Submission to

National Women's Health Policy

From: Women's Centre for Health Matters Inc.

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Women's Centre for Health Matters

Submission to the Consultation on a National Women's Health Policy

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Introduction

The Women's Centre for Health Matters Inc. (WCHM) is a community-based organisation that works in the ACT and surrounding region to improve women's health and wellbeing. WCHM focuses on groups of women who experience disadvantage and uses social research, community development, advocacy and health promotion to empower these women to achieve the highest possible standard of health and wellbeing.

WCHM believes that health is determined not only by biological factors, but by a broad range of social, environmental and economic factors known as the 'social determinants of health'. We also acknowledge that that the environment and life circumstances that each woman experiences have a direct impact on her health, and in many cases, women's poor health is rooted in social disadvantage. For these reasons, WCHM is committed to taking a 'whole of life' and social approach to women's health.

Responses to Guidance Questions

WCHM has chosen to limit its responses to those questions relating to areas in which it has the most knowledge and expertise, and to support its responses with evidence published by the Centre and its partners on the specific needs of ACT women.

1. Gender Equity

How can the health system be more responsive to the specific needs of women?
In what way can the Policy actively promote participation of women in health decision making and management?

WCHM believe that the following issues are crucial in achieving a health service which is more responsive to the specific needs of women:

a) Education and practices:

One of the main focuses of the work of WCHM is in improving women's access to gender-sensitive health practitioners and services.

A health system that is gender sensitive will include the following principles:

- Barriers to access are identified and where possible removed. For example:

    - Each service is located as close to possible to where the woman lives
    - Information is presented in a way that is appropriate to service users
    - The service is financially accessible to the service users.
- Health and hospital service development and delivery takes into account the many factors that impact on women's well-being—e.g. children, relationships, housing, income
- Gender awareness training is provided for all health and hospital workers. This training would include the issues of culture, age, sexuality, ethnicity, child and other caring responsibilities that impact on women's health and well being.
- Choice is available about the service that the woman receives. For example, there is a choice about the people who provide care and treatment to them and/or the type of support or treatment received.
- Women need the time and space to talk and staff must recognise and honour that need.
- Women must feel safe and secure, because they are treated with respect and their confidentiality is ensured.
- Women only spaces are provided.
- The system is strengths based and works to an empowerment model.

A gender sensitive health practitioner is one who has qualifications in women's health and/or is trained to understand and consider the impact of gender on health and well-being. Gender-sensitive health practitioners are also aware of the impact that culture may have on women's health and wellbeing. If we are to improve women's access to gender-sensitive health practitioners, we must first invest in training our health practitioners to be gender-sensitive to begin with. WCHM believe that the concept of 'gender-sensitive practice', and the ways in which the social determinants impact on women's health and well-being, should be key components of all health education. While it is important to teach health professionals (such as GPs, pharmacists and nurses) about traditional 'women's issues', such as pregnancy, menopause and reproductive issues, this alone, is not sufficient in creating gender-sensitive practitioners. Health education must also equip training practitioners with an understanding in the concept that *all* health issues and life events can affect men and women differently across their lifespan. This includes teaching health practitioners to recognise and response to a broader range of factors which impact women's health, such as domestic violence, mental health, eating disorders, the effects of ageing and disability and women's multiple and often conflicting roles of workers, mothers and carers.

b) Access:

Research has found that women are the primary seekers of health care and health and well-being information, not only for themselves, but for their children and other family members. Despite this, women face significant challenges as they try to manage their own and their family's health. A National Women's Policy must recognise the barriers

that women face in accessing both gender-sensitive health information and gender-sensitive health practitioners.

Consultations with women in the ACT show that access and service pathways within the ACT Health system are not clear to many marginalised and isolated women. The reasons for this included:

- being unable to understand written information because of language and/or literacy reasons
- lack of support people to assist women in negotiating the system if they do not understand it
- lack of suitable interpreters for women who need information in their prime language in order to understand the care that they are receiving or being recommended (this may include Deaf women)

The factors which will ensure that pathways of care are easy to navigate include access to information in preferred formats, a workforce that empathises with women who do not understand the health system and services provided, and access to assistance in navigating the pathways.

WCHM supports the right of women to choose who administers their medical care, and for many women, this means choosing a female GP or health practitioner. Because of this, women, particularly women on low-incomes are often the most negatively affected by the shortage of GPs and the closure of small medical practices, as finding a female GP who bulk-bills is nearly impossible (e.g. WCHM research in October 2007 found that 82.6% of female GP's in Canberra did not regularly bulk bill). This lack of access is compounded for those who require urgent medical assistance or who have limited access to transport and require a GP close to their home. In fact, in a 2008 survey of ACT women on their health and wellbeing, WCHM found that:

> *28.8% of women responding reported not acting on physical health and wellbeing issues due to financial constraints. Other significant reasons were: long waiting lists to see a practitioner (18.8%), the health issue not being deemed a priority (17.7%), not knowing where to get help (15%), not having the time to take action (12%), not being able to access a bulk-billing practitioner (11.6%) and not having access to transport (6.6%).*

WCHM is concerned about women in the ACT, particularly those who have low-incomes or who are socially isolated, who may be forgoing essential medical care because they are unable to access a GP who meets their needs. A National Women's Health Policy should also promote innovative models for reaching the most isolated and marginalised women, such as outreach and through-care models of service.

c) Representation:

In line with our values, WCHM believe that 'women are their own experts', and that women are best placed to make decisions about the issues which affect their health and wellbeing. Therefore, involving women in both consultations and senior decision making in health sector governance is crucial in creating health services that are more responsive to their needs.

In decision making roles:
WCHM acknowledge that while the health sector is predominantly staffed by women, they are not always equally represented at the most senior decision making levels. A National Women's Health Policy should actively encourage health services to seek out representatives from minority groups of women (such as women with disabilities and women from Culturally and Linguistically Diverse backgrounds) to input into decision making processes. When doing this, it is essential that the barriers to these women's participation, such as flexible meeting times, accessibility issues, transport and child care arrangements, are also actively addressed.

In consultations:
WCHM believe that while consultations with women are essential in planning and delivering Government funded health services, the voices of those women most likely to be using these services often go unheard. When conducting consultations, Governments should make every effort to include the opinions of socially isolated and marginalised women so that their opinions and ideas can influence policy and practice. Often, the reason why these women's voices are not heard is because their preferences for sharing information do not fit within the traditional consultation processes. For example, in some cultures it is unacceptable for women to discuss health matters with certain people (e.g. older women discussing issues with young women etc.). There can also be stigma around personal health issues that prevents women from sharing their experiences, particular in group settings. WCHM believe that the new Policy should encourage innovative ways of consulting with traditionally 'hard to reach' women, and where possible, engage community service organisations to consult these women on behalf of the Government.

2. Health Equity Between Women

How can the health system be more responsive to those groups of women most at risk? How can access to services be improved? Should the policy promote specialist or outreach services for particular groups of disadvantaged women? Are there particular health workforce issues that are impacting on certain groups of women?

Throughout our submission, WCHM have suggested ways in which our health service can be more responsive to women most at risk of poor health outcomes. Central to these ideas is the idea that a 'one size fits all' approach to women's health is not sufficient in ensuring positive outcomes to socially isolated and marginalised women. A new Policy should consult closely with at-risk groups of women to determine *how* they

currently access information about their health, how they *prefer* to access this information, and what barriers they face in accessing information about their health. Knowing this will greatly assist health services in better reaching these women.

The multiple dimensions of inequality should be addressed. Inadequate housing, transport, access to health care, and other services that support marginalised and isolated groups have all been identified as key areas that need to be addressed within the ACT.

Similarly, difficulty in supporting women with complex needs, access to affordable health and wellbeing professionals, and the provision of information on health and wellbeing for marginalised and isolated women have been identified as areas that require policy development and further services.

Many women do not have just one challenging issue that makes them vulnerable. It is easy for women with one issue to get into a cycle of difficulties. For example:

a) chronic pain may lead to depression which may lead to alcohol and drugs misuse
b) a mental health issue may lead to unemployment which may result in living below the poverty line, and then in homelessness
c) new mothers may experience domestic violence for the first time antenatally or postnatally; when relationships break down in situations like this women are vulnerable and there are many complicating factors. For example the woman may decide to flee but crisis accommodation is difficult to access, resulting in some women remaining in unsafe situations.

The health care system must respond to those with special needs. We would like to highlight issues for women with the following specific needs:

- Women with disabilities
- Women with mental health issues
- Institutionalised women
- Women from culturally and linguistically diverse backgrounds
- Women who are homeless

<u>Women with disabilities</u>

A wide range of service and support are offered for women with disabilities in the ACT. However, Women with Disabilities Australia (WWDA)[1] has identified that major issues for women with disabilities regarding health and well-being are low self-esteem, access to information, educating others, physical access to services and the logistics involved in making and keeping appointments. These issues lead to poor access to screening programs, such as pap smears and mammograms, lack of education about their reproductive rights, capabilities, sexuality, pregnancy, and parenting.

[1] Information from health related submissions and reports at http://www.wwda.org.au/

Women with mental health issues

The WCHM *Marginalised and Isolated Women* report identified research into psychological health in midlife among Australian women who have ever lived with a violent partner indicates that women are more likely to experience depression and anxiety if they have experienced domestic violence. This study utilised data collected as part of the Australian Longitudinal Study of Women's Health, and reports that women who have experienced domestic violence are three time more likely to be single, twice as likely to have been diagnosed with mental illness, and were more likely to have income management difficulties.

Congruent with these findings, anecdotal evidence suggests that a history of women being subjected to violence is a primary reason for why women access mental health support services in the ACT. The Women's Health Service provided 4050 occasions of counselling to women in 2006-07. Anecdotal evidence suggests that around 80% of the women who accessed this service had experienced violence[2].

At a consultation meeting held by WCHM in August 2007 for the Senate Community Affairs Committee Inquiry into Mental Health Services in Australia with women with mental health issues and service providers, the following points were made and provided to the Inquiry[3]:

- There must be women only services in the whole range of mental health services, from early intervention to crisis/hospital treatment and care. Many women with mental health issues are dealing with the results of abuse and/or violence from male perpetrators; it is not appropriate for these women to be receiving care and/or treatment in the same place as men.
- There needs to be a greater awareness of the holistic needs of women (for example homelessness, poverty). While there is greater acknowledgement by the service system, there is still much progress to be made in the support offered to women.
- Women need and want continuity of care and support. Unfortunately, mental health workers change frequently; the system must take steps to address the consistency of workers. This would involve investigating the reasons for such change, and we expect that issues such as levels of pay (particularly in the community sector), training needs and the end for system change would be highlighted.
- There is a need for greater resources being devoted to early intervention. Women need to be supported when they first express the need, and not have to wait until they are in crisis; a shift to strengths based and recovery approaches will support this.

[2] Maslen, Sarah (2008) p. 17

[3] From WCHM Submission to Senate Community Affairs Committee Inquiry into Mental Health Services, August 2007

- Women with children have additional stresses that need to be addressed. In particular the critical crisis of separation times, including hospitalisation, remand, detox, and/or children being removed.
- Amongst the services that would assist are parenting support groups, self help models of support, more community development initiatives, and services to assist with access and reconciliation of families.
- The mandated use of advanced agreements was suggested, as a way for a woman to plan for herself and her children in times of being unwell.

Institutionalised women

Women's offences and experience of prison differs from men's. The majority of women offenders experience entrenched disadvantage. This contributes to their incarceration and also to poor mental and physical health. In addition, a significant proportion of women in and post prison have responsibility for dependent children.

WCHM *Marginalised and Isolated Women report* defines institutionalised and post-institutionalised women as including women who are currently, or have been, imprisoned, or detained in a detox facility, in girls' homes, or have been institutionalised for mental health reasons. Women who have been institutionalised for any reason are at high risk of social, economic, political, and legal marginalisation and isolation that extends beyond the institutionalised period. Consultation with the ACT Women and Prisons Group identified that rehabilitation, employment opportunities, and social inclusion are key issues faced for women who have been institutionalised, particularly in prisons. Mental health issues and dependencies are common problems for ACT women who have been institutionalised. Similarly, as a result of women's criminal records, women's employment opportunities are restricted primarily to low paying positions, often causing poverty and homelessness[4].

As a result, women who have been or are currently institutionalised are at high risk of health and wellbeing problems and require **targeted health support**.

Women from culturally and linguistically diverse backgrounds

Marginalised and Isolated Women report found statistical and anecdotal research suggesting that general health and wellbeing levels are lower for women from a culturally and linguistically diverse background, than for the population at large. Research into the experiences of maternal depression for culturally and linguistically diverse women in Melbourne, for example, indicates that there is significant prevalence of maternal depression for women who are under 25 years of age, have been resident in Australia for a short period, speak little or no English, have migrated for marriage, have no relatives in the area or no friends to confide in, have physical health problems,

[4] Maslen, Sarah (2008) p.25

and/or baby feeding problems. The research also showed that socio-economic status was not a factor for women's experience of maternal depression, and the biggest identified problem for these women was social isolation[5].

Homeless women

In research undertaken by Inanna Inc [6] in 2005, insight was provided into front-line service providers' widespread beliefs that women experiencing or at risk of homelessness generally experience poor physical health. Service providers reported that although homeless women encounter similar problems to women who are not homeless, homelessness tends to perpetuate and exacerbate these problems.

Women who were homeless reported the following key points:

- Some women were generally unhappy with and reported bad experiences with the type of public health services received. Other women reported good experiences with health care in the ACT
- That health care services are not affordable and do not generally bulk bill
- Access to good affordable food was an issue but not a high priority, and
- Women want to self-care where possible.

The report recommended that an approach be made to ACT Health and the Australian Government to fund a program that improves access to health services for women experiencing (or at risk of) homelessness in the ACT.

For many at risk groups where possible, health care should be provided at home or in community settings, and individual needs should be central to the service provided.

When hospitalisation is necessary the principles highlighted under our response to *Gender Equity – Education and practices* should be followed. For example, when a woman with a mental illness requires hospitalisation in an acute care facility, the system should automatically ensure that:

- women only space is offered
- there is anunderstanding of possible concerns about children, partners, family obligations
- cultural factors are taken into account
- information – verbal and written – is provided in the woman's preferred language, or in an accessible format.

WCHM supports the gender analysis tools and culturally appropriate frameworks discussed in the consultation discussion paper, and believe they have the potential to improve health equity between women. WCHM believe that different variants of these tools will be useful at all levels of Government, and also in community organisations

[5] Maslen, Sarah (2008) p. 23
[6] An electronic copy of this report is available from WCHM

who work 'on the ground'. WCHM also supports innovate models of service delivery including outreach, 'wrap around', and through-care models of service for disadvantaged and hard to reach groups of women.

WCHM is also concerned about the impact of an ageing population on a health service which is predominately staffed by women. WCHM believes that where possible, the new Policy should aim to influence other sectors outside health, particularly education and employment, so that they invest more resources to make the health sector a viable career choice for younger women.

3. A Focus on Prevention

Which women in our community are most at risk of poor health? Should the policy identify priority groups for action? How can the Policy help to improve the health and wellbeing of those women most at risk?

WCHM believes that while preventative health strategies are useful, they must go beyond 'behavioural change' (such as reducing smoking, drinking and obesity) and address broader 'societal change'. The main focus for prevention in the discussion paper is on prevention of illness and disease, and this does not recognise that social and economic disadvantage can lead to poor health.

Health is shaped by the environment in which we live. The implication is that all government departments have a role. The new National Women's Health Policy needs to be connected to other national policies, and should consider long term change around the social determinants of health, which are driven from portfolios other than the health portfolio – but which have large impacts on women's health. Income security, employment status, transport, sport and recreation pursuits and family and community supports affect health. Adequate attention to these factors strengthens prevention and wellness.

A system that strengthens both prevention and wellness includes provision of suitable housing, affordable child care, adequate income support, accessible community and public transport systems, provision of a continuum of care, affordable to all women, tailored to individual needs, provision of early intervention, culturally appropriate, provides support to groups and/or to individual women, includes an outreach and follow-up component and has a work force that is trained in and understands integrated holistic women-centred service provision.

WCHM supports a focus on preventative health in the new Policy, although it is important to recognise that regardless of how much resources are invested in prevention, there will always been a need for primary health services dedicated to the needs of women. Over time, a preventative approach will reduce the burden on primary

health services, however in the early stages this should not be *at the expense* of good quality primary health care.

4. A Strong and Emerging Evidence Base

Are there gaps in our knowledge, including the need for further research and data collection that will help to assist in the development of a robust olicy and improve women's health and outcomes in the longer term?
Is there a need for more gender focused health research? In what ways? How can a national Policy address this need?

a) Supporting local evidence gathering

ACT women are generally better educated, have higher incomes, and have higher housing standards than women nationally. However, there are a significant number of ACT women who are marginalised and isolated from their community and its standard of living, at a great cost to their health and wellbeing. Due to the lack of accurate, gender-disaggregated data on marginalised and isolated groups, it is almost impossible to quantify the number of women in the ACT that are experiencing marginalisation and isolation. Key issues in the ACT, including addiction and substance abuse, transportation issues, and poor mental health all have extremely harmful impacts on health and wellbeing, and are significantly more prevalent amongst the socially and economically disadvantaged.

WCHM invests a lot of its time and resources into gathering local evidence on the specific issues affecting ACT women. This localised evidence has proven to be a vital resource for other ACT community and Government organisations, particularly in designing, evaluating and sourcing funding for their service. By gathering local evidence, WCHM is developing a better understanding of our unique community. For example, while national statistics often portray Canberrans as being relatively privileged (high incomes and levels of home ownership, low rates of homelessness etc.), localised research, such as that conducted by WCHM, has revealed pockets of disadvantage and groups at risk of social isolation. Gaps in service provision and policy exist with relation to all of the groups that are at risk of marginalisation and isolation. Insufficient respite for primary carers, inadequate exit points for women in refuges, not enough affordable, adequate and safe housing, transport issues, services for Aboriginal and/or Torres Strait Islander women, and support for institutionalised women with children are all issues that have repeatedly arisen.

Local evidence is also necessary to help services better understand the impacts of local events in their community, such as the recent GP closures and the opening of the new prison in the ACT. A National Women's Health Policy should promote evidence gathering at both a national and local level in order to develop a sound evidence base.

b) Broadening our understanding of word 'evidence'

While statistics and surveys can be useful ways of gathering evidence, WCHM also supports the other ways of understanding the impacts of life events on women's health. Many women, particularly those who come from 'story-telling' cultures (such as Indigenous women and many CaLD women) or those who have had negative experiences with Government institutions in the past, will often only share their experiences with someone who they trust, in an unstructured and supportive environment and in line with their cultural customs. WCHM believe that these women's voices often go unheard as their way of sharing their experiences does not fit with the formal consultation processes or evidence gathering methods. Consequently, the needs of these women are not reported in formal statistics. WCHM would like a National Women's Policy to acknowledge different types of 'evidence' and to take into account women's stories, not just women's statistics in decision making.

c) Providing a disaggregated analysis of statistics

WCHM believes that gender-disaggregated data alone is not enough build an accurate picture of women's health, particularly when it comes to women who experience disadvantage. WCHM supports A National Women's Health Policy which promotes, where feasible, the further disaggregation of women's health data to include indicators such as age, cultural background and disability.

5. A Life course Approach

WCHM supports a new Policy which takes a life course approach to women's health, as long as this is linked to the other social factors that influence health and wellbeing.

6. Other Issues

How can

WCHM urges the new National Women's Health Policy to continue to embrace and promote a social understanding of health. This includes utilising the Social Determinants of Health model (as promoted by the 1986 Ottawa Charter for Health Promotion) in regards to women's health. WCHM also notes that while we agree that a National Women's Health Policy should continue to set priority areas based on emerging issues and a strong evidence base, many of the key action areas and health issues that were considered a 'priority' 20 years ago, have still not been adequately addressed, and we still have not achieved health services in Australia which are acceptable and appropriate for women's needs, and which are accessible and affordable, particularly to those women most at risk.

<u>Key Action Areas of the 1989 Policy</u>

WCHM agree that the key action areas of 1989 Policy: Improvements in health services to women; provision of health information; research and data collection; women's participation in health decision making; and training of health care providers, continue to be worthy of the Government's attention. While improvements have been made in offering dedicated women's health services in 1989, there is still much progress to be made on the other four key action areas (WCHM has addressed these issues throughout its submission).

Priority Health Issues of the 1989 Policy

As the with key areas, many of the priority health issues that were identified in the 1989 Policy continue to be highly relevant for women today and should be included in the new National Women's Health Policy. Of particular relevant are the following areas (of the 1989) policy which WCHM believes must remain on the women's health 'agenda':

- **Reproductive and Sexual Health:** Although WCHM believe that reproductive and sexual health should continue to be a priority in women's health, we believe that the focus should be now be moving towards 'choice' and 'access'.

- **Health of Ageing Women:** As our population ages, it is essential that the health of ageing women remains a Government priority. WCHM would like the new National Women's Health Policy to acknowledge that women experience ageing differently to men, and while on average women may live longer than men, this also creates contributes to their risk of social isolation.
  Example: A recent survey of 209 older women in the ACT by the YWCA of Canberra found that 40.1% of respondents reported feeling 'excluded or alone' sometimes or more often. The survey also found that these feelings of social isolation were directly linked to a women's social networks, that is, older women who had a stronger social network were less likely to feel excluded alone that those who didn't have a strong social network. Respondents also listed some of the barriers they faced to social participation as time constraints (40.5%), low energy levels (34.7%), financial constraints (30.6%), health problems (20.4%), and lack of confidence (16.1%).

- **Mental Health and Wellbeing:** While the 1989 Policy referred to 'emotional and mental health', WCHM believe that word 'emotional' is unnecessary in the new Policy as it risks succumbing to the traditional stereotype of women as being irrational and 'overly emotional'. WCHM believes that women's mental health and wellbeing should continue to be a priority for the new Policy as it continues to be a primary risk factor for social isolation and a barrier for accessing health care.
  Example: Recent research performed by WCHM found that found roughly 17.8% of ACT women experienced mental of behavioural health conditions (including

alcohol and drug dependency). The 2004-05 National Health Survey (ABS) also found that while most ACT women experience low levels of 'psychological distress' (56.2%), 29.2% of ACT women reported 'moderate' levels of psychological distress, 11% of ACT women reported high levels of psychological distress and 4,500 ACT women reported 'very high' levels of psychological distress.

- **Violence against Women:** While WCHM believe that violence against women and the impact it has on women's health and wellbeing should continue to be a Government priority, we believe the National Women's Health Policy should acknowledge that violence against women is not simply a 'women's issue' but a broader societal issue and link it's aims and actions directly into the National Plan to End Violence Against Women.

WCHM's supports area 5.2.2 of the consultation paper which lists groups of women who are most at risk of poor health outcomes. To this list, WCHM would like to add:

- **Institutionalised Women:** Including women who were 'Forgotten Australians' (those who grew up in institutionalised care), Child Migrants, those women who have spent long periods in prison, remand or detention centres or any other institutional setting including psychiatric facilities, aged care facilities and so on. Research has shown that institutionalisation has a severe and long lasting impact on women's health and wellbeing.

Conclusion

In conclusion, this submission aimed to highlight issues from the perspective of women of the ACT. WCHM looks forward to the development of the new National Women's Health Policy.