



**National Women's Health Policy Development:  
Submission to the Consultation**

**Women's Health in the South East**

**June 2009**

## **1. Background: Women's Health In the South East**

Women's Health in the South East (WHISE) is a regional women's health service, for the southern metropolitan region of Melbourne. We are a community-based organisation run by women, for women, and are concerned with all aspects of women's health and wellbeing.

Our primary aim is to improve the health and wellbeing of women who are disadvantaged through gender, mental illness or disability, physical illness or disability, cultural and religious background, language, income level, location, and other complex personal, family or community conditions. We foster confidence and ability in women, so that they have the skills, information and ability to use mainstream health and community services appropriately and effectively.

WHISE provides its own programs, information and referral services for women, liaises with other health services, and works to promote women's health. Working from a feminist perspective, WHISE acknowledges the diversity of women and is open and accessible to all women in our region.

Our work is underpinned by a social model of health. We are committed to reducing inequities in health which arise from the social, economic and environmental determinants of health. We encourage women to make informed decisions about their own health and wellbeing, and that of those important to them – we see that information and confidence-building in women will have a ripple effect into the wider family, friends and community networks, thereby creating a much greater chance of improvement for everyone.

Women's Health In the South East welcomes the opportunity to respond to the development of a new National Women's Health Policy. Our vision is for a society in which the accepted approach to health and wellbeing is empowering and respectful of women and girls (and of everyone). We seek a society which is equitable and sustainable in opportunity, rights and responsibilities for all, together with a government approach which recognises the essential connections between the health and wellbeing of the individual, and the wider social, economic and cultural dimensions of our society.

It is timely therefore to consider the priorities of a new National Women's Health policy, which will shape the direction of our health services over the next decade.

Critical for this National policy, and a central theme of our submission, is the need for the provision of resources at a level which is realistic with the scope of the services being demanded by that policy. Equally critical is the provision of stability in the health services sector, so that services are not continually derailed by the imposition of new imperatives and priorities, which, with a little thought, may well be accommodated under existing service structures.

In this Submission, we present our own views, and endorse the recommendations already provided to the National consultation in the submissions from the Australian Women's Health Network, and the Women's Health Association of Victoria.

## 2. A Snapshot of Our Region

The catchment area of WHISE is the southern metropolitan region of Melbourne covering ten local government areas (Bayside, Cardinia, Casey, Glen Eira, Frankston, Greater Dandenong, Kingston, Mornington Peninsula, Port Phillip, and Stonington).

The population of the region is approximately 1.2 million people (about one-third of Melbourne's population, and one-quarter of Victoria's population<sup>1</sup>) - with slightly more than 50% female.

There is significant variation between the LGAs on most demographic and health indicators, as might be found in any group of LGAs across Melbourne or Victoria<sup>2 3</sup>.

Some of our LGAs register significantly higher than the Melbourne metropolitan averages, in terms of family violence, hospital admissions on the basis of mental and behavioural conditions, road traffic fatalities and injuries. The City of Greater Dandenong is ranked the most disadvantaged municipality in Victoria<sup>4</sup>.

The variation across municipalities has encouraged WHISE to consider where best to direct our programs and services, in keeping with our mission to work to improve the health and wellbeing of women who are disadvantaged through gender, mental illness or disability, physical illness or disability, cultural and religious background, language, income level, location, and other complex personal, family or community conditions - the complexity of disadvantage being the focus, rather than any one factor of itself. What is a disadvantage for one woman may not necessarily be a disadvantage for another woman.

## 3. Essential Elements of the New National Women's Health Policy

### 3.1 Gender and Equity of Provision

WHISE continues to affirm the importance of women's health services in their own right - and sees that gender is a primary social determinant of health and wellbeing, within the broader social model of health.

We support also the concept of working towards equity in health provision for women generally, particularly in terms of access to services, confidence in using services, and solid evidence and information as the basis for informed choice about the next step in health improvement.

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<sup>1</sup> ABS Census 2006

<sup>2</sup> Victoria: *Index of Relative Socio-Economic Disadvantage* 2007, with the LGA ranked 1 being the least disadvantaged, and the LGA ranked 80 being the most disadvantaged (currently Dandenong).

<sup>3</sup> Victorian Emergency Minimum Dataset (VEMD) 2007

<sup>4</sup> Victoria: *Index of Relative Socio-Economic Disadvantage* 2007, with the LGA ranked 1 being the least disadvantaged, and the LGA ranked 80 being the most disadvantaged (currently Dandenong).

**Recommendation:**

- That the new National Women's Health Policy continue to recognise gender as a fundamental determinant of the health and wellbeing of our society
- That the new Policy continue to work towards equity in health provision for women, particularly in terms of access to services

### 3.2 Complexity of Disadvantage

Our service experience across a range of diverse local government areas (and across a large geographic area) has encouraged WHISE to focus resources on the most disadvantaged women in our catchment area.

We work on the notion of complexity of disadvantage for women in any given area (regardless of whether the LGA is notionally higher or lower on any socio-economic rating).

It is not sufficient to assume that any given factor necessarily disadvantages women in relation to their health and wellbeing. Rather it is the combination of factors which may adversely affect the woman's health outcomes - and this combination of factors will vary from woman to woman.

We would therefore like to see encompassed in the new Women's Health policy the notion of complexity of disadvantage, rather than a simple classification of priority groups for action, as the basis for the provision of resources through our health service system.

**Recommendation:**

- That the new National Women's Health Policy encompass the concept of complexity of disadvantage, which may then be used as a basis for resources distribution and redirection of effort within the health services system

A complexity of disadvantage model<sup>5</sup> in relation to health and wellbeing might include two broad areas for consideration:

- a) Defined physical or mental illness, disability or condition
- b) Social, demographic, economic and individual factors which compound the effect of the physical or mental condition on the health and wellbeing of the woman.

These broad areas may then be sub-classified as follows.

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<sup>5</sup> The IRSED model used to classify local government areas on a scale of disadvantage could provide the model for a similar classification of disadvantage in the health sector - and also provide a model for the distribution of scarce resources to those most disadvantaged and most compromised in health and wellbeing

The physical or mental conditions might include:

- Diagnosed specific health conditions - physical, psychological, mental
- Congenital, developmental or acquired conditions
- Co-morbidities affecting physical illness
- Addictive and/or self-destructive behaviours.

The social and other factors might include:

- Culture and language
- Religious background
- Education level and employment
- Income, especially disposable income
- Age and family structure and support
- Homelessness or insecurity of living standards
- Knowledge and understanding of the major service systems of our society - health and community services, local government, education, employment, legal and justice systems.

Over time WHISE has come to identify a “compounding” effect on the capacity of women to make informed choices about their own health and wellbeing (and that of their families and children).

The foundation of any informed choice is knowledge and understanding of the choices available. However our knowledge and understanding is filtered through our language and culture - where we are familiar with the mainstream culture and the language of that culture, we are able to learn and understand mainstream systems and make informed choices. Where we are not familiar with the mainstream culture, and have little facility in the mainstream language, our capacity to improve and maintain our health and wellbeing is considerably diminished.

***Recommendation:***

- That the new Policy recognise the importance of knowledge and understanding as keys to using the health sector effectively, and therefore as the foundation for informed choice about health and wellbeing

### **3.3 Holistic approach**

One only has to look back over the countless submissions made to government about improving the Australian health system, to realise the importance given by us all to health promotion and prevention of illness.

However our health promotion messages, particularly those broadcast through print and electronic media, are often targeted at single conditions, without consideration of the whole person - the holistic approach to health and wellbeing is missing.

Put simply, the holistic approach recognises that capacity to understand and manage illness is filtered through gender, cultural and religious background, education level and language facility, and through social, economic and demographic factors - and that mental wellbeing would appear to be the over-riding defining factor in the success or otherwise of any health treatment.

We have a health system which has been traditionally based on a single illness / physical illness / acute episode approach. This approach is often successful for those who are not significantly disadvantaged (as outlined above), and who have developed the capacity to understand and manage their illness effectively.

However our health system, especially admissions to hospital and to residential care, is increasingly receiving those who have co-morbidities, or are significantly disadvantaged in terms of being able to make informed choices about health options or to manage their own illness effectively.

We need to turn our health system on its head - figuratively speaking - and recognise the increasing importance of psychological wellbeing in enhancing or compromising the outcomes of treatment for both physical and mental illness.

The implementation of a real holistic approach to health service provision requires resources and time - together with changes in our attitudes and understanding, and in our education programs which train our health professionals.

As a simple example, a recent client of WHISE, resident in the southern suburbs, pregnant, newly arrived in Australia, husband working in the western suburbs, has been referred to an outer suburban hospital for pre-natal care and delivery - she is not considered a high-risk pregnancy, so the suburban hospital is appropriate for delivery. However she cannot drive, has no family or friends able to transport her, and her husband works in the western suburbs (a considerable distance away). She has little language facility, and is naturally considerably anxious about how she will access pre-natal care, let alone what she will do when it is time to deliver her child.

The simple single treatment approach is to refer the client to the hospital most appropriate in terms of her risk assessment with regard to the birth. The holistic approach recognises that her increasing anxiety about where she is to go for pre-natal care, her inability to understand why she must do so, her lack of disposable income.... and so on. A much more extensive approach, but one, if taken up properly, will achieve the better health and wellbeing outcome for the client.

Each health service provider is able to provide numerous similar examples - what we do not have sufficiently is the time or resources to implement the holistic approach - especially for those who are significantly disadvantaged in managing their own health and wellbeing.

**Recommendation:**

- That the new Policy accept the holistic approach to health and wellbeing as the most effective for women who are significantly disadvantaged in managing their own health and wellbeing
- That the new Policy commit to the realistic and sustainable resourcing of the holistic approach, in order to improve the health and wellbeing of those women most disadvantaged in our society

### 3.4 Evidence Base

It is important for any policy to require a solid evidence base for the improvement of service provision.

Such evidence has been (and is continuing to be) collected, in various ways and formats, by service providers since the commencement of the health service system.

It is probable much collected evidence has not contributed effectively to policy development - for a variety of reasons - often because of incompatibility of data systems, lack of time, lack of knowledge that such evidence has already been collected in some way.

As with all things needed in an effective health system, lack of compatibility between systems, or simple lack of systems, adversely affects the integration and comprehensive analysis of evidence.

While technological and electronic advances have been astonishing in the last two decades, the health system generally has not been able to keep pace with system advances, and has not had sufficient qualified staff resources to maintain and manage client data systems.

A good first step in the development of the strong evidence base would be for the systematic collection by the Federal Government of existing evidence - provided that this collection is done by qualified staff appointed for this specific task, and not as an adjunct to the existing duties of over-stretched staff.

**Recommendation:**

- That the Policy work to the systematic collection of existing data and evidence from health service providers across Australia, using specially appointed staff, as a good first step towards the building of an Australian evidence base for health service provision

### **3.5 A Lifecourse Approach**

The inclusion of "a lifecourse approach" in the Federal Government's discussion paper is a little confusing.

It would appear to be similar to the sections on prevention and health equity.

At this stage WHISE does not see the necessity for inclusion of another "approach" to women's health services.

If there is strong and sustained implementation of an holistic approach to women, especially those most disadvantaged, then matters such as age will be included under that approach.

## **4. Conclusion**

WHISE is very pleased to see the development of a new National Women's Health policy under way at Federal level.

We are delighted to be involved in this consultation process, and look forward to participating in State-based meetings as these occur.

We fully support the continuation of the gender approach in women's health policy, and the continued emphasis on health equity for women and between women.

We recommend:

- The implementation of a real holistic approach in health service provision, especially for women most significantly disadvantaged
- The realistic resourcing of the holistic approach
- The collection of existing data and evidence as the first step in the development of a comprehensive Australian evidence base for health service provision and outcomes.

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