



Women's Health:

Australian
Women's
Health
Network

The New National Agenda

Position paper | March 2008

Contents

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Women's Health: The New National Agenda:
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Foreword

The Australian Women's Health Network is pleased to present this position paper, *'Women's Health: The New National Agenda'*, as a vital contribution to the development of a new national women's policy.

Since the groundbreaking release of Australia's first National Women's Health Policy in 1989, many other developed and developing countries followed Australia's lead and developed their own women's health plans. However over the last decade women's health has slowly disappeared as a policy priority on our national agenda.

It was therefore with great relief that AWHN and many others greeted a commitment by the Federal Labor Party in the leadup to the 2007 election to establish a new women's health policy if elected to government. This commitment recognised the critical importance of improving women's health outcomes, not only for individual women, but for the benefit of the whole community. It also acknowledged the critical role of broad-based consultation in developing a policy that would 'actively promote participation of women in health decision making and management' (ALP, 2007).

In addition, AWHN strongly supports the new government's commitment to shift the focus of the health system towards a greater focus on preventative health and health promotion, both of which are critical to addressing many of the health problems caused by gender inequality.

With the changing and increasingly demanding roles filled by Australian women, we believe it is more important than ever that the health needs of women are framed as an integral part of our national health policy—not as a special interest group or as a subset of reproductive health issues. Health policy in turn must be framed within other major national debates such as economic growth and productivity, affordable housing, better work and family balance, climate change and other environmental concerns.

The fields of health research, health care and health funding are highly contested and constantly evolving. Within this broad ranging discourse, it is vital that the voices and concerns of women are raised, including the voices of women's health organisations and the myriad other groups dealing with women's health outcomes on a daily basis.

At the 2005 National Women's Health Conference, it was agreed that significant effort was required to bring women's health back onto the national health policy agenda before our next conference in 2010. This position paper, based on an earlier discussion paper and consultations that followed our national women's health summit in Canberra (September 2007), represents a central part of that effort.

Australian Women's Health Network

March 2008

About the AWHN

The Australian Women's Health Network (AWHN) is a community-based, non-profit, consultative organisation that provides a national voice on women's health issues. AWHN was established in 1986 and operates as a women's health advocacy and information organisation, working with government policy makers and other agencies to improve the health and wellbeing of Australian women.

AWHN has affiliated Networks in all states and territories of Australia. Both the state/territory groups and the umbrella national organisation represent a wide cross section of women, and organisations representing specific groups of women. As health is interpreted in a broad social context, women from a range of interest groups take up AWHN membership. The organisation cuts across political, economic, social and ethnic barriers. Women's Health Networks frequently consult with other organisations representing women and work together to address major issues facing women.

The broad aims of AWHN are:

- To maintain and increase a national focus on women's health issues.
- To be a national advocacy and information sharing organisation.
- To be an umbrella organisation for state and territory women's health networks and for other national women's organisations which embrace our objectives and philosophy.

AWHN is funded from membership fees and does not receive government funding.

For further information, including contact details, go to: www.awhn.org.au

Related papers

Proceedings from the AWHN Summit and Aboriginal Women's Talking Circle held in Canberra September 2007 can also be found on www.awhn.org.au

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Chris Black, author of *Women's Health: The New National Agenda*, on behalf of AWHN.

All organisations and individuals that provided input and feedback on the discussion paper, and through the National Women's Health Summit.

AWHN acknowledges with appreciation the support of the ACT Government and the Office of Aboriginal and Torres Strait Islander Health in running its 2007 National Women's Health Summit in Canberra.

Executive summary

The purpose of this position paper is to set out a new national agenda for women's health in Australia. It does so by outlining the key arguments for making women's health a priority of governments, health professionals and the broader community and proposes a framework and process through which this can be achieved.

Section 2 describes 'why women's health matters' and how women's experience of life (and health) differs from that of men. It underscores the fact that improving the health of all women will have a marked impact on the health of the broader community.

Section 3 provides a summary of the development and achievements of Australia's first National Women's Health Policy, widely acknowledged as a world leading best practice example of how to approach women's health. It notes that the framework and commitments of that first policy still have great relevance and currency today, and provide a strong base for the development of a new policy.

In **Section 4**, statistics compiled for the Australian Government's publication, *Women in Australia 2007*, are used to demonstrate some of the key social, economic and health issues facing women today. These statistics highlight achievements that have been made over recent decades, as well as continuing inequities and differences that demonstrate the need for a coordinated and holistic approach to women's health and wellbeing.

Section 5 outlines the differences between the terms 'gender' and 'sex' and how each impacts on women's health experiences and outcomes. It also shows how a gender equity approach has been used by international bodies and other national governments to maximise the effectiveness of investment in health services.

Section 6 proposes five key criteria to be used in the development of a new national women's health policy, namely:

- using a social model of health
- incorporating a diversity analysis to ensure that the needs of all groups in the community, including Aboriginal and Torres Strait Islander women, are taken into account
- developing priority areas for women's health (outlined in Section 7)
- the benefits of adopting a gendered approach to the already agreed national health priorities
- using an inclusive and accountable process for further development and implementation of the new women's health policy.

Section 7 outlines five priority areas for a new national women's health policy. This is likely to be a contested area as there are always calls for different aspects of health to be prioritised. However we propose that the following broad areas are made priorities in the first iteration of the new national women's health policy:

- women's economic health and wellbeing
- women's mental health and wellbeing
- preventing violence against women (in all its forms)
- women's sexual and reproductive health
- improving women's access to publicly funded and financially accessible health services.

Importantly all of these issues should be tackled from within the perspective of a diversity analysis, meaning that all women within the community are adequately catered for and their particular needs appropriately addressed. This means a specific focus within each priority on:

- Aboriginal and Torres Strait Islander women and the particular issues they face around accessing health services and life expectancy
- women living in rural and remote communities
- women from culturally and linguistically diverse backgrounds
- older women in our rapidly ageing population
- health needs of young women and girls
- women with disabilities
- lesbian, bisexual, transgender and intersex women
- recently arrived migrants and refugee women
- mothers and women with other caring responsibilities
- women from disadvantaged socio-economic backgrounds.

Finally, the [Appendices](#) contain background information about international developments in women's health policy and a more detailed record of the way in which the first National Women's Health Policy was developed. They also contain an overview of how women's health policy and programs have more recently been delivered through the Public Health Outcomes Framework Agreements (PHOFAs) negotiated between the Australian and state and territory governments.

This paper represents AWHN's position on the goals, objectives and priorities that should inform the new national women's health policy framework, as well as a process by which these can be delivered. AWHN intends to make this paper widely available to all key stakeholders, and work with the Australian Government to help bring its vision for women's health to life. We also look forward to working with other organisations and individuals who have a similar commitment to improving women's health outcomes, and all the other benefits that will flow from achieving this critical goal.

Understanding why women's health matters

Women are different from men and experience life differently, both in sickness and in health. Throughout their lives, from childhood to old age, women will have different health experiences and outcomes based on both biological factors and gender roles.

As well as the obvious anatomical differences, other differences include genetic, hormonal, psychological and social factors. In responding to women's health issues it is important that these differences are recognised and acknowledged, without overshadowing or dismissing the commonalities women share with men. Similarly, many aspects of men's health could be improved by considering their gendered roles in society.

There are some conditions that affect more women than men such as arthritis, major depression, osteoporosis, eating disorders and the health impacts of all forms of violence. There are also some conditions that affect women differently than they affect men. Heart attacks and HIV/AIDS are two of the more serious conditions that doctors sometimes overlook in women because the signs and symptoms look different than they do in men.

In addition, there are some conditions related to reproductive health that will only affect women, such as pregnancy, childbirth and menopause. However women's reproductive health issues represent just some of their health concerns. As will be detailed throughout this paper, there are many other health issues related to their productive roles (as workers, carers, active community members, etc) and their gendered roles that are just as critical to address.

Better outcomes in women's health and wellbeing have benefits for the individuals and their families, and for the broader community. Flow on benefits are extensive and include greater participation and productivity by women in the paid and unpaid workforce, and less demand for high cost health services to be funded by government.

As highlighted in the South Australian Women's Health Policy (Government of South Australia, 2005) 'women are the majority of health consumers, the majority of health service providers and the majority of carers. Improving the health of **all women** will improve the health of the whole community.'

These better health outcomes can only be reached by having a health policy that is approached from a gendered and whole of government perspective—one which responds to the broad range of economic, social and cultural factors that impact on health outcomes for women.



“Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical wellbeing and is determined by the social, political and economic context of their lives, as well as by biology.”

UN Platform for Action
(Para. 89), Beijing, 1995

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Building on the first Australian National Women's Health Policy

In Australia we are lucky to already have a strong framework for addressing women's health that could be used to build a refreshed and strengthened vision for the future. Australia's *National Women's Health Policy*, adopted in 1989 (Commonwealth Department of Health, Housing, Local Government and Community Services, 1993), led the world in delivering a health policy that responded to the specific needs and issues facing women. It was very progressive in adopting a social model of health that went beyond the dominant biomedical model of health and acknowledged that social, environmental, economic, biological and gender factors all influenced health outcomes. It was also highly effective because it was supported by a National Women's Health Program with clear implementation strategies and special purpose funding.

This paradigm shift from a biomedical to a social model of health was influenced by new thinking at the national and international level (through the World Health Organization and other bodies) and driven by women's health organisations and advocates. It also reflected the significant involvement of women and women's organisations in the extensive consultation processes that were undertaken by government.

The National Women's Health Policy (NWHP) was developed following calls for action at the 1985 National Women's Health Conference. In response, a commitment was made by the Australian Government to pursue a national approach and consultation occurred with more than one million Australian women. The policy provided both a framework and action plan to improve the health of women in Australia to the year 2000. Its focus was on those women considered most at risk, and to encourage the health system to be more responsive to the needs of women.

Unfortunately the specific issues so important to Aboriginal and Torres Strait Islander women's health were left to one side because a separate inquiry into the health of Indigenous people was being undertaken around the same time.

Principles underlying the National Women's Health Policy were:

- an understanding of health within a social context, as emphasised by the World Health Organization and endorsed by the Australian Government, recognising that:
 - health is determined by a broad range of social, environmental, economic and biological factors
 - differences in health status and health outcomes are linked to gender, age, socioeconomic status, ethnicity, disability, location and environment
 - health promotion, disease prevention, equity of access to appropriate and affordable services, and strengthening the primary health care system are necessary, along with high quality illness treatment services
 - information, consultation and community development are important elements of the health process

- the need to encompass all of a woman's lifespan, and reflect women's various roles in Australian society, not just their reproductive role
- the need to promote greater participation by women in decision making about health services and health policy, as both consumers and providers
- recognising women's rights, as health care consumers, to be treated with dignity in an environment which provides for privacy, informed consent and confidentiality
- acknowledging that informed decisions about health and health care require accessible information which is appropriately targeted for different socioeconomic, educational and cultural groups
- the importance of using accurate data and research concerning women's health, women's views about health, and strategies which most effectively address women's health needs.

The Australian Government and all state and territory governments became signatories to the policy and committed funding to establish the National Women's Health Program. In the first four years of the program, it was agreed to tackle seven priority health issues for women:

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

In implementing the policy, there were five key action areas identified as necessary within the health care system to improve women's health, and to be delivered through the Commonwealth-State agreed National Women's Health Program. These were:

- improvements in health services for women, based on a dual approach which meant the provision of more women's health services, and complementary improvements to existing general health services
- provision of health information for women, in both the prevention and treatment of health problems
- research and data collection on women's health (which led to the establishment of the Longitudinal Women's Health Study)
- women's participation in decision making on health, at government and community levels, and as consumers of health services
- training of health care providers, at both undergraduate and postgraduate levels, around women's health care needs.

A review of the first four year program led to it being renewed for a further four years (1993–97). Another evaluation in 1997 (unpublished) concluded that the program had been highly effective and highly valued by the women who used its services. However with the introduction of the new Public Health Outcomes Framework Agreements (PHOFAs) in 1997, the specific focus on women's health policy at the national level was lost (see Appendix B for details on history of the policy and current arrangements).

On a more positive note, in reviewing the 1989 NWHP today, it is clear that many of its goals and principles remain highly relevant in 2008 and beyond.

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Current status of women in Australia

Many Australian women are undoubtedly experiencing higher levels of economic prosperity, educational attainment and good health than in previous decades, and certainly in comparison to women in developing countries. However there are still many women living in poverty, subsisting on inadequate pensions, trapped in under-employment or low income occupations and experiencing poor health outcomes. The following statistics are compiled primarily from the *Women in Australia 2007* report (Australian Government Office for Women, 2007), and represent some of the key social, economic and health issues faced by women.

Population — *women live longer than men*

- As at June 2006 women numbered 10,348,070 and comprised 50.2 per cent of the population (ABS 2006, Cat. No. 3101.0).
- Women on average live 4.8 years longer than men, and by the age of 85 years, women outnumber men two to one (ABS 2005, Cat. No. 3302.0).
- On average, Aboriginal and Torres Strait Islander women die much younger, with the life expectancy of Aboriginal and Torres Strait Islander women 64.8 compared to 83.3 years for non-Indigenous women (ABS 2005, Cat. No. 3302.0).

Economic security — *women are less economically secure*

- In December 2006 nearly 58 per cent of women were in the paid labour force compared with 72 per cent of men (ABS 2006, Cat. No. 6202.0.55.001 Table 2).
- Between November 1996 and November 2006, full-time ordinary time earnings for women increased by 18.8 per cent in real terms—however at the end of 2006 the ratio of female to male full-time earnings showed a gender earnings gap of 16 per cent (ABS 2006, Cat. No. 6302.0).
- Women's average weekly full-time earnings are \$941 compared to \$1125 for men (a gap of \$184 per week), and average earnings for all women (including part-time) was \$666 per week (ABS 2006, Cat. No. 6302.0).
- Women are less likely than men to have superannuation, and women have lower superannuation balances than men across all age groups, particularly those women working part-time or not in the labour force (Clare, 2004).

- As at June 2004, there were nearly 2.6 million women in receipt of income support payments (compared to 1.8 million men) with Age Pension, Parenting Payments and Partner Allowances being predominantly paid to women (Australian Government Department of Families, Community Services and Indigenous Affairs, 2004).

Women as mothers and carers — *women maintain the primary caring role*

- In 2005 the fertility rate was 1.81 babies per woman, the highest rate since 1995 (ABS 2005, Cat. No. 3301.0).
- Women are continuing to delay childbearing with the greatest fertility rates now in the 30-34 year range, while for Aboriginal and Torres Strait Islander women the greatest fertility rates are for women under 30 years (ABS 2005, Cat. No. 3301.0).
- Women continue to do the majority of housework and child care (ABS 1997, Cat. No. 4153.0).
- More women than men care for the elderly and people with a disability (ABS 2003, Cat. No. 4430.0).
- The majority of one-parent families (83 per cent) were headed by single mothers (ABS 2003, Cat. No. 4442.0).

Violence against women — *a debilitating and costly problem in all communities*

- Violence against women of all ages takes many forms including physical and sexual assault, as well as emotional, psychological and financial abuse.
- A 2004 survey on violence against women found that one in ten Australian women had experienced physical and/or sexual harm during the previous 12 months (Mouzos & Makkai, 2004).
- Domestic violence is the leading contributor to death, disability and illness in Victorian women under the age of 45 years (VicHealth, 2004).
- Aboriginal and Torres Strait Islander women are around three times more likely to experience physical violence or sexual assault than non-Indigenous women (Mouzos & Makkai, 2004).
- Non-heterosexual women have been found to experience at least double the incidence of abuse during their lifetime than heterosexual women (McNair et al 2005).
- In 2002–03 it was estimated that domestic violence cost the Australian economy \$8 billion each year (VicHealth, 2004).
- While the 2005 ABS Personal Safety Survey showed a decrease in the reporting rate of violence for all women, there was an increase in reports from women aged 45 years and over (ABS 2005, Cat. No. 4906.0, Table 6).
- Rates of reporting to police remain low, with only 18 per cent of sexual assaults and 33 per cent of physical violence being reported (ABS 2005, Cat. No. 4906.0).
- In 2003–04, 75 per cent of female homicides were at the hands of their partner or another family member (Mouzos, 2005).

Women's health outcomes — *divergent issues and outcomes*

- Based on self-reporting surveys, the majority of women report being healthy but nearly twice as many Aboriginal and Torres Strait Islander people report only fair or poor health (ABS National Health Survey 2004–2005, Cat. No. 4364.0).
- However nearly four in five women suffer from at least one long term ill-health condition, with women experiencing higher prevalence asthma, hypertensive disease, chronic sinusitis and arthritis than men (ABS Cat. No. 4364.0).
- As women live longer, they experience more chronic disorders, requiring higher service use and they are far less likely to have a partner carer in their declining years.
- Women are less likely to report alcohol and drug problems than men, but 1.5 times more likely to report anxiety-related and mood (affective) problems (ABS Cat. No. 4364.0, Table 4).
- Women are 1.5 times more likely to report high levels of psychological distress than men, but lower rates of low level distress (ABS Cat. No. 4364.0, Table 14).
- Heart diseases, stroke, dementia and breast cancer are the leading causes of death for women (AIHW 2006b, Table 2.19).
- Breast cancer continues to be the most common type of cancer in women. It is projected that the incidence of breast cancer will continue to increase to nearly 15,000 women by 2011, yet the survival rates for both breast cancer and cervical cancer are improving (AIHW 2006a).
- The most common health risk factor for women is inadequate fruit and vegetable consumption (84 per cent), followed by excess weight (45 per cent) and lack of physical activity (33 per cent) (AIHW 2006b, Table 3.7).
- Since 1995, nearly twice as many women engaged in risky levels of alcohol consumption, while smoking rates remain relatively stable (ABS National Health Survey 2004–05, Cat. No. 4364.0).
- More young women are engaging in early sexual intercourse, with nearly one quarter of year 10 girls reporting involvement in sexual intercourse (Smith et al 2003).
- Chlamydia is the most frequently reported sexually transmitted infection, with an increase of more than 400 per cent over the last decade (National Centre in HIV Epidemiology and Clinical Research 2006). It is thought that genital warts and genital herpes are more common, but these are not notifiable diseases (AIHW 2006, Cat. No. AUS73).
- In 2003 there were 84,218 reported induced abortions, with the highest incidence in the 20–24 age group (21,826), and the lowest in girls under 15 years (306) and women over 44 years (498) (Grayson et al, 2005). However abortion rates have steadily declined since 1996 (Chan & Sage 2005).
- Around 95 per cent of women at risk of unplanned pregnancy reported using some form of contraception (Richters et al 2003), however sexually active school age girls were less likely to report using a condom than were a similar cohort in 1997 (Smith et al 2003).

Gender as one of the social determinants of health

5.1 Gender v sex differences

Over the past few decades, there has been growing evidence of the relationship between gender and health, and an improved understanding of gender as an important determinant of health and wellbeing. The recently published report for the World Health Organization Commission on Social Determinants of Health, 'Unequal, unfair, ineffective and inefficient: gender equity in health—why it exists and how we can change it' provides an excellent outline of the evidence and extent of ongoing gender inequity in the health sphere internationally (Sen and Ostlin, 2007). It highlights that the resultant outcomes for both women and men are not only unequal and unjust, but they are also ineffective and inefficient and need to be tackled at both a government and community level.

Although the importance of gender to health outcomes is now widely accepted in many contexts, this concept remains absent from both policies and practices in many health settings, and is still often confused with sex differences. Disaggregating data by sex is an initial step in demonstrating the different ratios of men and women. It is then necessary to include a gender analysis to help understand what the different rates for health issues by sex means.

The World Health Organization provides the following definition:

Gender is used to describe those characteristics of women and men which are socially constructed, while sex refers to those which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles (World Health Organization, 2002a).

An example of these gender based behaviours is the increasing uptake of smoking among young women since smoking became 'acceptable' for women in the second half of the 20th century (Broom, 2006), with the resultant increase in the incidence of lung cancer among this group. There is also a strong link between smoking and socio-economic status, which again requires some gender-based analysis given the high levels of women-headed low income households.

As outlined in the 1989 National Women's Health Policy and many subsequent women's health plans both in Australia and internationally, it is important that gender is included as one of the many interactive factors that contribute to an individual's health status. Internationally, G8 leaders have made a particular call for a 'gender-sensitive response' and to ensure that 'greater attention and appropriate resources are allocated [to] the needs of women and girls.' Other leaders in the health area have gone so far as to say that 'the single most important issue on the face of the planet is gender equality' (Lewis, 2007).

It is equally important that processes for incorporating knowledge and awareness of gender issues are built into the policy making and planning for all human services, not just within mainstream health service systems and women-specific health services.



'Gender relations are present at every part of the health and disease pathway, and so gender needs to be considered at every stage of health promotion, disease prevention, health care and palliative care.'

Dr. Robert Hall, Director Public Health and Chief Health Officer, Victoria, 2006

5.2 Benefits of a gender equity approach

Gender equity is concerned with fairness and justness and recognises that men and women have different life experiences, different needs, and different levels of power and access to decision-making (NSW Health, 2000). It is therefore necessary to include the concept of gender equity in any policy analysis to achieve a clearer understanding of the determinants contributing to any given condition. Ideally this would happen across all government policy areas.

The specific benefits of adopting a gender perspective in health policy, as identified by the World Health Organization European Region (WHO, 1999 p.32), include that it:

- recognises the need for the full participation of women and men in decision-making
- gives equal weight to the knowledge, values and experiences of women and men
- ensures that both women and men identify their health needs and priorities, and acknowledges that certain health problems are unique to, or have more serious implications, for men and women
- leads to a better understanding of the causes of ill-health
- results in more effective interventions to improve health
- contributes to the attainment of greater equity in health and health care.

Gender analysis in health often highlights how inequalities disadvantage women's health, the constraints women face in attaining optimal health and ways to address and overcome these constraints (WHO, 2002a). Such a tool can be used to help distinguish the differences between women and men, the nature of their social relationships, their different social realities, life expectations and economic circumstances.

Using this approach, it is possible to identify a range of health issues that affect women only, some that are more common in women than men, and special conditions that are related directly to gender roles (Komaseroff, 2001, p12–16):

Some health issues that affect women only	Some health issues more common in women	Special conditions related to gender roles
■ menstruation	■ breast cancer	■ sexual abuse
■ pregnancy	■ heart disease	■ domestic violence
■ complications of pregnancy	■ osteoporosis	■ effects of prostitution
■ menopause	■ depression	■ anorexia/bulimia nervosa
■ gynaecological cancers	■ hypertension	■ conditions related to poverty, particularly in older women or as a result of women's role as carers
■ polycystic ovarian syndrome	■ arthritis	
■ endometriosis		

Similarly for men, there is a range of health issues that only affect them (such as prostate cancer), that are more common to men (alcohol use, lung cancer, pulmonary disease, hearing loss) and that are related to gender roles (stress related to overwork, lack of social connectedness, suicide).

The Canadian Government has taken this gendered approach to policies and programs even further by developing and mandating the use of 'gender-based analysis' as a tool for assessing the effects of gender on health and healthcare (Health Canada, 1999). Adopting a formal gender analysis tool such as this in Australia would help to ensure that health interventions are more effectively targeted at important health issues for women and can also inform the development of a new national women's health agenda.

A new national women's health policy



We are rapidly heading toward the year 2009 which will mark the 20th anniversary of the first National Women's Health Policy and Program. This is also the year in which the current Public Health Outcomes Framework Agreements (PHOFAs) are due to expire which currently fund a range of women-specific health programs.

Therefore the next 12 months represent an excellent opportunity for all stakeholders to review the achievements of women's health initiatives to date, and work collaboratively to develop a new way forward for national policy addressing women's health and wellbeing.

The following criteria are proposed as a starting point for the development of a new and effective national women's health policy for all Australian women:

- 1 That it is based on the **social model of health** outlined in the 1989 Women's Health Policy, and incorporates a specific focus on gender as one of the social determinants of health. (See Section 6.1).
- 2 That it includes a **diversity analysis** that considers factors such as Aboriginality, ethnicity and cultural diversity, geographic isolation, motherhood and work/family responsibilities, age and ageing, level of ability, and sexual orientation. (See Section 6.2).
- 3 That **women's health priority areas**, based on consultation and further analysis of current health indicators, are specified (See Section 7) with an initial set of priorities suggested as:
 - women's economic health and wellbeing
 - women's mental health and wellbeing
 - prevention of violence against women
 - women's sexual and reproductive health
 - access to publicly funded health services.
- 4 That a gendered approach is incorporated into planning and implementation of initiatives under **the agreed national health priorities**. (See Section 6.3).
- 5 That the policy is developed and implemented through an **inclusive and accountable process**, in collaboration with all stakeholders and in a transparent manner. (See Section 6.4).

6.1 Social model of health

As outlined in the principles for the first National Women's Health Policy (see Section 2 of this paper), a social model of health is considered essential in order to deal with women's health and wellbeing in a comprehensive and coordinated framework.

In a social model of health, importance is placed on understanding and reflecting the broader environment in which a woman lives—her family, community, workplace—and her ability to access health care services and other service systems. As explained in the NSW Women's Health Outcomes Framework (NSW Health Department, 2002), use of the social model of health:

'demonstrates that a broad range of environmental, socioeconomic, psychological, and biological factors impact on health and that, to large extent, it is the settings, conditions and experiences of every day life that determine good or poor health outcomes for women at all ages.'

The Canadian Women's Health Strategy developed a list of 12 social determinants including gender for their framework (Health Canada, 1999):

- income and social status
- employment status
- education
- social environment (including social support and social exclusion)
- physical environment (including access to food, housing and transport)
- healthy child development
- personal health practices and coping skills
- health services
- social support networks
- biology and genetic endowment
- gender
- culture.

A health determinants approach such as this could be adapted specifically for the Australian situation to identify appropriate responses both within the mainstream health care system and within specialist women's health services. Other items such as 'freedom from discrimination' could be added, given the importance of this issue for all women but particularly for women from marginalised groups within the community. Such a framework could also be used to identify and respond more appropriately to specific men's health priorities.

6.2 Diversity of Women

It must also be recognised that within the diversity of women that make up the Australian population, there are some that face even greater disadvantage when it comes to health outcomes. These include:

- Aboriginal and Torres Strait Islander women
- Women in rural and remote areas
- Women of culturally and linguistically diverse backgrounds, including refugees
- Women with disabilities
- Older women
- Women and girls as carers (both of children and elderly relatives)
- Lesbians, bisexual women, transgender and intersex people.

In response to the specific health needs of these groups, it is proposed that in addition to a gender analysis framework, a diversity analysis is overlaid that considers factors such as race, ethnicity, geographic isolation, work/family responsibilities, age, level of ability, and sexual orientation.

6.3 Starting with a gendered approach to the National Health Priorities

As a starting point to a new gendered approach to health policy and service delivery, all governments and service providers should ensure that the agreed National Health Priorities set by the Australian and state/territory governments are considered from a gendered perspective. While it is acknowledged that some states/territories have gendered initiatives in some of these areas, it is important that this is done consistently on a national level to ensure equitable service delivery and outcomes for women. Currently national priorities are identified as (Commonwealth Department of Health and Ageing, 2006):

- asthma
- cardiovascular disease
- cancer
- diabetes mellitus
- injuries and poisoning (including suicide)
- mental health problems
- arthritis and musculo-skeletal problems.

These priority areas account for 75 per cent of the national burden of disease and are critical in directing health funding for research and service provision. Many of these diseases and conditions have differential rates for men and women and contain gendered perspectives that should be acknowledged and addressed within a women's health policy, and within broader health frameworks such as the National Mental Health Plan and the National Oral Health Plan.

As a starting point for implementing a gender-based analysis of all health policy, these National Health Priorities should be subjected to a gender analysis to ensure that existing approaches are most effectively targeting and treating women and men. The Victorian Gendered Data Directory developed by Women's Health Victoria (released in July 2004 and revised 2008) could be used as the basis for a national directory to present data sources for a wide range of health indicators.

6.4 An inclusive and accountable process

One of the greatest successes of the first National Women's Health Policy was its foundation in consultation and collaboration between policy makers, service providers, advocacy groups, and women as health consumers.

It is considered essential that the new policy is both developed and implemented through similarly consultative and collaborative processes. In order to achieve this, it is proposed that the following criteria and commitments drive work around the development of a new policy and its agreed priority areas:

- that Australian, state and territory governments be asked to provide leadership and commit to supporting the development of this policy, through involvement of their health ministers and ministers for women's affairs
- that the process of developing a new national women's health policy is adequately resourced—to allow for consultations, development and distribution of background materials, and involvement of all stakeholders (including women identified in the diversity framework)
- that a 'Women's Health and Gendered Health' section be established within the Commonwealth Department of Health and Ageing to support the development and implementation of women's health priority initiatives including preventative and self-help activities
- that AWHN as the national peak body for women's health should be federally-funded, with key functions to include: advice to government on the development and implementation of policy affecting women's health, advocacy for women's health and health promotion, provision of a forum for the exchange of information relating to women's health and capacity to undertake action research and special projects as required
- that the new policy is linked to a funded National Women's Health Program, with outcomes based funding processes established for each aspect of the new policy, including annual reports on progress and performance against agreed key indicators under each of the priority areas
- that state and territory women's health plans be developed in line with the National Women's Health Policy priorities and directions, with appropriate advisory and reporting mechanisms established at the state/territory level
- that the National Women's Health Policy be actively linked with other national health priority areas (including the National Mental Health Plan, the National Health and Medical Research Council agenda, and the National Health Priorities)
- that improving women's health and wellbeing is promoted at cabinet level within government as a critical factor in other relevant national policy areas (such as social inclusion, welfare reform, taxation and superannuation policy, industrial relations, housing assistance, Aboriginal and Torres Strait Islander affairs, foreign affairs policy, etc)
- that a clear evaluation and program development framework be devised to ensure transparent and rigorous evaluation of the policy, with a commitment to evaluation processes being undertaken in a timely manner and ongoing program development occurring to ensure the policy remains timely and relevant.

Key women's health priority areas

The following five key women's health areas have been proposed as priorities for action under the new national women's health policy, based on evidence of current health and wellbeing outcomes and recent sector consultations undertaken by the Australian Women's Health Network:

- women's economic health and wellbeing
- women's mental health and wellbeing
- prevention of violence against women
- women's sexual and reproductive health
- access to publicly funded health services.

In addition to funding programs and initiatives in these priority areas, there should also be a commitment to fund further research in each of these priority areas to continue the development of evidence-based health policy, particularly research evaluating the translation of evidence into practice.

Key elements to be considered in the development of strategies for each of these priority areas are outlined below.

7.1 Women's economic health and wellbeing

A person's economic health and wellbeing has a major impact on their life chances, including their health outcomes. Unfortunately women continue to experience disadvantage on virtually every indicator of economic health and wellbeing, including their ability to financially support themselves through a longer life span than men and more years of disability. The reality of women's lives means that they typically:

- spend less time in the paid workforce
- need to take more time out from work to care for children and other family members
- face reduced job security through part-time and casual work, and therefore fewer career opportunities
- face sexism, racism and homophobia in the workplace in many instances
- are clustered in low income and low status occupations
- face longer time at the end of their working/caring life with fewer savings and resources, including significantly lower superannuation savings and lower levels of home ownership.

Many studies have provided evidence of the link between socioeconomic status and health status, with those from lower socioeconomic backgrounds having higher rates of mortality and morbidity. The statistics provided in Section 4 outlined some of the key areas where

women's economic security is compromised. These and other issues that act as barriers to women's greater economic health and wellbeing need to be addressed through:

- eliminating gender pay gaps
- addressing the chronic problems faced by women, particularly women-headed households, in accessing affordable and secure housing
- developing more family friendly workplace conditions (including introduction of a universal paid maternity leave scheme)
- increasing levels of secure part time work as opposed to casual employment
- reviewing the financially punitive policy approach to membership of private health insurance, with higher fees for those who join later in life
- removing inequities in retirement savings and superannuation schemes
- ensuring that sole-parent households (which are predominantly headed by women) have adequate child care and other supports to enable them to undertake education, training and employment.

A good place to start for eliminating gender pay gaps would be in the health care sector, where women medical graduates earn only 89.1 per cent of male earnings (Graduate Careers Australia, 2006) and hold less than 30 per cent of specialist medical practitioner positions (Australian Government Office for Women, 2007). In contrast, women make up 99 per cent of dental assistants and over 90 per cent of all nursing positions (AIHW 2006, p.323).

Until women's economic wellbeing is seriously addressed, it will continue to compromise their general health and wellbeing and their status in the remainder of the identified health priority areas.

7.2 Women's mental health and wellbeing

Mental health and mental illness are determined by multiple and interacting social, psychological and biological factors. Indicators of risk include poverty, low levels of education, all forms of discrimination, experience of torture and trauma, poor housing and social exclusion. Women as a group experience high levels of all these risk factors. There is also a direct link between women's mental health and their experiences of significant levels of violence.

Socially constructed gender roles, when interacting with biological differences, have been found to contribute to mental health problems and help seeking behaviours. They also have a strong influence on responses provided by the health sector (WHO, 2002b).

Mental health problems and illnesses include short term anxiety and depression (more commonly reported by women) as well as a range of longer term conditions. Women more commonly report experiencing very high levels of psychological distress and higher levels of psychiatric disabling conditions than men (AIHW, 2006, p.99).

Dementia is a major health problem for older women largely as a result of an ageing population and women living to an older average age than men. In Victoria it is projected that by 2016 dementia may take over as the greatest cause of ill health for women (DHS 2002, p.10).

Women are also more prone to depressive disorders, with population studies showing that women are twice as likely as men to experience depression (Andrews et al, 1999). Depression is the most prevalent mental health problem among women and is likely to be accompanied by other psychological disorders. The higher incidence and prevalence rates of depression for women are experienced particularly by same-sex attracted women (Hillier et al, 2005), and through the childbearing years by women in domestic partnerships—by

contrast married men experience better mental health than married women (Andrews et al 1999, Jorm 1997).

The severity of depression as an illness for women can be demonstrated by the following evidence (Rice & Tsianakis, 2004):

- ten to fifteen per cent of women suffer a major depressive episode shortly after childbirth
- one in four women and one in six men in Australia will experience depression at some time in their lives
- women with depression are significantly more likely to be prescribed anti-depressant drugs than men with the same diagnosis
- despite women being diagnosed with depression at a higher rate, it is not necessarily the case that depression in women is well recognised by doctors, family and friends.

Despite these overwhelming statistics, it is concerning that there is no gender analysis or response within the current National Mental Health Plan.

With mental health attracting significant new funding by the Australian Government in recent years, it is important that state contributions and future policy directions take into account the gendered nature of mental and emotional health so that more appropriate services and responses are provided.

7.3 Preventing violence against women

Violence against women takes many forms including physical, sexual, financial, emotional and psychological abuse. It also affects women from all cultural and socio-economic backgrounds.

Violence has been found to be the leading contributor to death, disability and illness in Victorian women aged 15 to 44, being responsible for more of the disease burden than many commonly accepted preventable risk factors such as high blood pressure, smoking and obesity (VicHealth, 2004). However older women also face high levels of family violence and elder abuse.

While the VicHealth study was conducted in Victoria, it is widely considered to be indicative of the scope and size of the problem in other parts of Australia, with women in Aboriginal and Torres Strait Islander communities facing even higher levels of violence. This report also found broad consensus internationally that intimate partner violence is best addressed in the context of human rights, legal and health frameworks and through the development of multi-level strategies across sectors.

As well as the high personal costs of experiencing violence, Access Economics has undertaken a study on the economic and social costs of family violence, and estimate that it costs the Australian economy around \$8 billion per year (Access Economics 2004). With one in four women affected by intimate partner violence, the health costs are already enormous. Family violence is also the leading cause of family homelessness in Australia, with half of the people using homelessness services being parents with children (AFHO 2006). Most importantly, family violence is to a large degree preventable with more effective community education, tougher policing and a range of other preventative approaches that have proven to be successful.

Other forms of violence such as sexual assault, carer abuse, elder abuse, pornography, and trafficking of women for sex are also preventable with adequate commitment and resources.

As part of the previous government's Partnerships Against Domestic Violence (PADV) initiative, there was a wide range of research and demonstration projects undertaken across Australia. However it is widely accepted that what is now needed is an integrated prevention and crisis response program, comprehensively funded to adequately address the unacceptably high levels of violence against women occurring throughout all communities. There is little hope that future generations of women will experience any better outcomes when it comes to physical, sexual, financial and emotional abuse when resources are not routinely allocated at the local community level to undertake comprehensive prevention and education strategies. Currently the existing women's refuge crisis service remains overwhelmed with demand. In addition, there is very limited access to services for women without children, Aboriginal women, women with disability, older women, women in rural and remote communities, and women facing violence in same-sex relationships.

Women's health services are already working in a range of ways to prevent violence against women (WHAV, 2006). Current and recent initiatives in primary prevention, early intervention for those at risk, and intervention for victims and survivors of violence have been undertaken in the following areas:

- research, monitoring and evaluation
- organisational development
- community strengthening
- communications/social marketing
- advocacy
- legislative and policy reform.

If the unacceptably high levels of violence against women are to be adequately addressed, it is clear that the current responses need a coordinated governmental effort along with additional resources and greater commitment from all parts of the community.

7.4 Women's sexual and reproductive health

Sexual and reproductive health is a fundamental issue for all women, affecting them at every life stage. It affects women's control over their own bodies, through access to safe and appropriate health services and information, and remains a central priority of women and the women's health movement.

Linked to this are the additional health issues related to motherhood, affecting 87 per cent of all Australian women (Weston 2004). These include breastfeeding problems, post-partum depression, mental health problems, incontinence, backache, amongst many others (Rowe, Amir & Fisher 2007). Another important and growing issue is the medical impact of the use of fertility treatments by women, which is being impacted by delayed parenting, conditions of both male and female infertility, and a range of other social and lifestyle factors (Labett 2006). High rates of caesarean sections and the prevalence of endometriosis and polycystic ovarian syndrome within the Australian community also need to be addressed.

In the absence of improved sexual and reproductive health information and accessible publicly funded health services (particularly for pregnancy termination services), we are putting the future health and fertility of all young people at risk.

The current development of a new National Sexual Health Strategy should go a significant way to addressing these issues, and must be closely linked with the new women's health policy.

Currently Australia has unacceptably high levels of sexual and reproductive ill-health, demonstrated by the following statistics compiled by the Public Health Association of Australia (PHAA, 2007):

- higher rates of early sexual activity among young people have increased the risk of unplanned pregnancy and sexually transmissible infections
- high rates of sexual violence (19.1 per cent of women and 5.5 per cent of men have experienced sexual violence of some kind)
- increasing rates of chlamydia and newly acquired HIV infections
- inadequate access to safe and effective contraceptive education and methods
- unacceptably high levels of teenage pregnancy compared to other developed countries (18.4 births per 1000 women aged 15–19 years)
- high estimated abortion rates (19.7 per 1000 females aged 15–44 years in Australia) compared with other countries (e.g. Germany 7.7, The Netherlands 8.7 and Finland 10.9)
- high rates of infertility (1 in 6 couples).

Many of the problems associated with these statistics are compounded by the failure to address sexual and reproductive health policies and programs in Australia in a coordinated and consistent manner. Currently there are significant differences in the legislation of various states and territories (including the inclusion of termination services in the Criminal codes of several jurisdictions), and a high level of variability and inconsistency in the sexual health and sexuality education provided to young people across the country.

In addition, there are culturally specific issues such as Female Genital Mutilation (FGM). Key stakeholders linked to the existing FGM program report that there has been a ten-fold increase in demand on services since it started in 1995–96 with no commensurate funding increases. The program has also faced changing needs from within different communities of newly arrived refugees and migrants, varying legal interpretations across jurisdictions, and problems with developing a nationally consistent approach to education and prevention activities. Such issues need to be addressed at a national level, ensuring consistency in policy and service responses for those women affected.

7.5 Improving women's access to publicly-funded and financially-accessible health services

It is widely acknowledged that access to affordable, appropriate and high quality health services are critical in both prevention and early treatment of disease and illness. As outlined above, women use health services in a way which is different to men and experience a range of health problems that are driven by either biological or gender-based differences. While all health services are required to ensure that they provide non-discriminatory services and access to women, it is clear that there are still a range of barriers encountered, many of which are entrenched within the health system.

Some of the existing and continuing barriers faced by women in accessing appropriate and affordable health care services include:

- reduced access to bulk-billing practitioners in many parts of Australia
- particular barriers for women in rural and remote areas, with doctor shortages only exacerbating an existing lack of women-specific health services (Alston et al, 2006)
- an expressed preference for treatment by female doctors cannot always be met, due to the under-representation of women in general practice and across all specialist areas, particularly in rural and remote regions
- limited availability of choice in birthing options, in particular continuity of care with a known midwife and better access to the option of homebirths
- the relative socioeconomic disadvantage of many women means they are unable to afford private health insurance or high out-of-pocket costs for medications or treatment
- limited transport options in many communities
- women use services more throughout a longer span of their lives, and when they are well (e.g. contraception and pregnancy)
- the unacceptably low levels of access to culturally appropriate health care services for Aboriginal and Torres Strait Islander women, cultural minorities and certain ethnic groups, particularly in remote communities
- lack of gender sensitivity in the design of some diagnostic tests and treatments, such as coronary heart disease (Payne, 2006, p.60)
- problems of gender bias in medical research and curricula (Payne, 2006, p.62), where the male body is still treated as the 'norm' for trials and teaching purposes
- lack of sensitivity and understanding about the specific health care needs of certain groups of women (such as same sex attracted and transgender women, refugee women, women with disabilities and older women), including the failure to screen for and diagnose reproductive health problems (Payne, 2006, p.62).

While many parts of the mainstream health service system provide excellent access and services to women, there are still many areas where significant improvements are required. Women's health services in all states and territories play a key role in the development and implementation of accessible women's health policies and programs. They have developed into a trusted and important part of the broader health service system, providing women with the opportunity to seek health advice from other women and with a greater voice as health consumers.

Since the first National Women's Health Policy, there has been a concerted advocacy effort to ensure that women's health services are adequately funded and supported as a

complementary specialist service system alongside the mainstream health services. This 'dual track' approach has allowed the development of a strong network of women's health services across the country, contributing to improved primary health care and health education for women. However there are concerns in many parts of Australia about the sustainability of women's health services due to factors such as:

- significant population growth without an increase in funding
- an over-stretched public health system
- high and increasing costs associated with accessing the private system
- complexities resulting from social changes such as increased drug and alcohol use, increased levels of family violence and diagnosed mental health problems.

It is critical that this dual track approach of generalist and women's health services is funded at sustainable levels, based on changing populations and shifts in demand. It is also important that the knowledge and expertise of the women's health service system is expanded and incorporated into future strategies to achieve better health outcomes for Australian women, their families and communities.

International developments in women's health policy

1975 marked a turning point in the approach towards women's health, with the United Nations International Women's Year conference in Mexico establishing the move towards an equity model, rather than a traditional welfare/poverty approach, to women's health.

UNIFEM (United Nations Development Fund for Women) was established in 1984 to recognise the importance of gender equality in international development projects including many health initiatives, with the General Assembly instructing UNIFEM to 'ensure women's involvement in mainstream activities'.

In 1995 the landmark UN World Conference on Women (Beijing) officially adopted 'gender mainstreaming'—i.e. the application of gender perspectives to all legal and social norms and standards, policy development, research, planning, advocacy, development, implementation and monitoring.

The Beijing Platform for Action that resulted from this conference has helped drive women's health policy over the last decade, including an emphasis on health as a basic human right and the importance of women to be free from violence in order to maximise their health outcomes. A key statement from the conference was:

Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

1995 also marked the formal adoption of a 'gender and development' approach by the Commonwealth Heads of Government in Auckland which recognised that many inequalities were created by society, and therefore need to be rectified by society (UK Commonwealth Secretariat, 2002, p.5). It also recognised that both men and women needed to be involved in developing solutions to these gender based inequalities.

The UN Beijing +5 Women's Conference (2000) further strengthened the concept of gender mainstreaming in its resolutions. By adopting the Beijing Platform for Action, governments throughout the world—including Australia—effectively committed to effective integration of a gender perspective throughout all their policies, programs and service delivery. Their performance in delivering in each of these areas is subject to regular reviews, and Australia's performance is reliant on reporting by both Australian and state/territory governments.

Women's health policy in Australia (1985–2007)

APPENDIX B

Based on the AWHN Position Paper, June 2004, 'Women's Health under the Public Health Outcomes Funding Agreements', Australian Women's Health Network.

Development of the National Women's Health Policy 1989

The International Decade for Women, which ran from 1976 to 1985, raised many issues of particular concern to women across Australia, including their health status and the appropriateness of existing health care responses.

Following a national conference in 1985, the Australian Government agreed on the need for a specific focus on women's health. After an intensive development phase involving consultations with over one million women across Australia, the National Women's Health Policy (NWHP) was officially launched in April 1989. It was signed off by Australian, state and territory ministers and subsequently endorsed by both Liberal and Labor governments.

The goals of the policy were to improve the health and wellbeing of all women in Australia, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of women. The central premise of the NWHP is a social view of health, which recognises that social and environmental factors, as well as knowledge, attitudes and behaviours of individuals, determine the health of populations and of individuals. The NWHP received acclaim throughout the world as a far-reaching, forward-thinking response to the health needs of women.

The National Women's Health Program, a bilateral Australian–state/territory program, was established to implement the NWHP. Both levels of government provided matched dollar for dollar funding for the program. The success of the policy across Australia was largely due to this commitment of funding to implement its key platforms.

From the late 1980s through the 1990s the National Women's Health Program was responsible for funding an extensive network of women's health services and initiatives throughout Australia. In line with the NWHP, the focus of the program services and projects was on achieving equitable outcomes for women by addressing the social determinants and conditions that affect health, particularly for women in most need. In adopting an 'upstream' (early intervention/prevention) approach, the program was in many ways ahead of its time.

The subsequent very successful National HIV/AIDS Strategy built upon learnings from the women's health program. More recently, evidence based population health promotion strategies are replicating the community capacity building approach taken in the women's health program. There is a growing body of evidence to support this approach as a means to reduce the risk factors and strengthen the protective factors underlying morbidity and mortality.

1997–98 to 1998–99 Public Health Outcomes Funding Agreements (PHOFAs)

In 1997, the National Women's Health Program, Alternative Birthing Program and the Female Genital Mutilation Education and Prevention Program were all incorporated under the new Public Health Outcomes Funding Agreements (PHOFAs). These agreements were developed between the Australian Government and the state and territory governments. They effectively 'broad-banded' the previous specific purpose programs, giving states and territories greater flexibility regarding the use of federal funding.

The first PHOFA agreement between the Australian Government and the state and territory governments operated from 1997–98 to 1998–99. The stated aim was to improve *'the health and wellbeing of Australians through the enhanced delivery of public health activities and more flexible funding arrangements within the spirit of nationally agreed policies and strategies'*. *The Agreements were 'seen as part of a continuing development process to achieve shared public health objectives.'*

Under the first PHOFA agreements, it was stated that the Commonwealth and the states/territories would *'continue their commitment to implement agreed National Strategies'*, including the National Women's Health Policy. However this was somewhat undermined by the abolition of the Australian Health Ministers' Advisory Committee's (AHMAC) Subcommittee on Women and Health.

The agreements specified few performance measures, with those that were included being regarded as part of jurisdictional effort, but not intended to limit it.

1999–00 to 2003–04 PHOFA Agreement

The 1999–00 to 2003–04 PHOFA Agreements between the Commonwealth and the states/territories continued to cover agreed outcomes for a range of public health initiatives. These were delivered under the following eight 'broadbanded' funding categories:

- HIV/AIDS
- Women's health
- Alternative birthing
- Education on Female Genital Mutilation
- Breast screening
- Cervical screening
- Childhood immunisation
- Illegal drugs

In line with the overall goal, *'to improve the health and wellbeing of all women in Australia, with a focus on those most at risk, by improving the responsiveness of the health system to women's health needs, particularly those most at risk of poor health and wellbeing outcomes'* the agreements specified five outcomes:

- 1 Health departments maintain community based services for women, based on national health policies, principles and specific strategies in place to target at risk female populations.
- 2 Health departments foster partnerships/collaborative programs between gender specific health services and mainstream services based on national health policies or principles as they relate to women.

- 3 Health departments encourage midwife based birthing services to be established in the publicly funded health care system and for Aboriginal and Torres Strait Islander women.
- 4 Health departments work with communities to develop and implement information resources and programs to prevent occurrence of female genital mutilation and to minimise harm to those at risk or subjected to female genital mutilation.
- 5 Health departments take steps to decrease the proportion of Aboriginal and Torres Strait Islander newborns with birth weight <2500g, per 1000 live births.

In a review of the early years of the PHOFAs (1999–00 to 2001–02) it was found that there were both positive and negative aspects with regards to its women's health component. There was seen to be a need for women's health programs to be more directly linked to national health outcome trends and for the reporting and performance frameworks around women's health to be reviewed.

A better approach may be to identify an agreed set of common objectives... for nationally relevant health issues (eg antenatal care, smoking, interventions in the early lifecourse of women to address issues such as chronic disease prevention and avoidable pregnancy; lifecourse interventions targeting low SES women) which could be incorporated into broader (than current) outcome categories.

The review also pointed to need for national level strategic guidance for women's health and family planning, suggesting that the National Public Health Partnership could develop a much stronger role in this regard. *'The performance indicators highlight that an investment is required by both levels of government in this area.'*

The review recommended that: *'an investment in the development of priorities and better indicators [for women's health] is urgently required by both levels of government in this area.'*

The 2004–05 to 2008–09 PHOFAs

Contrary to the recommendations of the Review and its call for a strengthening of the national role with regard to women's health, the initial draft of the 2004–05 to 2008–09 PHOFAs left out any mention of the National Women's Health Program and only included a single indicator from the previous agreements—that relating to low birthweight Aboriginal babies.

The National Women's Health Program, the Alternative Birthing Program and the National Education Program on Female Genital Mutilation had effectively disappeared from the national agenda. However, after considerable lobbying by AWHN, by state and territory governments and others with an interest in women's health issues, the final agreements were reworded to include an indicator relating to 'availability/access to community based health services for women, including at-risk female populations'. This change committed jurisdictions to maintaining some focus on women's health. Concerns from stakeholders regarding the inclusion of this indicator within a broader category labelled 'health risk factors' fell on deaf ears.

Current approaches to women's health by jurisdiction

In addition to their reporting requirements against specific women's health initiatives under the PHOFAs, state and territory governments continue to develop a range of women's health policies and programs to respond to the needs of women in their own jurisdictions. The following table provides a list of current initiatives and emerging priorities of each jurisdiction.

Jurisdiction	Approach and Initiatives
Commonwealth	Some women's health program areas remain jointly funded under the Public Health Outcomes Framework Agreements (PHOFAs). The term of the current agreement is 2004–05 to 2008–09.
Victoria	Victorian Women's Health and Wellbeing Strategy (2006–2010)
New South Wales	Strategic Framework to Advance the Health of Women (2000). Currently developing a NSW Women's Health Strategic Implementation Plan (consultation paper due for release before June 2008)
Queensland	No specific current women's policy/strategy, however Queensland Health funds 11 women's health services through their PHOFA.
South Australia	South Australian Women's Health Policy (commenced 2005)
Western Australia	Domestic Violence initiative currently being developed.
Tasmania	Women's Health Program
Northern Territory	Women's Health Strategy
Australian Capital Territory	ACT Women's Plan and ACT Government Health Action Plan (2002) include commitments to address women's health.

Milestones in women's health in Australia

1896	Queen Victoria Memorial Hospital founded in Melbourne (one of three hospitals in the world founded, managed and run by women, for women)
1914	First baby health centre opened
1920s/30s	Growth of maternal and infant health programs
1970s	Family planning program established
1973	Women set up health centres, refuges and crisis centres in all states and territories. Some were later funded under the Commonwealth Community Health Program
1975	'United Nations International Year of Women' (followed by UN Decade for Women 1976–1985) First National Women's Health Conference, held in Brisbane Medibank introduced (Australia's first universal health insurance scheme)
1983	Medicare scheme introduced (revised from Medibank)
1985	Second Women's Health Conference passes the resolution: 'That a National Policy on Women's Health be developed consistent with the World Health Organization Global Strategy for Towards Health for All by the Year 2000'
1986	Consultation with over one million women on the national women's health agenda
1987	Appointment of a special adviser to the Health Minister to coordinate development of a health policy for women
1988	Launch of discussion paper 'Women's Health: a Framework for Change' (Feb, 1988)
1989	National Women's Health Policy endorsed by all Health Ministers, and National Women's Health Program launched
1991	Breastscreen Australia and National cervical screening program established
1993	Second National Women's Health Program commenced National Public Health Partnership launched, with women's health program funding broadbanded into the Public Health Outcomes Framework Agreements (PHOFA) between the Australian and state/territory governments
1999	Second PHOFA Agreements included the National Women's Health Program, Alternative Birthing Program, and Female Genital Mutilation Education and Prevention Program
2001	National Women's Health Conference calls for 'a renewed national women's health policy and program' Third PHOFA agreement further broadbands funding to include three 'overarching public health priority categories' to incorporate women's health priorities
2005	National Women's Health Conference agrees on the critical need to redevelop the National Women's Health Policy and Program.

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