Submission to:

Emeline Cammack
Policy Division, ACT Health
Email: emeline.cammack@act.gov.au

Submission to the Draft ACT Primary Health Care Strategy 2011-14

Women's Centre for Health Matters Inc. (WCHM)

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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 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, that is also firmly situated within a human rights framework.

Response to the draft ACT Primary Health Care Strategy

WCHM supports the development of a primary health care strategy for the ACT. We welcome this opportunity to participate in this consultation process and in writing this submission, have chosen to limit our responses to those areas in which we have the most knowledge and expertise, and to support our responses with evidence published by the Centre and its partners on the specific needs of ACT women.

1. Do you have any comments on section one of the strategy?

Overall WCHM supports the primary health care philosophy put forward in the Strategy. There are, however, small but significant changes that we propose that we believe will strengthen the philosophy and make it more consistent with the directions for changes and action areas set out in the Strategy.

Recognition of the multiple determinants of health including housing, education, transport, planning, communication, social and other services: Point two of the philosophy articulates the importance of recognizing the "multiple determinants of health including housing, education, transport, planning, communication, and social and other services". WCHM would like to commend the strategy for its inclusion of the social determinants of health as the starting point for primary health care planning and coordination. When primary health care services are organised around a solid understanding of the social, biological and economic determinants of individuals' health, it can be extended beyond the traditional hub of general practice to include and recognise the importance of community pharmacy, community health centres, NGO's

that provide health services, nurse led clinics and consumer organisations that provide integral primary health care services in the ACT, to name but a few.

However, gender was not listed as one of the determinants of health despite its centrality in determining a range of health outcomes, including but not limited to the range of illnesses that will affect individuals, the presentation and diagnosis of those illnesses, and the treatment options available.

Women and men are different, both as a result of biological differences and because of the differences in the ways that they live, work and play. Because of these differences, men and women have different health needs. Women, certainly, are affected by sex specific diseases such as cervical cancer, but the influencing factors that determine women's health are far broader than the traditionally principle reproductive issues.[1] [2] The differences in social roles assigned to women and men affect the "degree to which women and men have access to, and control over, the resources and decision-making needed to protect their health",[3] which results in inequitable patterns of health risk, use of health services and health outcomes.'[4]

To be more specific, social and biological factors in our society can influence women's:

- Access to and understanding of information about disease prevention, management and control
- Subjective experience of illness and its social significance
- Attitudes towards the maintenance of one's own health and that of others
- Patterns of service use
- Perceptions of quality of care[5] [6]

These differences manifest in such a way that sees women accessing health services more than men and with greater frequency. It is true that women in the ACT have a higher life expectancy than men but they also have higher rates of chronic illness and disability, and are more likely to be alone in old age when they require care. Also, women are more likely to seek health care than men, seek it earlier and seek it for others.

In addition, gender can influence the way in which health practitioners and services provide their services, how effective the service is, and the degree to which they meet the needs of women consumers. For example, heart disease affects both men and

[1] The Women's Health Council, *A Guide to Creating Gender-Sensitive Health Services*, 2007, p. 1.
[2] Carol Vlassoff & Claudia Garcia Moreno, "Placing gender at the centre of health programming: challenges and limitations", *Social Science and Medicine*, 54(11), 2002, p. 1714.
[3] World Health Organization, *Madrid Seminar on Gender Mainstreaming Health Policies in Europe, 2002* http://www.euro.who.int/document/a75328.pdf
[4] *ibid*.
[5] The Women's Health Council, *op cit.*, 4-5.
[6] Carol Vlassoff and Claudia Garcia Moreno, *op cit*, 1713.

women, however, the symptoms associated with heart disease, such as severe and sustained chest pain, are those that commonly only present in men. Women present with different symptoms, such as abdominal pain, fatigue and nausea and are commonly recommended less urgent and less aggressive treatments than men.[7]

Accessible, acceptable and affordable services and technology: Point five of the philosophy articulates the importance of the provision of "accessible, acceptable and affordable services and technology" to which WCHM recommends adding the words *appropriate* and *available* (we would also recommend removing the word *acceptable*, or providing a footnote as to its meaning in this context). When women have good quality health services that are *available, affordable, accessible* and *appropriate*, they are enabled to maintain their own health and wellbeing, and to assist in the maintenance of the health and wellbeing of their children, partners and other family members.

Through our research WCHM has learned that one of the greatest barriers affecting ACT women's access to health services is not being able to see a primary health care provider—which prior to the opening of the nurse-led Walk-in Centre were primarily GPs—when they need one. This concern is acknowledged in the Strategy as well, which sites results from the *ACT General Health Survey* where waiting times to see a GP was the most commonly cited concern that individuals who believed there were inadequacies with the ACT health system identified.

That services be appropriate was also identified through WCHM research as important to ACT women. Through acknowledging that health services need to be appropriate, the Strategy will demonstrate that it truly intends to address issues of access and equity to ensure that the most vulnerable and disadvantaged groups have equitable access to health services. The word appropriate in this context means that services are provided in a setting that is safe and comfortable for its target audience and that primary health care providers are trained to work with and understand the needs of particular groups who experience disadvantage. For example, the Strategy identifies refugees as a population group vulnerable to disadvantage. Therefore, primary health care services with refugees as clients need to ensure that they are easily located (preferably on bus routes), that the health care providers are culturally aware and sensitive, that interpreters are available where necessary and that information can be provided in a format and language appropriate to the clients.

Eliminating causes of ill health through health promotion and disease prevention: Point six of the philosophy articulates the importance of "eliminating causes of ill health through health promotion and disease prevention". WCHM believes that health promotion

[7] Carol Vlassoff and Claudia Garcia Moreno, *op cit.*, 1716.

and in turn disease prevention can only be attained when individuals have good health literacy and access to good quality, up-to-date and trustworthy health and wellbeing information.

There are many sources providing a plethora of health and wellbeing information to women, ranging in quality, credibility, complexity and purpose. However, for women to be benefited by the health and wellbeing information they obtain they need to be able to understand it, assess its credibility and apply it to their own or their family members' lives, and it is with good health literacy that this can be achieved.

Health literacy is defined as:

> *"Health literacy is the ability to make sound health decisions in the context of everyday life – at home, in the community, at school, in the workplace, in the health care system, in the marketplace and in the political arena. It enables people to increase their control over their health, their ability to seek out health information, to navigate complex systems, take responsibility and participate effectively in all aspects of life."*[8]

There is evidence of "a strong association between health literacy and self-efficacy" with respect to improving health and wellbeing outcomes for women; adequate health literacy to know what one can do to improve health and wellbeing, and good self-efficacy to have the knowledge and belief in oneself to make any needed changes.[9] However, improved health literacy does not mean providing women with more information, as information alone will not assist women in managing their health and wellbeing or promote lasting behaviour changes.[10]

A sufficient degree of health literacy assist individuals to communicate with health professionals in a more balanced and informed manner, reducing the risk of negative interactions.[11] Individuals with low health literacy can be overwhelmed by health professionals' language,[12] may not feel respected for what information or understanding they do have, and can feel patronised.[13] Good health literacy, however, ensures that women can engage in productive conversations with their health care providers. This helps the primary health care provider/client relationship to be one of trust and mutual

[8] Kickbusch, I., *Healthy Societies: Addressing 21st Century Health Challenges*, Adelaide Thinkers in Residence; Adelaide, 2008, p. 46.
[9] Torres, R. & Marks, R.,"Relationships Among Health Literacy, Knowledge About Hormone Therapy, Self Efficacy and Decision Making Among Postmenopausal Health", *Journal of Health Communication*. 14(1), 2009, pp.43–55.
[10] Renkert, S. & Nutbeam, D., "Opportunities to improve maternal health literacy through antenatal education: an exploratory study", *Health Promotion International*, 16(4), 2001, pp.381–388.
[11] Torres, R. & Marks, R, *op cit*.
[12] Adams, R., Stocks, N., Wilson, D. & Hill, C., "Health literacy: A new concept for general practice?" *Australian Family Physician*, 38(3), 2009, pp.144–147.
[13] Wathen, C. & Harris, R., "'I Try to Take Care of It Myself.' How Rural Women Search for Health Information", *Qualitative Health Research*, 17(5), 2007, pp. 639–651.

respect, allows for the negotiation of health care decisions, and equalises the sharing of power and responsibility for maximising women's health and wellbeing.[14] Improved health literacy has also been shown to improve patient satisfaction.[15]

Low health literacy, by contrast, reduces an individual's understanding of their health, compliance with health plans, and results in poorer psychological and physical health and wellbeing outcomes and higher morbidity and mortality.[16,17,18] Low health literacy has ramifications for an individual's future health and use of health care services and has been associated with a poorer understanding of one's own health, reduced use of preventative health strategies, reduced use of primary health services, reduced likelihood of taking medications as prescribed, poor self-care, and a reduced ability to interact and engage with health care providers.[19]

Poor health literacy increases with age, low educational level and low income.[20] Men generally have poorer health literacy than women, however, regardless of gender, education, ethnicity, age and income, better health literacy still significantly increases women's self-rated level of health, and the chance of engaging in health promoting behaviours.[21] This is an important point for effective health promotion as it clearly shows poor health literacy is part of a complex tapestry of disadvantage.[22]

Women's health literacy and access to health and wellbeing information is vital for reducing the burden of preventable and chronic illness on the health care system and optimising women's health and wellbeing. In addition to good health literacy, access to good quality health and wellbeing information increases women's knowledge about health, wellness, illness and disease; assists them in making choices about their lifestyle and decisions about their health; and reduces anxiety about health issues.[23]

[14] Smith, S., Dixon, A., Trevena, L., Nutbeam, D. & McCaffery, K., "Exploring patient involvement in healthcare decision making across different education and functional health literacy groups", *Social Science & Medicine*, 69, 2009, pp.1805–1812.
[15] Adams, R., Stocks, N., Wilson, D. & Hill, C., *op cit*.
[16] Torres, R. & Marks, R., *op cit*.
[17] Tokuda, Y., Doba, N., Butler, J. & Paasche-Orlow, M., "Health literacy and physical and psychological wellbeing in Japanese adults", *Patient Education and Counselling*, 75, 2009, pp.411–417.
[18] *Ibid*.
[19] *Ibid*.
[20] von Wagner, C., Knight, K., Steptoe, A. & Wardle, J.,"Functional heath literacy and health promoting behaviour in a national sample of British adults", *Journal of Epidemiology and Community Health*, 61(12), 2007, pp.1086–1090.
[21] *Ibid*.
[22] *Ibid*.
[23] Murphy. M., Murphy, B. & Kanost, D., *Access to Women's Health Information: A Literature Review of Women as Information Seekers*, Women's Health Victoria; Melbourne, 2003, p. 8.

Recommendations

1. To include gender as a social determinant of health in the Strategy.

2. To change the wording in the philosophy from "accessible, acceptable and affordable services and technology" to *accessible, available, affordable and appropriate services and technology*.

3. To acknowledge the vital role of good health literacy and access to good quality health and wellbeing information as central to "eliminating causes of ill health through health promotion and disease prevention".

2. Does section two of the strategy adequately describe the background and drivers for change:

Area 2.3.5 of the Strategy sets out the population groups which are vulnerable to "inequities in health status and access to health care services". Included in the strategy so far are: Aboriginal and Torres Strait Islander people, adults and young people in detention, people living in residential aged care facilities and women, particularly women from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander women and women with a disability.

The strategy says that:

> *It is clear that although the overall ACT population enjoys relatively good health and access to health services, there are pockets of disadvantage which must be addressed along with attention to risk factors as part of the national approach to preventive health in order to minimise the impact of ageing and chronic disease in the future.*

WCHM welcomes this view as it is precisely that platform upon which WCHM conducts its core business. However, WCHM considers there to be other groups of women who are particularly vulnerable to inequities in health status and access to health care services, which include: women who are experiencing or at risk of experiencing violence and older women. WCHM believes that these groups of women require particular attention in all attempts to improve access and equity issues to primary health care.

Women who are experiencing or at risk of experiencing violence: Addressing violence against women is essential to ACT women's health, as the impacts of violence can include temporary or permanent disability, injury, and in some cases, death. A consequence of violence against women for example, is that they are more likely to

experience mental health problems, particularly depression, anxiety, sleep disturbances, loss of self-esteem, social isolation, eating disorders and substance abuse.[24]

A study by the Department of Human Services in Victoria, *The Health Costs of Violence-Measuring the Burden of Disease Caused by Intimate Partner Violence,*[25] found domestic violence to be a greater contributor to poor health outcomes than the more well known risk factors such as high blood pressure, smoking and obesity.

Despite the threats to health and wellbeing associated with the experience of violence, women with this experience are more likely to deal with the issues themselves or talk to family and friends rather than seek outside support due to barriers such as fear, isolation, lack of support and shame. There is a need therefore, for the Strategy to address the barriers that affect access to health services for women who are experiencing or have experienced violence.

Older women: As acknowledged in the Strategy, Canberra's population is projected to grow by 67,000 people to 389,000, with the proportion of our population aged over 65 expected to increase from 9.7 per cent to 25.6 per cent. According to the ACT Government's *ACT Strategic Plan for Positive Ageing 2010-2014,*[26] the ACT has one of the fastest-growing populations of people aged 60 years and over in Australia, where one in four older people live in lone households—the majority of these being female households—and one in five older people require care.

For ACT females, there is a life expectancy of 81.3 years. Since the incidence of many chronic illnesses and disabilities increases with age, and is linked to social isolation and disadvantage, there a need to look for ways to adjust current thinking and approaches within the ACT to help older women maintain and improve their health and wellbeing, assist them to connect with the community and raise the quality of their lives.

Through its research WCHM has learned that older women feel ambivalent about their ability to navigate the ACT Health System in order to access the most appropriate services for their needs. With an increasing number of older women in the ACT who are single and live alone it is important that the barriers that affect their access to health services are addressed.

[24] Danielson, K.K., Moffitt, T.E., Caspi, A. & Silva, P.A, "Comorbidity between abuse of adult and DSM-III-R mental disorders: Evidence from an epidemiological study", *American Journal of Psychiatry*,155, 1998.
[25] Department of Human Services, *The Health Costs of Violence-Measuring the Burden of Disease Caused by Intimate Partner Violence*, Victorian Government; Victoria, 2009.
[26] ACT Department of Disability, Housing and Community Services, *ACT Strategic Plan for Positive Ageing 2010-2014*, ACT Government, Canberra, 2010.

Recommendations

1. To include women who are experiencing or at risk of experiencing violence and older women to those groups considered vulnerable to inequities in health status and access to health care services as these groups experience unique challenges to good health and wellbeing and barriers in their access to health services.

Conclusion

In conclusion, this submission aims to highlight issues from the perspective of women in the ACT, particularly those who are vulnerable to disadvantage. WCHM looks forward to participating further in the consultation process, and the development of the ACT Primary Health Care Strategy.

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