cent of the overall burden of disease for Australian females).¹⁷³

Violence against women significantly impacts on women's mental health. A study which used Australian Longitudinal Study of Women's Health data found that women who had experienced intimate partner violence were twice as likely to be diagnosed with a mental illness.¹⁷⁴

The ageing of the population is leading to increasing numbers of older people with a disability, and this is particularly impacting on women, as much of their increased life expectancy is now being spent with profound or severe limitation.¹⁷⁵ In 2003, Australian women who were over 80 years old were twice as likely as men to experience severe or profound disability. For older Australians, limitations in functioning are more likely to be associated with cardiovascular diseases, stroke, cancers, dementia, and hearing and vision impairments.¹⁷⁶

People with a disability are more likely than other Australians to experience socioeconomic disadvantage, social isolation, reduced access to services and inadequate health care.¹⁷⁷ Some of the barriers to accessing health care services are outlined in the next section.

5.2.3 Barriers to accessing health care

Australian women accounted for 56 per cent of visits to General Practitioners (GPs) in 2006–07,¹⁷⁸ but the groups of women outlined above face significant barriers to accessing health care services and information.

- Aboriginal and Torres Strait Islander peoples have significantly lower levels of usage of Medicare Benefits and Pharmaceutical Benefits.¹⁷⁹ When Australian Government expenditure on programs such as Aboriginal Community Controlled Health Services is included, expenditure is still well below that for other Australians.¹⁸⁰ Lower levels of access to primary care partly explains why Aboriginal and Torres Strait Islander Australians are twice as likely as other Australians to present at hospital outpatient/casualty services. state and territory expenditure for Aboriginal and Torres Strait Islander Australians is 2.3 times that for other Australians.¹⁸¹
- Women living in rural and remote areas experience higher hospitalisation rates for some causes of ill health, which may partly be due to later presentation.¹⁸² Consultation with rural women has identified access to services as possibly the most significant issue of concern when considering health and well-being in rural areas. Later presentation for treatment amongst rural dwellers, compared to urban dwellers, may result in poorer outcomes.
- Women from disadvantaged backgrounds report a greater use of doctors and hospital outpatient services, but are less likely to use preventive health services.¹⁸³
- Women who are homeless are less likely than other Australians to use preventive and routine health care but are higher users of hospital emergency services, which often become the main point of access to health care.¹⁸⁴ However, many people who are homeless do not attend any health service when needed.¹⁸⁵

173 AIHW 2008. *Australia's Health 2008* op. cit. p224

174 Loxton d, Scofield M, Rafat H Psychological Health in Midlife Among Women who have ever lived with a violent partner or spouse *Journal of Interpersonal Violence* 21 no 8 (2006) 1098-1099

175 AIHW 2008. *Australia's Health 2008* op. cit. p293

176 AIHW 2005 *Australia's welfare 2005*. AIHW, Canberra. Cat. no. AUS 65

177 Maslen S 2008 *Marginalised and isolated women in the ACT 2008*

178 AIHW 2008. *Australia's Health 2008* op cit p319

179 AIHW 2008 *Expenditure on health for Aboriginal and Torres Strait Islander peoples 2004-05* Cat no HWE 40 Canberra

180 *ibid*

181 *ibid*

182 AIHW 2008. *Australia's Health 2008* op. cit.

183 Australian Institute of Health and Welfare 2004. *Australia's Health 2004*. Canberra: AIHW.

184 Fulde G The homeless and the emergency department: a special relationship MJA 2003; 179 (11/12): 651-652

185 Council to Homeless Persons http://www.chp.org.au/parity/articles/results.html?filename_num=00249

Barriers to accessing health care services, including preventive programs, are part of the social and economic conditions, that is the social determinants, of women's lives which can lead to health inequalities, and may include:^{186, 187, 188, 189, 190}

- shortages of general practitioners, specialist medical services, Aboriginal health workers, and a range of other health services, particularly in rural and remote areas, but also an issue in urban areas;
- a lack of affordable health care services;
- a lack of female doctors including Aboriginal and Torres Strait Islander service providers;
- a lack of awareness of existing services;
- health services being ill equipped to deal with the complexity of the health, social and emotional wellbeing and cultural needs of women from these groups.

Additionally, in relation to Aboriginal and Torres Strait Islander women and immigrant and refugee women:

- a lack of culturally appropriate services and information;
- a lack of services and information available in other languages;
- feelings of shame and embarrassment in the area of reproductive and sexual health;
- a philosophy and concept of health that is based on a biomedical model which focuses on curative rather than holistic health and an Aboriginal and Torres Strait Islander sense of healing.

Of particular relevance to women living in rural and remote areas, including Aboriginal and Torres Strait Islander women:

- distance to health care services and lack of affordable transport, particularly in rural and remote areas, but also an issue in the outskirts of cities;
- staying away from home to receive treatment often without family support and with increased financial costs; and
- perceived lack of confidentiality in rural and remote areas.

Of particular relevance to women with a disability:

- inaccessibility of buildings, services and information for people with disabilities; and
- communication difficulties, for example experienced by women with hearing or intellectual disabilities.

186 Boustany J. 2000. *Health access problems facing the Aboriginal community* <http://www.medicineau.net.au/clinical/abhealth/abhealt3504.html>.

187 Ansari Z. A review of literature on access to primary care health care. *Australian Journal of Primary Health* Vol 13 No 2 August 2007

188 AIHW 2007. *Aboriginal and Torres Strait Islander Health Performance Framework, 2006 report: detailed analyses*. AIHW cat. no. IHW 20. Canberra: AIHW.

189 http://www.chp.org.au/parity/articles/results.chtml?filename_num=00249

190 NRWC, 2005. *HEALTHY WOMEN – HEALTHY COMMUNITIES* <http://www.nfaw.org/assets/socialpolicy/Health/healthywomen.pdf>

6. Principles underpinning the new National Women's Health Policy

Five principles have been suggested as a basis for the development of the new National Women's Health Policy:

- Gender equity
- Health equity between women
- A focus on prevention
- A strong and emerging evidence base
- A lifecourse approach

6.1 GENDER EQUITY

In 2002, the World Health Organization (WHO) released the Madrid Statement on mainstreaming gender equity in health. It defined gender equity as:

fairness and justice in the distribution of benefits, power, resources and responsibilities between women and men. The concept recognizes that women and men have different needs, power and access to resources, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.¹⁹¹

Gender equity means that women and men are given equal opportunity to realise good health.¹⁹² A gender equity approach recognises that gender is a determinant of health and that men and women face different challenges in managing their health, including their different health requirements and the different barriers they face in accessing services.

Gender equity is not a question of which sex 'really' has worse health. Rather, it is about social justice in the sometimes gendered distribution of those resources fundamental to good health.

6.2 HEALTH EQUITY BETWEEN WOMEN

There is substantial evidence that some population groups of women in Australia have not benefited from the overall improvements in health experienced by most women. The new National Women's Health Policy will address the needs of groups of women within the Australian population who are generally considered to be at higher risk of a range of health problems through the consideration of interventions which are culturally appropriate and designed to target areas of health inequity ('the avoidable inequalities in health between groups of people within countries and between countries'¹⁹³). These groups include:

- Aboriginal and Torres Strait Islander women;
- immigrant and refugee women;
- women from disadvantaged backgrounds, including women experiencing homelessness;
- women from rural and remote areas; and
- women with a disability, including mental illness.

191 World Health Organization 2002 *Mainstreaming gender equity in health: The need to move forward*. Madrid Statement, World Health Organization, Denmark,

192 Doyal L. Payne S. Cameron A 2003 *Promoting gender equality in health*, University of Bristol.

193 World Health Organization 2008 Commission on the Social Determinant of Health, *Key Concepts* op cit

6.3 A FOCUS ON PREVENTION

The Australian Government has made a clear commitment to strengthening preventive health care in Australia. Proposed measures include the development of a National Preventative Health Strategy which will address the growth of preventable diseases, such as cardiovascular disease and type 2 diabetes, by tackling the key risk behaviours which are known to cause them – smoking, obesity and excessive consumption of alcohol.

Prevention is characterised by activities which minimise harm and reduce the possibility of adverse occurrences. The prevention of illness and disability requires the identification of the determinants of poor health in order to modify, reduce or eliminate them.¹⁹⁴ Conversely, protective factors can be built and strengthened.

Promoting healthy lifestyle behaviours, such as healthy eating, adequate physical activity, maintaining a healthy weight, not smoking or drinking alcohol excessively, is also critical to prevention approaches.

A recent assessment of Australian Government prevention programs indicated that ‘public health campaigns to reduce tobacco consumption, increase childhood immunisation, tackle HIV/AIDS, and prevent road trauma and heart disease not only averted deaths and reduced the disease burden but yielded significant returns on the investment.’¹⁹⁵ Much more can be done as the leading causes of death and burden of disease are largely preventable.

Australian women have greatly benefited from preventive health measures, such as the National Cervical Screening Program. However, there is a need to target our preventive health programs and strategies better. Factors such as the availability of services, sex and gender differences, disadvantage and cultural differences can impact on the success of population health campaigns. For example, cervical cancer incidence and mortality has remained high for Aboriginal and Torres Strait Islander women.¹⁹⁶

The new National Women’s Health Policy will highlight the importance of prevention and the need to ensure that sex and gender differences are taken into account when developing and delivering preventive health strategies and programs. It will also highlight the importance of accounting for the needs of groups of women within the Australian population who are generally considered to be at higher risk of a range of health problems.

6.4 A STRONG AND EMERGING EVIDENCE BASE

As the population ages, the growing burden of disease will impact increasingly on health resources. An evidence based approach to improving women’s health is important in order to maximise the effectiveness of policies and programs and to facilitate the allocation of resources to cost-effective interventions.

There is a need for comprehensive gender-relevant evidence. The Australian Longitudinal Study on Women’s Health, a 20 year study that commenced in 1995, has provided valuable information on the social, behavioural and economic determinants of women’s health and their relationship to health outcomes and use of health services at key points in women’s lives.

However, more gender focussed research is required and the National Women’s Health Policy could identify priorities for future research. For example, engaging in healthy lifestyle behaviors involves a complex interaction of environment, social, cultural and psychological factors. A better understanding is needed of why women take up unhealthy lifestyles, the barriers to change for women and how the barriers can be modified in relation to women.

194 AIHW 2008. *Australia’s Health 2008* op. cit.

195 Russell L, George LR Leeder S. Preventive health reform: what does it mean for public health? *Medical Journal Australia* 2008; 188 (12): 715-719.

196 AIHW 2008 *Australia’s Health 2008*. op. cit. p181

Data collection methods and gender sensitive performance indicators should be developed and improved to enable the collection of comprehensive sex disaggregated data in the health system, to facilitate gender analysis, monitoring and evaluation from a gender perspective.

For the same reason, there is an important need to develop and improve sex disaggregated information in relation to policies and programs which are addressing health inequities between different groups of Australians and the Government’s wider social inclusion agenda.

Effective communication to health professionals and the community across a wide range of women’s health issues is also essential.

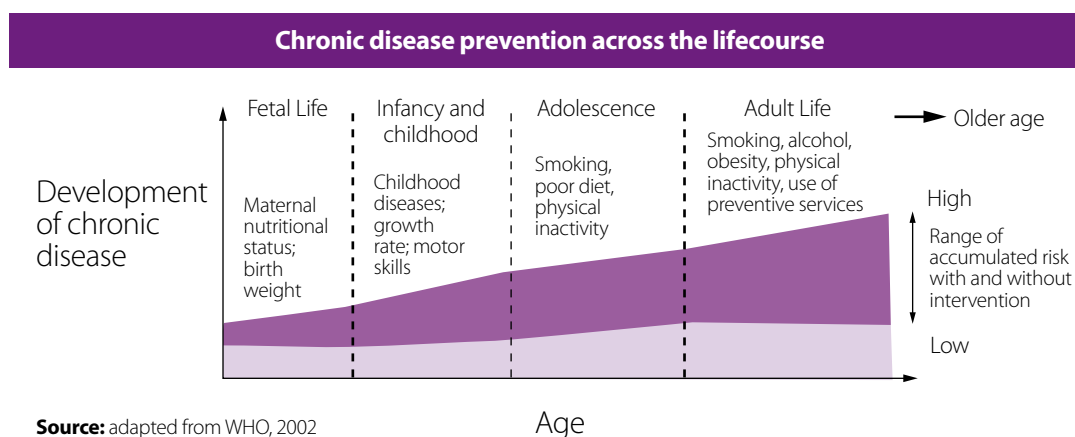
6.5 A LIFECOURSE APPROACH

Over the past two decades, scientific understanding of the role of risk factors and their impact on health has been further informed by studies showing that events and exposures early in life have implications for the risk of disease in adult life. These studies show that both biological and social risks accumulate and interact over the life cycle. Rather than a static view of health and disease, the lifecourse approach recognises the impact of different types of risk exposure at each stage of life, and the cumulative impact of these exposures as a person ages.

This perspective has been particularly important in informing approaches to intervention in the early years, as well as in understanding the factors which best ensure good health in older age. Lifecourse studies have also helped to explain the existence of the socioeconomic differentials in adult health. The differential patterns of health across populations and the unequal experience of mortality and morbidity are the consequence of the operation of social and biological factors interacting with each other at population and individual levels.¹⁹⁷

The lifecourse perspective, as it concerns the development of chronic disease and disability, is illustrated in Figure 1, with examples of risk exposures across the lifecourse.

Figure 1: Lifecourse approach to chronic disease prevention and healthy ageing



There are particular lifecourse transitions that can increase vulnerability to poor health. These include pregnancies, childbirth, school entry, puberty, school leaving, workforce entry, partnering, menopause, and widowhood.

¹⁹⁷ Kelly M Morgan Bonnefoy A ButtJ Bergman V 2007, *The Social Determinants of Health: Developing an evidence base for political action, Final Report to World Health Organization Commission on the Social Determinants of Health*, National Institute for Health and Clinical Excellence.



The ALSWH has highlighted the importance of key events in women's lives, such as quitting smoking or childbirth, when women may become more susceptible to weight gain.¹⁹⁸ Obesity in pregnancy has trebled in the past decade and the implications are significant for women and their babies. Any pregnancy in an obese woman is high risk, requiring higher levels of obstetric and pediatric support, with significantly greater health care costs.^{199,200}

Smoking during pregnancy is linked with a range of adverse outcomes, including miscarriage, which increase with the number of cigarettes smoked.²⁰¹ Mothers who smoke during pregnancy are more likely to deliver babies with low birth weight which is associated with short and long-term health problems. These babies are also more likely to be stillborn, and there is greater risk of sudden infant death syndrome in children whose mother smoked during and after pregnancy.²⁰²

Menopause is associated with shifts in weight distribution to the abdomen, which is associated with a greater risk of heart disease and diabetes.²⁰³

More research on, and greater awareness of, these lifecourse risks for women is needed.

7. Developing the new National Women's Health Policy

The Government has stated that the purpose of the new National Women's Health Policy is to:

- improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health;
- encourage the health system to be more responsive to the needs of women;
- actively promote the participation of women in health decision making and management; and
- promote health equity among women.

There needs to be discussion and input from women in general, women's health stakeholder groups, health professionals and others about how these aims can be achieved. Part of the discussion needs to be around the 1989 National Women's Health Policy to see if its priority areas are still current, and to assist in identifying strategies that have worked in improving women's health over the past decade or two.

198 Adamson L, Brown W, Byles J. 2007. *Women's weight: Findings from the ALSWH*. Department of Health and Ageing.

199 Callaway LK, Prins JB, Chang AM, McIntyre HD. 2006. The prevalence and impact of overweight and obesity in an Australian obstetric population. *Medical Journal Australia*; 184: 56-59. http://www.mja.com.au/public/issues/184_02_160106/cal10167_fm.html

200 Allenby K. 2008. *Labour and delivery in obese women*. O&G Vol 10 No 4 Summer 2008

201 McDermott, L et al 2002. *Cigarette smoking among women in Australia*. Canberra: Commonwealth Department of Health & Ageing.

202 *ibid*

203 <http://www.mayoclinic.com/health/belly-fat/WO00128>

7.1 THE 1989 NATIONAL WOMEN'S HEALTH POLICY

Australia's first National Women's Health Policy, which was endorsed by all Commonwealth, state and territory Health Ministers, was launched in April 1989. The 1989 Policy aimed to improve the health and wellbeing of all women in Australia with a focus on those most at risk and on making the health care system more responsive to women's needs.

Seven priority health issues for women were identified in the 1989 Policy²⁰⁴:

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

In addition, the policy identified five key action areas in response to women's concerns about the structures that deliver health care and information. These were: improvements in health services for women; provision of health information; research and data collection; women's participation in decision making in health; and training of health care providers.²⁰⁵

Consideration needs to be given in the new Policy to whether these priority areas are still current and appropriate for 2010 and beyond. The lessons learnt in improving women's health since the development of the 1989 Policy also need to be identified and considered so that they can inform the development of the new Policy.

7.2 IMPROVING THE HEALTH AND WELLBEING OF ALL WOMEN IN AUSTRALIA, ESPECIALLY THOSE WITH THE HIGHEST RISK OF POOR HEALTH, AND PROMOTING HEALTH EQUITY AMONG WOMEN

Earlier discussion in the paper has considered the leading health issues and risk factors for Australian women and girls, and the health inequities experienced by women most at risk. The causative factors of health inequities between women, which are linked to the social determinants of health, have been considered, and some of these factors lie outside the health system. There are, however, broader Government strategies such as the social inclusion agenda which will address some of the social health determinants of women's health.

Encouraging the health system to be more responsive to the needs of women and promoting the participation of women in health decision making and management, are two key ways that the health portfolio can seek to improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health, and promote health equity among women.

²⁰⁴ Commonwealth Department of Community Services and Health 1989, *National Women's Health Policy Advancing Women's Health in Australia*, Report presented to Australian Health Ministers, Australian Government Publishing Service, Canberra.

²⁰⁵ *ibid*

7.3 ENCOURAGING THE HEALTH SYSTEM TO BE MORE RESPONSIVE TO THE NEEDS OF WOMEN

The responsiveness of the health system can be improved by providing health policy makers, program managers and service providers with tools that will promote a gendered approach to health service planning and delivery by:

- raising awareness of gender, the different needs of women and the diversity of those needs; and
- guiding health professionals in taking gender into account in policy development, program implementation, service provision and evaluation.

Governments in Canada, the United Kingdom, Victoria and New South Wales are among those which have pursued gender equity in health by using gender assessment tools and conducting gender analyses to improve the responsiveness of their health systems.

Canada, in particular, is considerably advanced in the field of gender based analysis:

- its *Federal Plan for Gender Equality* (1995–2000) committed to gender analysis of all subsequent policies, programs and legislation (where appropriate); and
- its *Agenda for Gender Equality* (2000) was a government wide initiative to accelerate gender based analysis.

Health Canada's *Women's Health Strategy* provides the framework for its gender based analyses, which is integrated into the day to day work of the department. The Women's Health Bureau was established by Health Canada to ensure the successful implementation of the *Women's Health Strategy* and *Gender-based Analysis Policy* within Health Canada.

7.3.1 Gender analysis tools

The various gender analysis tools generally provide broad advice about gender and the importance of taking the differences between men and women into account, along with a short checklist for ready use by researchers, policy makers, program developers and managers.

The checklist usually breaks down the steps involved in research, policy development and implementation, program management and evaluation, and asks key gender related questions at each stage. The questions are intended to provide a prompt and guide to gender based analysis.

As outlined in Health Canada's *Exploring Concepts of Gender and Health*, the following questions should form the basis of such a tool:²⁰⁶

- Are differences in the contexts of the lives of women and men, girls and boys addressed?
- Is the diversity within subgroups of women and men, girls and boys identified and analysed?
- Are women and men engaged in the process in meaningful ways to assess the impacts?
- Are intended and unintended outcomes identified?
- Are other social, political and economic realities taken into account?

Such tools could be utilised or developed and applied to policies, strategies, programs and priority areas, to ensure that differences between women and men, and between groups of women, are adequately accounted for.

7.3.2 Culturally appropriate frameworks

Tools have also been developed to assist with Aboriginal and Torres Strait Islander and multicultural health issues, however, these are not gender differentiated and new tools would need to be developed which incorporate gender analysis.

Tools which specifically deal with gender and cultural issues could be used to ensure that health policies and programs are not just gender appropriate but are also culturally and linguistically appropriate.

*The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009*²⁰⁷

This Framework may be an appropriate tool to guide the development of culturally relevant, gender based policies and service delivery, and thus contribute to improved health outcomes for Aboriginal and Torres Strait Islander women. It addresses:

- knowledge and awareness – where the focus is on understandings and awareness of the history, experience, culture and rights of Aboriginal and Torres Strait Islander peoples;
- skilled practice and behaviour – where the focus is on changed behaviour and practice and recognition of the legitimacy of traditional health practices;
- strong (customer and community) relationships – where the focus is on agency or institutional business practices upholding and securing the cultural rights of Aboriginal and Torres Strait Islander peoples; and
- equity of outcomes – where the focus is on the outcomes for individuals and communities.

The Framework provides guidance, for example, in the area of population health national screening programs. It recommends that: strategies to deal with cultural issues that affect access be activated; that cultural competence guides the planning and design of population health initiatives; and that respect is given for cultural difference in the delivery of population health programs.

The Framework has been endorsed by the Australian Health Ministers Advisory Committee and by the Australian Women's Health Network Aboriginal Women's Talking Circle.²⁰⁸ The Australian Women's Health Network Aboriginal Women's Talking Circle recommended in 2007 that the Framework be 'implemented, monitored and evaluated in all jurisdictions'.²⁰⁹

As the Framework is gender neutral, it could form the basis of a tool which addresses issues relating to Aboriginal and Torres Strait Islander women and girls. Such a tool would need to be developed in close consultation with Aboriginal and Torres Strait Islander women.

Cultural frameworks for immigrant and refugee women

A framework or tool (or a series of tools) could be developed to assist in addressing the diverse needs of immigrant and refugee women and girls. The standards and indicators contained in the *Multicultural Centre for Women's Health Quality Standards: Multilingual Health Education Programs, Putting Immigrant and Refugee Women's Health First*²¹⁰ could provide the basis for the development of such a framework or tool. The standards and indicators ensure that the Multicultural Centre for Women's Health's multilingual education programs are delivered in a culturally and linguistically appropriate manner. Immigrant and refugee women would be consulted in developing such a tool.

207 Australian Health Ministers' Advisory Council's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party (2004) *The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009* Department of Health South Australia

208 Report of the Aboriginal Women's Talking Circle Meeting *ibid*

209 Report of the Aboriginal Women's Talking Circle, 2007 AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004 – 2009

210 Multicultural Centre for Women's Health Quality Standards: Multilingual Health Education Programs, Putting Immigrant and Refugee Women's Health First

7.4 PROMOTING THE PARTICIPATION OF WOMEN IN HEALTH DECISION MAKING AND MANAGEMENT

Increased participation by women in health decision making and management is a key way of making the health system more responsive to the needs of women, improving the health and wellbeing of all women in Australia, especially those with the highest risk of poor health, and promoting health equity among women.

Women's participation in health decision making and management needs to be strengthened to ensure that women's opinions and views are heard and that their needs are adequately addressed. The Beijing Platform for Action considered that 'the active participation of women and the incorporation of women's perspectives at all levels of decision making' is essential for the achievement of equality.²¹¹

The National Women's Health Policy will examine ways in which women, as consumers and service providers, can increase their participation in health decision making and management in relation to the development and delivery of health care services and programs, and about their own health.

There needs to be discussion and input from women in general, women's health stakeholder groups, health professionals and others about how this can be achieved in the health sector.

One way to enable women to participate in decision making is to address the barriers to participation. Childcare and flexible arrangements for health decision making bodies need to be available to enable women with caring responsibilities to participate in meetings. Health decision making bodies also need to be flexible enough to cater for the differing needs of women and to overcome barriers to participation such as those involving geographic location, cultural appropriateness, language and disability. Similarly, the provision of health related information, crucial to women making informed choices and participating in their own health decision making, needs to be provided in accessible formats (available in rural and remote areas, culturally appropriate, in other languages, in plain English, and in alternative formats for women with a disability) to ensure that all women have the information needed to make health related decisions.

There are a number of women's health organisations, such as the Australian Women's Health Network, that have an advocacy and advisory role on women's health issues, provide women with health related information, and provide support for women to participate in health related decision making.

Aboriginal and Torres Strait Islander women's capacity for active engagement in decision-making about their health, and that of their families, is improving through Australian Government funded programs such as New Directions and Healthy for Life.

The Australian Government is also committed to building the capacity (including leadership capacity) of the Aboriginal and Torres Strait Islander health workforce, through such initiatives as the Puggy Hunter Scholarship Scheme.

The Government's social inclusion agenda will address some of the underlying factors that hinder the participation by women from groups who are at risk of poor health in health decision making. Those who are socially excluded have very little control or power over their own lives. A reasonable level of education, income, employment and housing are some of the factors that enable women to participate in public life and take part in health decision making and management.

211 Beijing Declaration and Platform for Action, Fourth World Conference on Women (1995) Platform for Action, Critical Area G para 181

All levels of government can take a leadership role in seeking to ensure that health decision making bodies and management positions are representative of the diversity of the Australian community, and in ensuring that government policies and documents are gender aware.

The Australian Government has a number of initiatives in place to ensure that women are represented on Government boards and bodies, such as:

- AppointWomen – allows women to register their interest in appointment to Australian Government boards and bodies and provides Australian Government departments with a source of women for that purpose;²¹² and
- Government Boards Reporting System – is managed by the Office for Women and provides a whole of government status report on the representation of women on Australian Government boards and bodies.

The Australian Government, through the Office for Women, currently funds four national women's Alliances, representing 71 women's organisations which are a primary vehicle for consultation between women's non-government organisations and Government. The Australian Women's Health Network is one of the organisations represented through this network. Many of the other organisations are not specifically related to women's health, but represent women more broadly.

The 2008 National Rural Women's Summit was convened by the Australian Government Office for Women to strengthen the voice of rural women at the national level. Recommendations were made across a range of areas, including increasing the role of women living in rural and remote areas in decision making and leadership, and on health issues. The Government is considering ways to strengthen the capacity of women living in rural and remote areas to participate in policy debate affecting their communities.



8. How you can have your say?

Consultations for the development of the National Women's Health Policy will take place during 2009. Key women's stakeholder groups and peak bodies will be included in the consultations which will importantly consider lessons of the previous National Women's Health Policy so these can be built on in the new policy.

Specific consultations with Aboriginal and Torres Strait Islander women, immigrant and refugee women, women from rural and remote areas, women with a disability, and other disadvantaged women will be a key part of the process.

An Advisory Group under the Australian Population Health Development Principal Committee (a subcommittee of the Australian Health Ministers' Advisory Council) will provide input to the process. The Advisory Group has representatives from state and territory governments.

The National Women's Health Policy is expected to be finalised in 2010. Information about the development of the policy is available on the Department of Health and Ageing's website www.health.gov.au/womenshealthpolicy. This website will be updated with new information and papers as the consultation progresses. If you want to provide feedback or comments log onto the website for details about how to do this.

