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AUSTRALIAN WOMEN'S HEALTH NETWORK SUBMISSION

TO THE ENQUIRY INTO AUSTRALIA'S RESPONSE TO THE WHO COMMISSION ON THE SOCIAL DETERMINANTS OF HEALTH REPORT, "CLOSING THE GAP WITHIN A GENERATION".

BEING CONDUCTED BY

THE SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS

OCTOBER, 2012

Introduction

The Australian Women's Health Network (AWHN) welcomes the Senate's enquiry into Australia's response to the crucially important WHO report, *Closing the Gap within a Generation.* In raising discussion about Australia's response, an important opportunity to improve the health of Australians in a comprehensive, sustainable and innovative way is created. This inquiry represents a positive step towards strengthening our health structures and building an enabling environment for all Australians to live healthier lives.

AWHN is an advocacy organisation that provides a national voice on women's health, based on informed consultation with members. Through the application of a social view of health, it provides a woman-centred analysis of all models of health and medical care and research. It maintains that women's health is a key social and political issue and must be allocated adequate resources to make a real difference.

It aims to foster the development not only of women's health services but of stronger community-based primary health care services generally, which it sees as essential to improve population health outcomes. It advocates collaboration and partnership between relevant agencies on all issues affecting health. To this end, AWHN coordinates the sharing of information, skills and resources to empower members and maximise their effectiveness. The coalition of groups that comprises the organisation aims to promote equity within the health system and equitable access to services for all women, in particular those women disadvantaged by race, class, education, age, poverty, sexuality, disability, geographical location, cultural isolation and language.

Like the WHO Commission on the Social Determinants of Health, a fundamental underpinning of AWHN work is a social model of health and recognition of gender and the social gradient as key health determinants.

The social determinants of health (SDoH) perspective, which differs markedly from a medical approach to illness and treatment, has wide support in Australia, especially amongst health experts. It has been endorsed recently in the final report of the Health and Hospitals Reform Commission, in the report of the National Preventive Health Task Force, in the *National Disability Strategy* and by most State and Territory governments. The Australian women's health movement, the Aboriginal health movement and the new public health movement, like the WHO Commission, have all argued that the social causes of ill health need to be considered when health policy is formulated.

Evidence about the social causes of poor health provides an underpinning for arguments that conventional medical care systems, like that of Australia, are unnecessarily narrow and miss a great deal that is critical for optimal human health. In a social view, the focus is on population health as well as individual health whereas conventional medical care focuses only on the latter. International research shows undeniably that health outcomes emerge from complex interactions between social, economic, cultural, environmental and biomedical factors, rather than arising from biological determinants alone.

There is no clearer association in the epidemiological evidence, in whichever nation it is gathered, than that between poverty and inferior health outcomes. However, it is not only the poor who are affected. A definite social gradient in health has been clearly demonstrated, which shows that everyone's health is less robust than it might otherwise be, perhaps affecting even those at the top of the socioeconomic scale. Health outcomes consistently improve as socioeconomic status improves, with the biggest differences obviously found between those at the very top and those at the bottom. It follows therefore that comfortable, middle-income people, for example, have poorer health outcomes than they might have (WHO 2003:10–11). Recent research suggests that levels of inequality, material and social, can explain the social gradient. Countries with the largest gaps between rich and poor experience more mental illness, more drug and alcohol-related problems, more obesity, higher rates of teenage pregnancy, poorer educational performance and literacy scores and higher rates of homicide (Wilkinson and Pickett 2009).

Inequality works to undermine health; it is suggested, by increasing stress right across society. Stress, medical research shows, produces a range of diseases and behavioural problems. In heavily unequal societies, the rich fear the poor and the poor suffer from status anxiety and shame, making everyone's health poorer than it would otherwise be. More equal societies enjoy higher levels of trust and lower levels of stress. Low status, low levels of respect and feelings of low self-esteem, rather than material deprivation per se, contribute more to poor health and help explain the social gradient (Wilkinson and Pickett 2009).

Such arguments fit with the findings of earlier studies. For example, Kawachi et al. (1999) studied men and women in 50 American States and found that both smaller wage gaps between the sexes and higher levels of women's political participation were 'strikingly correlated' with lower female *and male* morbidity and mortality. Status, the authors concluded, reflects 'more general underlying structural processes associated with material deprivation and income inequality'. The arguments of Australian Aboriginal people, for example, who point to the devastating health consequences of colonisation and racism are corroborated by these findings. It follows that it is in the interests of all members of society that comprehensive research into all the causes of poor health is produced.

In the case of the health of the most disadvantaged, the close association between poverty and very poor health outcomes holds both between countries—some rich, some poor—and within countries, whether they are OECD countries or those that are less well off (WHO 2008). Moreover, women in Australia, as everywhere, are over-represented amongst the poor, thus highlighting the need for a gender lens to be applied in all health-related debates.

A biomedical approach to health policy, focusing as it does on the services supplied by hospitals and doctors, cannot capture more than a partial view of the causes of population health outcomes. Comprehensive public policy responses are needed, therefore, to address the social determinants.

A huge amount is known about the social basis of health outcomes, both in Australia and internationally, through work already done. Australia, as noted, has expertise which can and should be drawn on to translate what we know into cross-organisation strategies to achieve better health outcomes.

While many organisations in Australia acknowledge the implications of the SDoH, few explicitly recognise gender as a core determinant. Application of a gendered analysis in policy, program

development and service delivery is sporadic at best. The key organisations that are charged with responsibility to provide leadership in addressing the SDoH often do not take gender into account.

This submission, therefore, focuses on why gender is key social determinant of health. It outlines the benefits of gender mainstreaming and gender equity approaches as well as the need for a 'Health in all Policies' approach. This Senate committee Inquiry is an opportunity to improve the way these key organisations provide leadership by including gender as a key determinant.

Gender: A key determinant of health

Gender is a system of power relations that permeates the structures, processes and practices of all aspects of life, in the domestic and public spheres, in work, workplaces and employment. It shapes the character of institutions and their functions (Doyal 1995; Acker 2006). Gender is about social experiences and social relations between men and women. Such relations affect health outcomes.

Gender, then, is a key determinant of women's health (Sen and Ostlin 2007; CSDH 2008). Australia's gender pay gap, for example, contributes to economic insecurity, increasing the number of low-income families, especially female-headed families, with a negative impact on health, including the health of children. It also contributes to financial vulnerability for women, especially women in retirement. The effects of the pay gap are exacerbated by socially prescribed caring responsibilities, which reduce the workforce participation rates of women, whether they be mothers, daughters, friends or neighbours.

Violence is another gendered 'cause of the causes' of poor health, and one that particularly affects women. While the underpinnings of violence are complex, there is wide agreement that intimate partner violence, in particular, is firmly embedded in gender inequality. Violence is detrimental to women's health in many ways. A major WHO study found that violence had a negative impact on women's physical, sexual, reproductive, psychological and behavioural health, as well as having fatal consequences in cases of AIDS-related mortality, maternal mortality, homicide and suicide (Krug et al. 2002).

Post-traumatic stress disorder (PTSD) is more prevalent among women who have experienced violence, along with neurological disorders as a result of head injuries and attempted strangulation. Women who have experienced violence have more sexually transmitted and urinary tract infections, more migraine headaches, more chronic pain and poorer reproductive health outcomes (Coker 2005:1; Taft et al. 2003). Moreover, studies show that the health consequences of abuse can persist for years, even throughout life, and that the more severe the abuse, the greater is the detrimental impact on health, with multiple episodes having a cumulative impact.

Workplace conditions are other factors that can give rise, directly and indirectly, to poor health outcomes. Discrimination or harassment in the workplace, for example, might lead to anxiety, depression and other mental health problems and economic insecurity—all closely associated with reduced life chances and poorer health. The Canadian Women's Health Strategy (Health Canada 1999) identified 12 key social determinants of women's health: income and social status; employment status; education; social environment, including social support and social exclusion; physical environment, including access to food, housing, transport, clean air and the like; healthy child development; personal health practices and coping skills; access to health services; social

support networks; biology and genetic endowment; gender; and culture. Indeed, each of these categories is an umbrella for more specific determinants.

While women's health movements have championed a social view of health and illness, this perspective is equally relevant to men's health. Gender, as one of the social determinants, helps shape the conditions of men's lives, just as it does those of women. Male gender roles might work to undermine health by encouraging physical risk taking and, perhaps, the denial of emotions, physical discomfort and pain. The expectations held about what is required of breadwinners, as another example, might induce men to work in stressful, dangerous occupations or to work unhealthily long hours. Risk-taking behaviour can have untoward effects on the health of both men and women, particularly in relation to sexual activity. We might not be able to tell for sure whether women suffer more morbidity than men (Broom 1991: 47–52), but a social health perspective tells us for certain that many men and women suffer high levels of avoidable ill health as a consequence of the constraints and requirements of masculine and feminine gender roles.

The impact of gender on health demonstrates the need to continually work towards reforms such as equal pay, increasing the number of women on boards and government committees and working in comprehensive ways to reduce violence against women and children.

Broadly, there are five areas in which gendered public policy interventions can influence the determinants of health to produce more equitable health outcomes:

- the values, norms, practices and behaviours across society which are discriminatory towards women;
- the effect on women and men of differential exposures and vulnerabilities to disease, disability and injuries;
- gender analysis in health systems and policy that reveals differential effects of caring between men and women;
- gender in health research; and
- the legal frameworks and social norms that determine women's opportunities to participate equally in the paid economy, and to access needed services that are essential to quality of life.

Addressing these areas is necessary for improvements to women's health and well-being, and indeed, necessary for improving population health as a whole. Inaction will continue to have serious economic, health and social consequences for girls and boys, for women and men, and for their families and communities (Sen and Ostlin 2007).

It may appear to be paradoxical that Australian women, on average, live longer than men, but have poorer health across their lifespans and significantly less access to income throughout their lives. The truth is that while life expectancy has been increasing for both women and men as living standards rise, as health literacy increases (although it is far below desirable levels) and as more effective treatment options are developed for previously life-limiting illnesses, this trend may not continue in the presence of soaring obesity levels. Other major risk factors for poor health include smoking, alcohol and substance misuse and violence against women and children. As a social determinants perspective shows, all these factors impact most heavily on the least well off sections of our community.

Gender Mainstreaming and Gender Equity

One of the actions that health systems can take to improve health outcomes for women is gender mainstreaming. The aim of gender mainstreaming is to infuse gender analysis, gender-sensitive research, women's perspectives and gender equity goals into policies, projects and institutions.

Despite its pioneering work on women's health policy, gender mainstreaming has been minimal in Australia, and gender equity is rarely, if ever, identified as an outcome measure for policy and programs (Keleher 2012). Indeed, the degree of gender blindness in Australia's health policies suggests that there may be active resistance to gender mainstreaming and/or that there is a lack of specialist expertise regarding women's health among policy makers (Keleher 2012). Certainly, some Australian States (NSW, Victoria and South Australia) have demonstrated capacity for women's health policy based on the social determinants of health and the need for strengthened intersectoral work that is necessary to secure effective outcomes for women, particularly in the area of violence against women. However, as at the national level, health policies at state and territory levels are only rarely gender-informed (Keleher 2012). Taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources (Sen and Ostlin 2007, p. viii).

If women's health and population health are to be improved, health systems have a responsibility to acknowledge social relations, social factors and conditions. Equitable gender outcomes are derived from redressing inequitable social, economic and political determinants of health that arise from disempowering social norms and unequal distributions of power and resources.

Women's Health and Well-Being in Relation to Work

Through their unpaid work as carers, women are largely responsible for meeting the physical, social, emotional and financial needs of younger and older populations, as well as family members with illness and disability. Responsibility for unpaid work has serious implications for women's financial independence and for their health. Indeed, there is a growing feminisation of poverty among women and their children. In 2005, the annual cost of replacing unpaid carers was estimated to be $30.5 billion (NATSEM 2004 cited by Carers Victoria 2003). Health system reforms are increasingly shifting the care of sick persons from institutional care to home care, yet the effects on health of caring is under-researched and to a large degree remains invisible. Respite care is scarce, while support for carers is limited and provided on an ad hoc basis (Carers Victoria 2003).

Despite gains in paid work participation rates over time, women's earnings remain persistently lower than men's. Over their adult lives from 25 years of age, men can expect to earn 1.5 times the income of women (FaHSCIA 2010). In 2006, men held around 66% of total superannuation account balances, compared to 34% for women. By 2008, superannuation balances and payouts for women were approximately half of those of men. While the gap has narrowed, women will remain vulnerable to poverty in retirement, as the gap is predicted to persist for coming generations (Australian Human Rights Commission 2009).

Participation in the economy is a key determinant of health. Women are increasingly participating in the paid workforce and managing careers to provide needed household income while carrying a disproportionate burden of caring for family members. Women are intensely vulnerable because of

the social pressures associated with dual roles in the paid and unpaid economy, as well as the unrecognised impact on them of economic reforms, health sector reforms, and changing employment regimes. It is primarily women who find that they are expected to juggle unpaid caring responsibilities with paid work while absorbing the financial impact of economic reforms—such as the increasing casualisation of work, i.e., insecure work without paid leave entitlements—concentrated among occupations and industries that are typically low paid (Richardson 2012).

Much more workplace health focus is necessary on upstream policy and program approaches to ensure more gender equitable work places. The structure of work in terms of family-friendly workplaces, job and income security, job protections, maternity leave and child-care (see below) are all essential for healthy work environments for women. Governments, unions, managers, employers, small organisations and large corporations all have leadership roles to play in ensuring women are enabled to work in ways that advantage rather than disadvantage their health, and that are equitable and fair.

Why Citizenship Matters for Women's Health and Well-Being

There are strong connections between civil citizenship rights, political citizenship rights, and social citizenship rights, albeit that political and civil rights mean little if citizens are so unequal or impoverished that they cannot exercise those rights (Brodie 1997). Those civil, political and social rights include the rights to economic security and to affordable healthcare as well as the conditions in which good health is attainable. Women's citizenship and political participation, therefore, are structural determinants of health, as well as mechanisms through which social inclusion occurs.

Women's movements have challenged the legal and social barriers that undermine women's citizenship, including rights at work, rights to equal pay, sexual and reproductive rights, and rights to inheritance (Summers 1994). Women's legal rights within their homes are better recognised than in the past, although public attitudes to women's citizenship rights could still be strengthened, particularly for lesbians, women with disabilities, and refugee women, while efforts to overcome discrimination for women marginalised by sexuality, race or ethnicity need to be intensified (Sen and Ostlin 2007).

Health in All Policies and Intersectorality

'Health in All Policies' or 'healthy public policy' is internationally recognised policy practice for supporting efforts to address the SDoH. The United Nations General Assembly (UNGA) resolutions of September 2011 put the three concepts of health in all policies (HiAP), the SDoH and governance "… front and centre [of action required to address the causes of poor health], with particular emphasis on the global impact of non-communicable diseases" (McQueen, 2011).

In the order to effectively create health systems and structures that are informed by the SDoH, there must be whole of government commitment to embedding these principles at every level and in every sphere. This includes in organisations and institutions, in businesses and workplaces, in education and in homes, and action must occur at local, state and national levels. The role of government is to provide supportive structures, incentives and accountability mechanisms, and to enshrine and implement laws and policies that communicate the rationale and practical 'how-to' of

social determinants of health. This approach is outlined in the *Adelaide Statement on Health in All Policies: moving towards a shared governance for health and well-being,* which states:

> … government objectives are best achieved when all sectors include health and well-being as a key component of policy development. This is because the causes of health and well-being lie outside the health sector and are socially and economically formed. Although many sectors already contribute to better health, significant gaps still exist.
>
> The Adelaide Statement outlines the need for a new social contract between all sectors to advance human development, sustainability and equity, as well as to improve health outcomes. This requires a new form of governance where there is joined-up leadership within governments, across all sectors and between levels of government. The Statement highlights the contribution of the health sector in resolving complex problems across government (South Australian Government, World health Organisation, 2010).

The need for a HiAP approach is emphasised in Commission on Social Determinants of Health (CSDH) in its *Closing the Gap in a Generation* Report, calling for policy coherence across government by placing:

> … responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all ministerial and departmental policy-making. Ministers of health can help bring about global change – they will be pivotal in helping to create buy-in by the head of state and from other ministries (CSDH 2008)

Without such an approach, efforts to address the SDoH and achieve lasting improvements in health outcomes for Australians will fail.

As mentioned above, Australia has expertise from which to drawn on to translate what we know about the SDoH into cross-organisation strategies to achieve better health outcomes, particularly within the women's sector. This existing expertise could be capitalised on through the strengthening of this sector and subsequent development of collaborative partnerships with it in the development effective cross-government and sector policy and implementation strategies informed by the SDoH.

Responses to the Senate Committee Inquiry Terms of Reference

In relation to Senate Committee Inquiry terms of reference:

(a) Government's response to other relevant WHO reports and declarations;

(b) impacts of the Government's response;

(c) extent to which the Commonwealth is adopting a social determinants of health approach through:

(i) relevant Commonwealth programs and services,

(ii) the structures and activities of national health agencies, and

(iii) appropriate Commonwealth data gathering and analysis;

There is little evidence that the Commonwealth has taken the systematic approach which is required to effectively create health systems and structures that are informed by the SDoH.

A number of initiatives have been undertaken that address different aspects of the SDoH in response to other relevant WHO reports and declarations. Examples include the *National Women's Health Policy* (2010), the *National Plan to Reduce Violence Against Women and their Children* (2011) and *A Ten Year Roadmap for National Mental Health Reform.* However, such efforts are often made in relative isolation without reference to and linkages with other policies and agendas. Moreover, initiatives like the *National Women's Health Policy* have had no resources attached.

Therefore, a systematic approach by government to the SDoH, that establishes appropriate structures, such as community-based health services, and embeds, monitors and evaluates progress, is needed.

Structural Barriers to Improved Population Health

As well as healthy public policy across the board, measures are needed in Australia today to facilitate people's access to conventional hospital and medical services. Australia's Medicare system and the Pharmaceutical Benefits Scheme go only part way towards achieving universal access.

Australia exhibits a number of entrenched structural barriers that impede full access to hospital and medical treatment services are no. These include (but are not limited to) the fee-for-service system of doctor remuneration, the Australian preference for small medical practices, increasing user charges and imbalance in the geographical spread of services. Financial barriers also inhibit access to allied health services, including dentistry, physiotherapy, dietary advice and the like. Further, there is still excessive emphasis on a medical model of care in medical and nursing education with insufficient emphasis on training to increase awareness of prevention and of cultural, sexuality and gender differences. Culturally inappropriate services constitute a serious barrier to access.

Although Medicare is a type of national health insurance, it provides only partial coverage against the cost of medical services outside hospitals. Australian user charges—that part of the cost of a service paid for by the user—have been allowed to increase steadily since 1984 and are now among the highest in the world (Schoen et al. 2010:2327). There is a large international literature showing that user charges constitute a serious financial barrier to access, especially for low-income people (reviewed in Gray 2004:65–77). In 2009, 22 per cent of Australians went without care because of cost, 21 per cent paid user charges of $1000 or more and 8 per cent reported being unable to pay medical bills or having serious problems paying . Moreover, the cost of accessing the services of allied health professionals is beyond the financial capacity of a great many Australians and is difficult if not impossible for low-income people, especially women.

These structural impediments mean that those lower down the social gradient are often missed by conventional medical systems, bringing to mind 'the inverse care law' coined by Welsh doctor, Julian Tudor Hart, some 40 years ago. 'The availability of good medical care', Hart argued, 'tends to vary inversely with the need of the population served' in systems where market forces are allowed to operate (Hart 1971:405).

Some people are deterred from accessing services because health professionals are not trained in cultural or gender competence and are not trained to understand the health problems faced by those with non-heterosexual orientations. For example, Aboriginal people report experiencing racism when using mainstream services, while people from backgrounds other than Anglo-Australian often find that the circumstances of their lives are misunderstood. For similar reasons, GLBTIQ (gay, lesbian, bisexual, transgender, intersex and queer) people identify the production of appropriate health services as a top priority.

The inverse-care law also operates strongly in relation to residents of rural and remote areas, where services of all types are in short supply, despite evidence that rural people suffer poorer health than people living in metropolitan areas.[1] For example, sexual and reproductive health services and services to respond to violence against women and children are sparsely located outside Metropolitan areas. If we were to take the optimisation of population health seriously, gap identifying research would be undertaken and reforms implemented to modify and, in an ideal world, eventually eliminate, all of these structural barriers.

Australian health policy has failed to deal with the overt barriers that impact adversely on access to hospital and medical treatment. These fundamental shortcomings must be addressed as a preliminary step towards improving health outcomes.

Access to affordable, geographically dispersed comprehensive primary health care services that focus on prevention as well as cure is fundamentally important to improved population health. Access to appropriate community data is also important in the development of effective health systems and structures that are informed by the SDoH. However, under current arrangements the difficulty of getting health status data that is gender disaggregated is considerable.

Recommendations:

1. A whole of national government commitment to the creation of healthy public policy, systems and structures , to be informed by the SDoH, and to be cognisant of gender in particular to be adopted as soon as possible.
2. A national health strategy for Australia to be developed as a priority which addresses the social determinants of health.
3. Long-term funding to be allocated for a Social Determinants of Health Centre of Excellence, or similar body, to be responsible for the systematic and coordinated implementation, monitoring and evaluation of efforts to address the social determinants of health, which include gender as a key determinant.
4. The Australian National Preventive Health Agency to provide leadership to health promotion and preventative health programs in gendering action across the SDoH, at both intermediary and structural levels.

[1] We do not have geographical access problems of such magnitude in the public education system because services do not operate as private business entrepreneurs.

Furthermore, the Agency Expert Committees on Obesity, Tobacco and Alcohol to incorporate into its work comprehensive gender and health analysis.

5. The Australian Health Ministers' Advisory Council to provide leadership on improving health equity through implementation of action promulgating understanding of how the SDoH and gender in particular impact on health outcomes across population groups and in all policy areas, e.g., through the inclusion of gender equity as a key performance indicator in all policies, programs and funding agreements.

6. The Commonwealth Government host a forum of key health experts and opinion leaders to explore ways to increase investment in Australian analysis of gender and of non-communicable diseases (chronic conditions), particularly within those population groups that are marginalised and/or socially excluded, and to outline the application of solutions by funded health and preventative health agencies.

In relation to Senate Committee Inquiry terms of reference:

(d) scope for improving awareness of social determinants of health:

(i) in the community,

(ii) within government programs, and

(iii) amongst health and community service providers.

These terms of reference are somewhat limiting with regard to achieving better outcomes against the SDoH as, optimally, it is the business of all organisations and institutions, in businesses and workplaces, in education and in homes, and action must occur at local, state and national levels.

The following recommendations therefore reflect the need for such an expanded approach and are organised under the areas of Capacity Building, Work & Economic Security and Policy & Implementation.

Capacity Building

Recommendations:

7. The scope for improving awareness of social determinants of health in the community is acknowledged by the government to be inclusive of all organisations and institutions, in businesses and workplaces, in education and in homes, and that action must occur at local, state and national levels.

8. The Commonwealth Government commission the development of a gender and diversity analysis training package, and fund its delivery to those involved in policy development: this will ensure that state and federal government policies reflect gender equity as well as the diversity of the communities they serve.

9. All Commonwealth, state and territory health policies, whether they concern cancer, heart disease, mental health, or ageing women, be revised—after consultation with women's health and NGOs for information regarding best practice—to incorporate a guide for health practice and programs which ensures that:

- health systems are responsive to women's particular needs;
- strategies are developed to improve the health status and experiences of all women, but particularly vulnerable and marginalised women;
- there is a commitment to expanding service, workforce and system capacity for gendering of policies and programs;
- there is accountability, whereby outcomes for women are measured and transparent;
- gender mainstreaming is promoted by the health sector in order to embed gender in policies across sectors, e.g., in social inclusion, or disability and employment policies.

10. Priority be given to meeting set targets for gender equity in local, state and federal parliaments, and on boards: this is necessary given that the representation of women in politics, positions of leadership, and decision-making in public life, business and industry are critical determinants of the conditions that impact on women's health and well-being.

11. AWHN supports the recommendation made by Women's Health Victoria that the government in partnership with research institutions and health promotion agencies, create a Social Determinants of Health Framework, which includes key indicators, such as gender equity, to be considered across all government departments.

12. AWHN supports the recommendation made by Women's Health Victoria that the government in partnership with research institutions and health promotion agencies, create a systematic tool for reporting, monitoring and evaluation of the Social Determinants Framework.

13. National Health and Medical Research Council research priority be given to the effects on the health of individuals who care privately for disabled, elderly, or chronically ill charges: this is necessary as health system reforms are increasingly shifting the care of sick persons from institutional care to home care, yet the effects on health of caring is under-researched and financial or other support for carers is limited.

14. The Commonwealth Government commission a report into cardio vascular disease diagnostic and therapeutic procedures to identify gender bias in their application, and to make recommendations for achieving more equitable outcomes.

15. Funding is secured and investment strengthened for women's health services which have expertise in gendered and diversity analysis in the structures and delivery of Australia's health system.

16. Improving awareness of social determinants of health by health and community service providers is achieved through the strengthened of health service accreditation to include demonstration of gender-sensitive practices.

Work & Economic Security

The recommendations in this section emphasise the imperative for all policy, including superannuation and housing for example, to be gendered, as we are already seeing the impact of

economic insecurity in the homeless sector with increasing client numbers of older women presenting who have inadequate superannuation for retirement.

Recommendations:

17. AWHN supports the recommendation made by Women's Health Victoria to include the economic contribution of household work, care work, and voluntary work in national accounts and strengthen the inclusion of informal work (consistent with Recommendation 13.3 in *Closing the gap in one generation)*.

18. AWHN supports the recommendation made by Women's Health Victoria to support women in their economic roles by guaranteeing pay equity through law, ensuring equal opportunity for employment at all levels, and by setting up family-friendly policies that ensure that women and men can take on care responsibilities in an equal manner (consistent with Recommendation 13.5 in *Closing the gap in one generation)*.

19. National, state and territory governments give preference to organisations/businesses that can demonstrate that:
    1. gender equity is a goal in the organisations strategic plan, and
    2. there is high-level support and direct top-level policies for gender equality and human rights.

Policy & Implementation

Recommendations:

1. AWHN supports the recommendation made by Women's Health Victoria to set up and provide adequate and long-term funding for a gender equity unit that is mandated to analyse and to act on policies, programmes, and institutional arrangements that impact on gender equity (consistent with Recommendation 13.2 in *Closing the gap in one generation*).

2. The entirety of the *National Plan to Reduce Violence Against Women and Their Children* be implemented and adequately funded at both federal and state levels.

3. The Commonwealth Department of Health and Ageing provide leadership to mental health services in gendering action across the social determinants of health through the mental health strategy, *A Ten Year Roadmap for National Mental Health Reform.*

Key Resources

The key resource document used in the development of this submission is Keleher H., AWHN. (2012). *Women and Health and Well-being Position Paper.* Australian women's health Network.

Considerable reference was also made to the Women's Health Victoria submission to the Senate Committee Inquiry.

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