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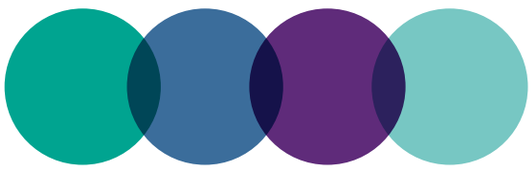

WOMEN AND HEALTH REFORM

Position Paper 2012

Australian Women's Health Network

Women and Health Reform

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Executive summary

This paper examines health reforms in the context of women's health, gender analysis and gender mainstreaming. Gender analysis can add value to decision making about health reforms by making visible potential impacts on women who are central to the functioning and capacity of the formal and informal health systems. The paper builds on the foundations of learning provided by the network of women's health services and the guidance provided by women's health policies at national and state and territory levels. There is a wealth of experience and knowledge arising from the work of the women's health sector and women's policy units over many decades. Yet the sector has not been formally consulted in Australia's recent health reform process. Women's perspectives are not apparent in health reform documents or indeed, in Australia's health policies. Only by working with the women's health sector can consideration be given as to how reforms are likely to impact on women. Consultation is critical for ensuring that women are visible in policies, programs and reforms, while gender analysis is required to understand the differing effects of reforms on women and stratified analysis is necessary to unpack the effects of reforms on different groups of women.

Not only is it best practice to consult with the women's health sector in health reform processes, but the evidence shows that this experience and knowledge gained from consultation will also strengthen policies and reforms and lead to increased effectiveness. To support consultation strategies, this paper sets out the meaning of commonly used terms (gender, gender equity, gender mainstreaming) and processes (gender analysis, principles, tools) used across policy and program development. A common platform of terminology will help policy-makers and the women's health sector to communicate more effectively than is currently the case.

The context for gendering of health reforms includes the fact that the health workforce is historically and starkly gendered in patterns that have changed little over decades. However, health system governance is characterised by hierarchies of health care work that are dominated by men at the highest levels. The following analysis emphasises that a relationship exists between this gender imbalance and the lack of gendering of health system policy, programs and service delivery. When gender perspectives are invisible in the development of health reforms, and the participation of the women's health sector in those reforms is not facilitated, then women's visibility in the wider political sphere is also diminished.

Women are the primary providers of care in the formal and informal spheres, with many also living on low incomes while being responsible for the care and wellbeing of family members. One of the main barriers to access is the upfront user fees in primary health care, which does not seem to be addressed in the current health reforms.

AWHN's position on health reforms is that the following elements of a good health system are essential to improve outcomes for women:

- a comprehensive primary health care sector that includes specialised women's health services, community health services, and Aboriginal community-controlled health services alongside general practice;
- recognition in policies and programs of the social causes of ill health and structural influences on health, many of which lie outside the health sector;
- universal health insurance that provides affordable access to hospital and medical services in a timely manner;
- primary health care that is not subject to point of service, upfront fees;
- health services that are committed to gender-sensitive practices;
- locally controlled primary health services that are not based on strategies imposed from outside, but are developed in consultation with local communities;
- health services that are geographically balanced across metropolitan, regional and rural areas;
- a funded women's health sector that includes women's health services and other women's NGOs;
- integration of women's health policy with other areas of policy both within and beyond the health sector;
- policy that requires health services, including hospitals and primary health services, to work with women's health services to integrate gender-sensitive health care through a commitment to gender-sensitive practices;
- structures that promote multidisciplinary care and interdisciplinary collaboration;
- systems that empower individuals and communities with the knowledge and skills necessary to achieve health for themselves.

Recommendations

AWHN makes the following recommendations to strengthen gender analysis in the structures, delivery, and financing of Australia's health system:

1. Health and medical care more actively takes account of the determinants of health, recognising that gender is core to all other determinants;
2. Funding for women's health services is secure;
3. The women's health sector is actively consulted about proposed health reforms;
4. A national roundtable is supported to discuss how Medicare Locals and the women's health sector can work effectively together and provide guidance to health services about what is good practice for women's health;
5. Gender equity is included in Medicare Locals funding agreements as a key performance indicator;
6. A report is commissioned to examine the extent to which the health system relies on women's labour, expertise, and caring;
7. Health service accreditation is strengthened to include demonstration of gender-sensitive practices;
8. Women's leadership at senior levels in health systems is increased by purposeful policies and strategies;
9. Policy at all levels is gendered to ensure women's concerns are visible;
10. Health reforms continue to strengthen comprehensive primary health care that is affordable and accessible, with stronger orientation towards prevention.

Definitions

Gender/gender analysis: Refers to the economic, social and cultural attributes and opportunities ascribed to being female or male. While gender analysis is sometimes used to refer to female and male issues, the primary focus of gender analysis on women's issues is consistent with the Beijing Platform for Action (UN 1995) and the WHO Commission on the Social Determinants of Health (CSDH 2008), which call for action on gender to improve the health, social status and social experience of women and girls.

Gender equality: The absence of discrimination on the basis of a person's sex in authority, opportunities, allocation of resources or benefits, and access to services. It is, therefore, the equal valuing by society of both the similarities and differences between men and women, and the varying roles that they play (MWIA 2001).

Gender equity: Redressing inequitable social, economic and political determinants of health that arise from disempowering social norms and unequal distributions of power and resources that affect women (Sen, Ostlin and George 2007).

Gender mainstreaming: The process of infusing policies, projects and institutions with gender analysis, gender-sensitive research, women's perspectives and gender equality goals.

Health reform: Planned and purposeful health sector and health system change that is intended to affect both financing and delivery of health care (Frenk 1994).

Hospital in the Home (HITH): The delivery of acute and post-acute care in the patient's home as a substitute for being in hospital. See http://www.hithsociety.org.au/

Inequalities: Measurable differences or variations between groups in a particular condition such as health status or income levels.

Inequities: Those inequalities that are deemed to be unfair or stemming from a form of injustice. Inequities involve relations of equal and unequal power (political, social and economic) as well as justice and injustice.

Primary health care: "[E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation…" (WHO 1978). Primary health care is concerned with health inequalities in the population as a whole and focuses on the provision of a comprehensive range of community based services, including prevention. In contrast, primary medical care is mainly concerned with conventional treatment services targeted towards individual episodes of disease, and is not necessarily concerned with community participation and input.

Social determinants of health: The fundamental structures of social hierarchy and the social, economic and politically determined conditions that result in good health, ill health or disease, and in which people grow, live, work and age. Social determinants include income and the social gradient, education, employment, gender, health care, culture, food security, social support and social exclusion.

Social gradient: In general, the lower an individual's socioeconomic position, the worse their health; a social gradient in health runs from top to bottom of the socioeconomic spectrum.

Social model of health: An approach to service delivery, health promotion and community development that addresses the broader determinants of health and acts to reduce social inequalities and injustices, with emphases on community engagement and participation, and empowerment of individuals and communities (Keleher & MacDougall 2011, p. 320).

Violence against women: "[A]ny act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (UN 1993).

Introduction

Health is influenced by social, environmental, political and cultural factors which determine both women's material circumstances and the degree of self-determination possible for women. Gender is an important social determinant of health which has meaning for both women and men, but is crucially important for women because they have less power in society than men, have lower incomes than men, work fewer hours in paid work, spend significantly more hours each day across their lifetimes caring for children and other family members, are more likely to live with violence, and live with higher levels of chronic illness than men. Gender critically affects issues such as sexuality and reproduction, gender-based violence, and mental health (Gijsbers Van Wijk, Van Vliet and Kolk 1996).

Health reform refers to planned and purposeful health sector and health system change that is intended to affect both financing and delivery of health care (Frenk 1994). Commonly, reforms are intended to achieve cost-savings and greater efficiencies for governments, which fund the majority of health care provision in Australia. However, health reforms are also intended to focus health systems more closely on issues of equity and inequity because of the financial and social effects of inequity on health systems, and society more broadly (NATSEM 2012). Those who are most socio-economically disadvantaged are twice more likely to have a long-term health condition than those who are the least disadvantaged. Improving the health profile of Australians of working age in the most socio-economically disadvantaged groups would lead to major social and economic gains, with savings to both the Government and to individuals. If prevention and disease management were more effective for low-income working-age adults, 500,000 socio-economically disadvantaged people could avoid long-term chronic illness, $2.3 billion in annual hospital costs could be saved, and the annual number of taxpayer-funded Pharmaceutical Benefits Scheme prescriptions could be cut by 5.3 million (NATSEM 2012).

The importance of understanding gender in relation to health reforms is recognised internationally (UN 1995; World Bank 2005; CSDH 2008). Health reforms are a constant process, but for any reforms it is necessary to understand not just what is changing but how the reforms will work, who benefits and who will not benefit. This paper examines the ways that women's health is advanced or diminished by health system actions and changes, and what it means for health systems to be gender-informed. Gender is central to any examination of health reforms because when gender-informed analysis is used, we better understand the constraints and structure of social relations that permeate women's health and health system practices that play a key role in the health status of women.

The quality of services provided by the health system and the extent of gender-sensitivity of providers and care systems are strong influences on the health of women (Gijsbers Van Wijk 1996; Doyal 1995). Women use medical services more frequently than men throughout their lives and commonly have responsibilities for the health of others: as a consequence women have higher annual health care expenses. Women are over-represented in the two low-income quartiles of socio-economically disadvantaged people. Of all lone-parent families, 87% are headed by women. Women are frequently the primary providers of care to children and older family members, increasing the demands on their incomes for health care expenses while reducing the time available for paid work.

These influences on women's health were recognised by the first National Women's Health Policy (NWHP) (DoHA 1989), which represented a milestone for women's health after decades of advocacy by women for a dedicated women's health policy and program. Women were intent on reforming the system's tendencies towards sexism, stereotyping and lack of responsiveness to women's health needs, concerns that were given legitimacy by the first NWHP. It was found that women wanted equitable access to health care services which were preventive in orientation as well as geared to the treatment of diseases. A clear preference was found for moving towards a system with a preventive approach, with increased emphasis on innovative community-based services to complement those provided by general practitioners (DoHA 1989:77). A comprehensive and accessible network of primary health services would be available to women, as well as access to quality hospital and medical services. In addition, mainstream hospital and medical services were to become more responsive to women's needs through a "dual strategy." Special women's health services were to examine new issues and develop new models of care that were responsive to the needs of the women who regularly participated in decision-making at the local level. These new modes of service delivery pioneered in the separate women's health sector would influence the mainstream to become more responsive to women's concerns (DoHA 1989: 82). The second National Women's Health Policy (DoHA 2010) continues the commitment of the National Health and Hospitals Reform Commission, the National Primary Health Care Strategy and the National Preventive Health Taskforce, to build an environment in which more can be done to ensure that all Australians have improved health and health care. Women, however, remain concerned about many aspects of the health reforms and the current health care system:

- Access to affordable sexual and reproductive health services impacting on the cost of contraception and severely limiting the availability of termination of pregnancy services;
- Cost barriers to primary health care, particularly the co-payments charged by general practitioners and costs for specialist medical and dental services;
- The poor health of carers, most of whom are women, and the lack of respite services;
- The additional burden of caring caused by early hospital discharge policies and hospital in the home programs which impact on women's paid work;
- The health of women in rural and remote Australia who face many challenges as a result of their relative isolation, particularly access to a full range of treatment options when they are needed;
- Long waiting lists for essential publicly funded allied health services, elective surgery, and outpatient clinic appointments;
- The lack of culturally appropriate primary health care for new arrival and refugee women, and for many Aboriginal women and their children, whose health needs are complex and would benefit enormously from access to no-cost, comprehensive primary health care.

A critical question for health systems is why gendered health inequities exist and how they can be remedied (Sen, Östlin and George 2007). "Taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources" (Sen, Östlin and George 2007, p. viii). Gender inequities, which are caused by both social factors and the health system, can be redressed. For example, targeted social inclusion programs can make an enormous difference to women who are marginalised by full-time caring or disability, to those living with violence or mental illness, and to refugee and new arrival women who are struggling with both their health and issues related to their resettlement in Australia. The provision of health services to marginalised women is severely restricted: unless gender inequities are appropriately addressed, this underservicing results in significant poorer health outcomes.

> *Underserved women are those who are unable to obtain quality health care by virtue of barriers created by poverty, cultural differences, race or ethnicity, geography, sexual orientation, gender identity, or other factors that contribute to health care inequities. Underserved women are typically in need of more health services because of high rates of chronic conditions and unmet reproductive health care needs. Moreover, underserved women are at an increased risk of health problems related to limited access to quality health care in addition to elevated levels of poverty and geographic and social isolation. (ACOG 2012, p. 1)*

Women's health policy

The 1989 National Women's Health Policy (NWHP) was accompanied by the National Women's Health Program (NWH Program) which continued the establishment and expansion of Women's Health Services (WHS) in every State and Territory, building on the women's health centres, sexual assault services and women's refuges established from the 1970s–80s. The Program consolidated the women's health NGO sector that was dedicated to the provision of responsive, respectful, comprehensive, gender informed services provided by women, for women. The NWHP and NWH Program created strong foundations for innovation in gender-sensitive programs and service delivery, and the knowledge and skills in and for advocacy in support of women's health issues. They drew international recognition for innovation and leadership in women's health. Yet, neither of the two National Women's Health Policies, nor the considerable experience of the women's health sector have been used to inform health reforms or to inform Australia's National Health Priority Areas (Keleher 2012).

The consolidated women's health sector gave women space to support each other on issues such as mothering, eating disorders, cancer, violence and mental health, sexuality, the health of women as workers and carers, and migrant women's health (Gray Jamieson 2012). In the decades since the first NWHP and NWH Program, providers of women's health care and consumers have developed considerable expertise in the provision of information that women need to improve their lives in service delivery, policy, evidence-informed advocacy, and advancement of women's rights. Since the 1980s, women's health services and other women's NGOs have been critical to the generation of knowledge and understanding about the societal-level changes needed for sustainable improvements in health and for women.

Women's health services are operated and managed by women, for women. However, while women's health services are open to all women, the number of women who are practically able to access them and use their services is restricted by the small number of services available in each State and Territory and their relatively small funding base. Women's health services have been substantially and chronically under-funded for the work they have been expected to undertake, often across geographically huge and demographically diverse catchments of population.

Alongside women's health services, other women's NGOs undertake important roles that support the advancement of women's interests and concerns. They work with the most disadvantaged groups of women in the areas of violence and abuse; support for lone mothers and their children; support for elderly women; women with disabilities; newly arrived and refugee women; women in prison, Aboriginal women; and women living in rural and remote Australia.

Women's health services and NGOs have developed expertise in:

- the provision of comprehensive primary health care including primary and secondary prevention;
- delivering outcomes that assist in reducing hospitalisation, homelessness and imprisonment;
- assessing changes in social conditions that affect women;
- performing operational functions such as program development, implementation and evaluation;
- advocating for women's rights and justice for women;
- providing input to agenda-setting and policy development processes, including consultation processes;
- monitoring compliance with international agreements for women's health; and mobilising support for those agreements; and
- collection, dissemination, and analysis of information.

When this valuable knowledge and experience is not considered in health reform debates and planning, a valuable opportunity to advance women's health and the health of all Australians is lost. This problem can be overcome by sound implementation of consumerparticipation strategies that are gender informed.

Health reforms

The national health reform environment in Australia is dynamic, with policy reforms during 2010–11 likely to influence the health system for many years to come. Major policy documents include:

- The *2nd National Women's Health Policy* (Commonwealth of Australia 2010), which has stated goals to:
  - highlight the significance of gender as a key determinant of women's health;
  - acknowledge that women's health needs differ according to their life stage;
  - prioritise the needs of women with the highest risk of poor health;
  - ensure the health system is responsive to all women, with a clear focus on illness prevention and health promotion;
  - mobilise effective and collaborative research, data collection, monitoring, evaluation and knowledge transfer to advance the evidence base concerning women's health.
- The *National Health and Hospitals Reform Commission Final Report* (Commonwealth of Australia 2009), which was intended to provide direction for structural reform of the health system with a greater focus on primary health care and prevention, and expansion and integration of services for groups with higher needs. However, there is no particular emphasis on gendered aspects of health care or women's health needs in this report. Moreover, as of the year of this Paper (2012), very few of the recommendations of the second National Women's Health Policy or the National Hospital and Health Reform Commission have been implemented.
- The *National Primary Health Care Strategy* (NPHCS) (DoHA 2010) is the first national policy focused on primary health care in Australia. The flagship reform has by July 2012 established 62 'Medicare Locals' (MLs) across the nation. MLs are intended to coordinate and integrate services delivered by the primary health sector in order to provide better access and increase equity. The main focus of the NPHCS is on general practice. There is no discussion of the place of women's health services in the primary health care sector, an absence that suggests a need for greater understanding by policy-makers about the importance and value of the women's health sector for primary health care.
- *Health Workforce Australia* **(**HWA) was established by the Council of Australian Governments (COAG) from 2011 to meet the future challenges of providing a health workforce that responds to the needs of the Australian community. HWA is developing policy and programs across four main areas: workforce planning, policy and research; clinical education; innovation and reform of the health workforce; and the recruitment and retention of international health professionals. HWA is also concerned with the adequacy and availability of workforce data for workforce planning and monitoring. This work will be enhanced by gender-informed thinking, given the predominance of women in the health workforce.
- *National Preventive Health Agency* (ANPHA) was established as a key recommendation of the National Health and Hospitals Reform Commission and the National Preventive Health Taskforce to strengthen Australia's investment in preventive health and help to turn the tide on the rising prevalence of preventable chronic diseases. In partnership with the Commonwealth and the State and Territory Governments, ANPHA is driving the national capacity for change and innovation around preventive health policies and programs.

Health systems as they are presently organised privilege the biomedical model of disease over the social model of health and primary health care, despite the evidence that greater integration of these models promotes more effective and more comprehensive health care (Baum 2002, 2007). The emphasis in Australia's health reforms on strengthening primary health care, together with an increased recognition of the need to act on the social determinants of health, is welcomed by the women's health sector. However, reforms need to make visible the hidden gender issues in health care reform and the gender inequities that arise from health sector reforms, as well as ensuring that health workforce analysis is also gender sensitive.

Primary health care (PHC) is core to Australia's health reforms and its importance for women's health cannot be underestimated. PHC is much more than general practice; PHC is a conceptual model for health system service delivery, with foundations in the social model of health (Keleher 2001), and is sustained by the principles and practices of the Alma Ata Declaration of Primary Health Care (World Health Organisation (WHO) 1978). These include the provision of holistic care that meets basic needs such as shelter; safety from violence; food security; core services of maternal and child health; social support; emotional and psychological support; health promotion; and timely, affordable diagnosis and treatment in general practice. The principles and practices of PHC and the social model of health on which they are based are closely aligned to those of the new public health and its strategies for health promotion and prevention (Keleher 2001; WHO 2008; Gray Jamieson 2012). The National Primary Health Care Strategy does establish a reform agenda for primary health care in general practice, but it is silent on the social model of health, women's health and the women's health sector.

Similarly, the Australian National Preventive Health Agency will benefit enormously from consulting with the women's health sector about effective programs and strategies for women in prevention and health promotion. Given its priorities in reduction of the use of alcohol and tobacco and in the prevalence of obesity, strategies that are gender-blind will be much less effective than strategies informed by gender-specific knowledge and experience.

There is strong evidence that the integration of the social determinants of health into the structures and processes of health systems is critical if the expected outcomes of the health reforms are to be realised (CSDH 2008; Sen, Östlin and George 2007). However, there is very little analysis of the social determinants of health in Australia's health reform documents. Women experience the social determinants of health in different ways to men, leading to inequitable health outcomes. Differential exposures to health-damaging factors that women experience include vulnerabilities to chronic disease, violence, poor mental health, and differential economic and social consequences of illness and the demands on women of their reproductive health (Sen, Östlin and George 2007). These differential exposures and vulnerabilities are strong indicators of the necessity of engendering health systems and health research.

THE SOCIAL MODEL OF HEALTH

The social model of health is an approach to service delivery, health promotion and community development that addresses the broader determinants of health and acts to reduce social inequalities and injustices, with an emphasis on community engagement and participation and empowerment of individuals and communities (Keleher & MacDougall 2011, p. 320). Practitioners working from the social model of health recognise the effect of social, economic, cultural and political factors and conditions on health and wellbeing and seek to prevent and reduce illness and address inequities and disadvantage. The effect of these factors on living conditions and on health is central to primary health care, together with recognition of the need to work with sectors beyond health to influence those conditions that create good health and those that cause poor health and illness.

The social model of health is most commonly practiced in the community and women's health sectors and is underpinned and informed by the values and principles of the Alma Ata Declaration on Primary Health Care (WHO 1978) and the Ottawa Charter for Health Promotion (WHO 1986). The social model of health includes:

- recognition of the broad social, economic and environmental determinants of health and illness;
- the importance of health promotion and disease prevention;
- the importance of community participation in decision making;
- the importance of working with sectors outside of health;
- an understanding that equity is an important outcome of health service intervention (VHA 2012).

Women provide the majority of formal and informal health care, but this fact is not reflected in Australia's health reforms. Women's roles and responsibilities range across all levels of Australia's health system, from informal care provided within households and the community to formal roles in the workforce, as well as volunteering. In other words, women are the backbone of the health system and of health care across Australian society. Therefore, the lack of recognition of the women's health and NGO sector in the health reform strategies is of concern. Despite the foundations set by the National Women's Health Program in the 1980s–90s, Australia's current health reforms seem to have ignored the knowledge and expertise about women's health that has been gained since then. There is a complete absence of gender analysis in current reform documents (Keleher 2012). Yet, health systems globally and in Australia are dependent on the paid and unpaid labour of women who are referred to as "critical, yet under-recognized, pillars" (Harvard Women and Health Initiative 2010) and the "shock-absorbers" of health system reforms (Sen, Östlin and George 2007). Their formal and informal health work absorbs funding cuts to hospitals and health services while their skill in managing multiple roles and pressures is often invisible but keeps systems, organisations and households operating effectively, albeit at the personal cost to women of their time, their energy, and their own health.

Women's health throughout their life is also of concern in relation to health reforms because women's specific concerns have been neglected in key documents. The most neglected and urgent issues involve Aboriginal and Torres Strait Islander women; women born overseas and from refugee backgrounds; women with disabilities; women on low incomes; and critical issues including access to abortion and the prevention of unsafe abortion; adolescents' sexual and reproductive health, which can have lifelong consequences; contraception; gender-based violence; and gendered aspects of chronic diseases. When health systems deliver high-quality services for women, they also benefit children and men for whom women are the primary providers of care (Sen, Östlin and George 2007; Harvard Women and Health Initiative 2010). Because women are also major providers of health information in their families and neighbourhoods, comprehensive women's health care also has the capacity to improve health literacy greatly in the general community.

Gender mainstreaming

There is evidence that health programmes are more efficient when they are gender-responsive (German BackUp Initiative 2010).

Gender is a core determinant of health (Sen, Östlin and George 2007; CSDH 2008). The concept of a 'gender lens' is one that makes clear the role that gender plays in shaping our male and female lives, work, experiences and choices (Victorian Women's Health Services 2009) and it can also be applied to policy and analysis of reforms. The deliberate incorporation of gender and the full range of other determinants of health into health systems are strongly supported by the World Health Organization (http://www.who.int/topics/womens_health/en/) and the United Nations, which has recently formed UNWomen, the UN Entity for Gender Equality and the Empowerment of Women (http://www.unwomen.org/).

Gender mainstreaming has been advanced at global levels since the early 1990s, with checklists, tool kits and 'how to' guides (Mukhopadhyay, Steehouwer, Wong 2006). Gender mainstreaming is the process of infusing gender analysis, gender-sensitive research, women's perspectives and gender equality goals into policies, projects and institutions. Despite its OECD status and its pioneering work on women's health policy, gender mainstreaming has not occurred in Australia and gender equity is rarely, if ever, identified as an outcome measure for policy and programs. Women's health NGOs and women's health services are not recognised in policies and rarely consulted on mainstream health policies (Keleher 2012).

This gender blindness is problematic because when health policies do not mainstream gender, they are failing to acknowledge or recognise the different and unequal position of women in society and are instrumental in perpetuating gender inequalities. Moreover, gender blind health policies fly in the face of international evidence about how to improve women's health in particular, and the health of the whole population in general. Processes of bringing about organisational change to promote gender equality can be political and meet resistance. However, if the health sector displayed leadership in mainstreaming gender into national health policies and programs, then other sectors such as human services would be likely to follow. In addition to gender mainstreaming, attention to gender in all sectors is critical because tackling gender inequity is not just the responsibility of the health sector or of women. While the mainstream health system exists to treat and manage disease and to maintain and promote health, other sectors have important roles to play in the creation of effective public policy and optimal environments for health.

For women, a good quality health system is one that is characterised by:

- recognition in policies and programs of the social causes of ill health and structural influences on health, many of which lie outside the health sector;
- comprehensive primary health care services that address health problems in a holistic manner;
- mainstreaming of gender into policy and programs, alongside other determinants of health;
- recognition of diversity among women and the particular needs of women from refugee and newly arrived, non-English speaking backgrounds;
- patient-centred practices which are engendered – that is, practices that are understood through a woman-centred lens;
- improving access and equity through community/consumer engagement and participation using community development strategies;
- social justice, respect for lay knowledge, and active participation in decision-making by women.

The integration of gender perspectives in policy and health reform, or gender mainstreaming, is critical to ensuring that women are visible in policies, programs and reforms. When gender perspectives are invisible in the analysis of health reform impacts, and the participation of the women's health sector in health reforms is not facilitated, then women's visibility in the wider political sphere is also diminished. The lack of effective and systematic gendered analysis is a structural barrier to women's health, and ultimately to women's participation in wider society, which is essential for good health outcomes.

WOMAN-CENTRED PRACTICE

Woman-centred practice is organised around women's needs. Care is delivered in a timely, safe and appropriate manner. For example, in a gender-conscious system, women-specific drug and alcohol and in-patient psychiatric services recognise the importance of the safety of women at times when they are most vulnerable, and the necessity of gender-informed models for effective treatment. Because violence against women is endemic in Australian society, and because women's mental health problems are frequently related to their experiences of violence, services that are provided where women are at further risk from violence because of mixed sex programs and facilities are counter-productive.

Health financing

Specific health financing reforms that impact on women include expansion of hospital in the home programs (HITH 2012) and early discharge, which assumes that a responsible individual is available in the home to take care of family members when they are discharged. As hospitals endeavour to shorten lengths of stay in order to reduce costs, the impact is overwhelmingly on women, who are prevailingly the conventional preference or the only option in caring for family members when hospitalisation is no longer available. The consequence is a negative impact on women's capacity for financial independence, with the burden of caring and lack of income also impacting on mental health.

The shift from publicly funded community based services towards the private sector also has major impacts on women. It represents a shift in the balance of power and responsibility for women's health services, particularly because private sector services have not demonstrated interest or capacity to develop women-informed services, or to represent women's concerns, advocate for their interests, or work from a social model of health that seeks to change the determinants of women's health. As health care is increasingly treated as a market commodity, the effects on women of privatising principles and practices need to be understood, particularly for vulnerable women who are at greater risk of poor health, including:

- women with disabilities;
- women affected by violence in their past or present;
- older women (particularly those on pensions);
- lone mothers;
- women living with depression, anxiety and continuing forms of serious mental illness;
- women who manage serious and chronic family health conditions and issues;
- women who are carers of family members with serious and continuing illness.

All these groups of women are primary users of hospital and medical services who need care that is understood not just through a diversity and gender lens, but also through an access and equity lens.

The importance of Medicare and the universality of health insurance coverage for all people in Australia cannot be underestimated, because it provides a level of stability and reassurance for women as they manage their own health and the health care needs of their families. Nonetheless, health care frequently falls short in relation to access, affordability and equitable provision of services. The significant increase in user fees and co-payments also impacts heavily on women. Affordability is a key to timely access to needed health services. Increasingly, user fees at the point of service are imposed, particularly by general practice. Private co-payments have a negative effect on overall public support for health systems, while financial barriers lower the confidence of users in the health system (Wendt, Mischke, Pfeifer, Reibling 2011).

User fees are now so high that accessible health care can no longer be guaranteed. This affects continuity of care, timely access, and trust in the health system. Trust-reducing factors include delayed care and unmet needs. Trust-enhancing factors include reliable access to health care, patient-centred care, and continuity of care (Wendt, Mischke, Pfeifer, Reibling 2011).

COST BARRIERS TO HEALTH CARE

The Commonwealth Fund International Health Policy Survey (2007) found that in a comparison of seven OECD countries, Australia has high cost barriers to health care. The survey determined that in systems with low cost barriers, people with poor health are less likely to skip a health professional visit owing to costs, but when cost barriers are high, visits to health professionals become unaffordable, particularly for those with chronic conditions, and the likelihood of attending decreases. Between one-fifth and one-quarter of the Australian population lacks confidence in receiving medical care when in need (Wendt, Mischke, Pfeifer, Reibling 2011). When the cost of primary health care prevents people from accessing services, the principle of providing appropriate and cost-effective care in a timely fashion is diminished.

Women in the health workforce

Employment is a core determinant of women's health. Income from employment gives women independence and increases their participation in the economy and in society more broadly. In the general workforce, women's labour force participation rate is 58%, with more than 30% of Australia's small business operators comprising women. However, there are features of women's general employment, including the top levels of the business world, which translate to the health sector. In ASX200 companies:

- women hold just 8.3% of Board Directorships;
- 51% do not include a woman on the Board;
- women hold 10.7% of executive leadership roles and 5.9% of operational leadership roles;
- 45% do not have a woman on the Executive Team (WA Department for Communities 2010).
- just over one third of executive level positions were occupied by women (Office for Women 2011).

Similarly, while the number of women in the health system workforce is substantially greater than that men, they hold a paucity of executive positions (management and governance levels), which are predominantly held by men. To redress this imbalance, the South Australian Government has set targets for all boards and committees to comprise 50% women by 2014, providing an example for all other jurisdictions.

In the medical workforce women constitute a small proportion of specialists. The majority of medical practitioners are male, although the number of female doctors in the workforce has steadily increased to 36 per cent of all working doctors (AFMW 2012). Similar to other professions, women in medicine are more likely to work part-time to accommodate family and caring responsibilities, and are less likely to own their own practice (PC 2005). Nonetheless, they also have longer working lives in their chosen profession.

The nursing profession is 92% female, and women also constitute the majority of people working in community service organisations. In 2010–11, women represented 84% of workers in community service industries, compared with 45% of workers in all other industries; in the Child Care Services industry, 96% of those employed are women; in the Residential Care Services industry, women comprise 86% of workers, while in the other Social Assistance Services industry, three-quarters (75%) of those employed are women (ABS 2011).

The allied health professions, e.g., podiatry, optometry, social work, occupational therapy, speech therapy, dietetics, physiotherapy, are 80% female. However, women in nursing, occupational therapy, physiotherapy, social work, speech therapy and dietetics are more likely to exit the profession before the age of 50 years than people employed in less female-dominated occupations (defined as < 50% female). Optometry, general practice and dentistry have a higher initial retention rate of over 85%, which stays above 68% until age 55 years. In contrast, social work, dietetics and complementary medicine have a flatter pattern across the age range, with retention rates never exceeding 43% (Leach, Segal and May 2010).

Recruitment and retention of a highly trained workforce are critical issues for health systems. Investment by government in the health workforce is undermined by workplaces and health workforce policy that are not sensitive to the needs of women. Those needs are likely to include the juggling of career and domestic responsibilities. Gender analysis of workforce policy is generally missing and is an important priority for Health Workforce Australia.

Summary: Implications for health reform

AHWN and the women's health sector are committed to advancing the social model of health as it reflects the broader environment in which women live and work. The social model of health encompasses the social, political, environmental, biological and gender factors that influence women's health outcomes and their ability to access health care services and other service systems. AWHN, with other community based organisations, is committed to ensuring that the social model of health is integral to health policy debates and decisions.

It is disappointing that despite the commitments by the National, State and Territory Governments to women's health, and the development of specific policies to guide women's health programs and services, the guiding documents for Australia's health reforms have largely ignored their own Government policies on women's health, along with failing to recognise the knowledge and expertise of the women's health sector. This is especially concerning in the National Primary Health Care Strategy, where specific steps are needed to ensure that Medicare Locals and their population health plans are informed by gender research and the program experience of women's health services. There is much to be lost by passive ignorance of gender equity issues in population health, and much to be gained by active engagement with gendered data and data directories which have been developed by the women's health sector to enrich population health planning.

By incorporating action on the social determinants of health into the guidelines and funding agreements for new structures such as Medicare Locals and Local Health Networks, the effectiveness of health reforms will be enhanced. Stronger support for the women's health sector in health reforms is in the interests of all women, and will benefit the health of the whole population. We therefore provide an outline of the elements required for a health system that will improve outcomes for women:

- universal health insurance that provides affordable access to all in a timely manner;
- a comprehensive primary health care sector that includes specialised women's health services, community health services, and Aboriginal community-controlled health services alongside general practice;
- primary health care that is not subject to point of service, upfront fees;
- health services that are committed to gender-sensitive practices;
- locally controlled primary health services that are not based on strategies imposed from outside, but instead are developed in consultation with local communities;
- health services that are geographically balanced across metropolitan, regional and rural areas;
- a funded women's health sector that includes women's health services and other women's NGOs;
- integration of women's health policy with other areas of policy, both within and beyond the health sector;
- policy that requires health services, including hospitals and primary health services, to work with women's health services to integrate gender-sensitive health care through a commitment to gender-sensitive practices;
- structures that promote multidisciplinary care and interdisciplinary collaboration;
- systems that empower individuals and communities with the knowledge and skills necessary to achieve health for themselves.

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