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AMA submission to the Department of Prime Minister and Cabinet – National Strategy to Achieve Gender Equality

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Introduction

The AMA supports the development of a National Strategy to Achieve Gender Equality (the Strategy). The AMAs response to the Discussion paper focuses on achieving gender equality in public health and healthcare from the perspective of medical practitioners.

Vision

While the AMA supports gender equality as the end goal of this Strategy, it is important to acknowledge the importance of adopting a gender equity agenda to address the barriers to achieving equality and supporting women and other disadvantaged groups to succeed.

Achieving gender equity requires removing unfair, unjust, and avoidable disparities in health. An equity approach supports policies and practices that allocate resources to groups according to their differing needs and seeks to reduce the obstacles that prevent all genders from realising their potential for health.

To be successful it is essential that the vision is owned by whole of government. For example, in Victoria, the Victorian Gender Equality Act is driving change and providing the levers and drivers to ensure gender equality is embedded in everything government does. The Victorian government has established a public website where it is reporting on what it is doing to promote gender equality. This creates a level of transparency and accountability for actioning the strategy while showcasing initiatives that are being implemented across key domains.

Strategy fundamentals

Several strategies have been developed by government over time, with varying levels of success. Causes of gender inequality exists in all levels of society, from individual perceptions to cultural and systemic biases and barriers. While achieving gender equality is everyone's responsibility, it is important that the Strategy clearly defines who is responsible and accountable for reaching specific targets to avoid the assumption that 'someone else will do it'.

To ensure this Strategy is accountable and actionable, the AMA implores the Department to ensure the Strategy is co-designed with all stakeholders and includes the following:

- specific indicators, targets, and timelines,
- clearly defining who is responsible for meeting these targets and timelines,
- a meaningful and effective accountability and reporting framework, and
- specific funding.

The AMA recommends that the Strategy align with the UN Sustainable Development Goals, especially the targets under goal 5 – *Achieve gender equality and empower all women and girls.*[1]

[1] United Nations (2022) *Goal 5: Achieve gender equality and empower all women and girls.*

The EU Gender Equality Strategy also presents policy objectives and actions that are insightful, noting its approach of overlaying gender mainstreaming and intersectionality in the development and implementation of the strategy.[2]

Sex and gender impact on our health, and access to health services

Public health

The National Women's Health Strategy outlines a range of vague objectives for women's health, but it does not have a focus on gender equity/equality. This Strategy should be linked with the Women's Health Strategy by actioning specific targets to help achieve gender equity and equality.

The Strategy must recognise that to achieve gender equity, due to biological and social factors, cisgender women need support in many circumstances relating to their health that a cisgender man does not. For example, a person who does not have the biological ability to give birth will not require the same leave, health care, and private health insurance to give birth. In addition, a person who does not menstruate will not have the financial disadvantage of buying menstrual products.

The social, cultural, and commercial[3] determinants of health should be used as key identifiers for developing strategies to reduce gender inequities. As per the AMA's 2020 position statement on *Social Determinants of Health*[4], the AMA notes that health inequities typically arise because of inequalities within society, they are avoidable and can be associated with forms of disadvantage such as poverty, discrimination, and access to goods and services.

Gender inequities differ between population groups. The AMA suggests inequities that face women in different population groups are reflected in the Strategy, such as in different life stages, Aboriginal and Torres Strait Islander populations, culturally and linguistically diverse communities, refugee and asylum seeker populations, socioeconomically disadvantaged populations, rural, regional and remote areas, women with a disability, the LGBTQIA+ community, and carers.

Gender plays a critical role in shaping patterns of morbidity and mortality, impacting on exposure to health risk factors, health seeking behaviour, and access to health services. Gender mainstreaming is an approach that factors these gender considerations into the design, implementation and monitoring of health-related policies.[5] The AMA recommends that gender mainstreaming is adopted in national, state, territory and local health policies, and that a gender perspective is integrated into all policies. Specifically, policies that impact women's health, including ageing and aged care; income and family support; employment and workplace relations; childcare reform; and judicial and corrective services. The responsibility for translating

[2] European Commission (2020) *Gender Equality Strategy 2020-2025*
[3] Gilmore et al (2023) *Defining and conceptualising the commercial determinants of health*. The Lancet.
[4] AMA (2020) *Social determinants of health.*
[5] UN Women (2023) *Gender Mainstreaming.*

gender mainstreaming into practice is system-wide and requires ongoing monitoring and accountability for outcomes.

Gender considerations should inform the development, implementation, monitoring and evaluation of health promotion policies and programs. Health education and promotion should be evidence based, age-appropriate and take into account the cultural, social and economic circumstances of different groups of women, including those who experience the most pronounced health disadvantages.

A gendered perspective should be incorporated into the planning and implementation of national preventive health strategies and initiatives under agreed national health priorities, including cardiovascular disease, asthma, arthritis, cancer, obesity, diabetes, mental health, dementia and injury.

Gender considerations should inform health service and workforce policy and planning in response to the convergence of population ageing and the growing burden of chronic disease. This should be supported by the incorporation of sex-disaggregated data and gender-based analysis into the monitoring of prevalence and trends of chronic disease conditions and risk factors.

Access to health care

The AMA advocates for women to have economic security so they may act as autonomous agents over their own health needs and treatment pathways.

The AMA recently lodged a submission to the Senate Community Affairs References Committee inquiry into *Universal Access to Reproductive Healthcare*.[6] The Department should consider the AMA's submission and the recommendations of this inquiry, once finalised, for incorporation into the Strategy.

The AMA strongly advocates that reproductive health services should be readily accessible throughout Australia. This requires the provision of and access to services to be timely, culturally safe, equitable, affordable and free of political or religious interference. Reproductive health is an essential element of good health and human development and support for the health of all mothers, other people who can get pregnant, and babies. Services should be provided throughout the preconception, pregnancy, birth and the post-natal periods.

Health literacy of communities is an important consideration, and translation of health messaging should be undertaken in a culturally appropriate manner if and where appropriate. The development of culturally appropriate messaging should be co-designed with communities and health literacy should be delivered by trusted, trained community leaders.

[6] Parliament of Australia (2023) *Universal access to reproductive healthcare.*

There are a range of issues highlighted in the AMA submission that the Strategy should address to achieve gender equity, for example:

- A range of safe and affordable methods of contraception should be accessible to all people who seek them, however there are currently issues with cost and accessibility. For example, there is a limited number of contraceptive pills subsidised by the Pharmaceutical Benefits Scheme.
- All women and other pregnant people should have access to legal and safe abortion and counselling services. However, in most state jurisdictions, abortion services are not provided by rural public hospitals.
- It is important that women and other pregnant people in rural and remote locations be able to access services as close as possible to where they live. However inadequate funding and regional workforce pressures have led to increasing reports of rural maternity services closing**.**
- Pregnancy care private health insurance should be affordable and accessible for Australian women and other pregnant people. However, it is only available at the top level (most expensive) of cover.

Gendered violence

While understanding and attitudes around gendered violence is slowly improving, Australia has a long way to go. The latest National Community Attitudes Towards Violence Against Women survey has shown that even though domestic violence is primarily perpetrated by men against women, 41% of respondents believe men and women are equal perpetrators. Concerningly, about a third of respondents believe that sexual assault accusations are commonly used to 'get back at men', despite evidence to the contrary.[7] Australia needs a serious cultural shift to reduce these misconceptions.

The medical profession has a key role to play in early detection, intervention and provision of specialised treatment of those who suffer the consequences of domestic violence, whether it be physical, sexual or emotional.

Interventions that are evidence-based and respond to consensus from victim/survivor voices include universal education, screening in antenatal care, first line supportive care, and referral for advocacy and psychological interventions, including mother–child work.

Health care staff require training, protocols, scripts, referral pathways, understanding of cultural safety and antiracist practice in service delivery, and leadership support to undertake this sensitive work, including support, if needed, for their own experiences of gender-based violence.

The AMA welcomed the release of the *National Plan to End Violence Against Women and Children 2022-2032*.[8] The Plan comprehensively outlines the current issues that women and children face, including those more vulnerable to violence, such as Aboriginal and Torres Strait Islander peoples,

[7] Anrows (2023) *Attitudes matter: 2021 National Community Attitudes Towards Violences Against Women Survey.*
[8] Commonwealth of Australia (2022) *National plan to end violence against women and children 2022-2032.*

people with a disability, culturally and linguistically diverse populations, and the LGBTQI+ community. The AMA's submission to this consultation can be found *here*.

The AMA notes that GPs are often the first person a victim-survivor turns to for support and advice, and we are pleased that the Plan recognises the important role of healthcare providers in terms of frontline support for victim-survivors. We agree that consistent training in family, sexual, and domestic violence response is needed across the healthcare sector and we support further attention to enhancing nationally consistent approaches to the safety and quality frameworks for detection and response to victim-survivors and perpetrators.

While the final version of the Plan comprehensively outlines the current issues and provides a long list of broad outcomes, the AMA looks forward to seeing clear implementation strategies and goals through the Action Plans and specific investment into this important issue. Several inquiries into this issue have already occurred and recommendations handed down. Now is the time to act.

This Strategy can complement the Plan by focusing on the cultural and societal shifts that need to occur to prevent gendered drivers of violence.

Research

Accurate and comprehensive data, sound research and ongoing evaluation are essential for effective policy, planning and service delivery for women. There is an increasing body of research about the differences in health care systems, treatment and outcomes by gender. For example:

- Women are less likely to receive best practice diagnosis and care for myocardial infarction.[9]
- Women have been found to be less likely to receive appropriate pain relief and this extends to female children.[10] This has been associated with stereotypes that cisgender women/girls overestimate and express their pain more so than cisgender men/boys.[11]
- The time from presentation to diagnosis of endometriosis is 7-12 years.[12]

Although there are recognised sex and gender differences in the incidence, treatment responses and prognosis of a range of diseases, women have historically been underrepresented in clinical research. Lack of evidence about the effectiveness of medical interventions in women may result in withholding treatments from women that may be beneficial, or exposing them to treatments that are suboptimal or even harmful. There remain gaps in knowledge around the differences between disease processes in women and men, and a lack of sufficient gender-sensitive studies,

[9] Khan et al (2018) *Differences in management and outcomes for men and women with ST-elevation myocardial infarction.* Medical Journal of Australia.
[10] Samulowitz et al (2018) *"Brave men" and "emotional women": A theory-guided literature review on gender bias in health care and gendered norms towards patients with chronic pain.* Pain Res Manag.
[11] Williams, A (2021) *Women's pain is routinely underestimated, and gender stereotypes are to blame – new research.* The Conversation.
[12] Department of Health and Aged Care (2021) *Clinical guidelines to improve diagnosis and treatment of endometriosis.* The Hon Greg Hunt MP media release.

analyses, investigations and sex-disaggregated data that can provide insights into these differences.

There is a need for more medical research on women's health and women's health problems and specific research and data collection methods should be developed. Further research is required into sex-based variation in drug efficacy and toxicity profile, in addition to sex and gender differences in the incidence and prognosis of a range of disease that affect both women and men. Such research should conform to the Guidelines laid down by the National Health and Medical Research Council.

In the absence of evidence, the findings from medical research based on males should not be assumed to apply to females. Women should not be excluded from medical research except when there are adequate ethical, medical and scientific reasons.

Health-related data should be sex disaggregated and take into account the relationship between gender and other variables such as socioeconomic status, geographic location, ethnicity, disability and sexuality. Such data should in turn be incorporated into cross-jurisdictional reporting mechanisms, with measurable indicators and benchmarks used to track overall performance and the impact of relevant health policy frameworks and strategies.

Economic equality and health outcomes

Economic equality is important for the health of women and their families. Aiming for economic empowerment requires that gender gaps in the labour market are closed and that women and people of all genders are free to pursue the path of their choice. Addressing the gender pay gap is fundamental to attaining gender equality, underwritten by processes that support pay transparency and tackle the impact of casualised work and its impact on pay equity.

Within the medical profession, women continue to earn less than men. While the starting salary in full-time employment between males and females in medicine in Australia is similar, as female doctors progress in their careers they can expect to earn less. 2016 figures revealed a 33.6% pay gap for full-time medical specialists, and a 24.7% pay gap among full-time general practitioners. When taking hours worked into consideration, the annual gross personal earnings for female specialists was, on average, 16.6% less than their male counterparts, and female GPs earned, on average, 25% less than male GPs.[13] This is related to female GPs spending longer time with patients but charging and earning less as a result of seeing fewer patients and is associated with the structure of the MBS. The AMA is calling for reform to MBS consultation items to rebalance the consultation structure across Level A-D items to better support GPs to spend the time required with patients as the complexity of their care needs increases. This will incentivise and reward quality, comprehensive, and value-based care and ensure that patients can spend the time they need with GPs.

A recent study exploring motherhood within medicine also identified several barriers, consistent with international research, across all stages of motherhood, from pregnancy planning through

[13] AMA NSW (2019) *Are we there yet.*

to working motherhood with negative impacts on work and family life, including delayed career progression, reduced income, delayed childbearing, stress, and negative emotions.[14] Our members also noted that women can experience pregnancy discrimination in the workplace regardless of their child bearing status.

Women in medicine also suffer fertility and pregnancy complications with a recent study among Australian and New Zealand doctors discovering 36% have suffered a pregnancy loss, while 50% have experienced pregnancy complications.[15]

COVID-19 and its impact on women in health care

During the COVID-19 pandemic, nearly four in five health care workers in the front line tasked with managing the pandemic were women, increasing their exposure and potentially their family members to the virus.[16] As pandemic-related work responsibilities increased, women were more likely to manage increased childcare and schooling obligations, coupled with disproportionate household responsibilities, even among dual earning couples.[17]

COVID-19 has not only exposed the comparative circumstances of women but has exacerbated the gender gap. Having been re-engaged in the workforce post COVID-19, women have lost superannuation contributions, wages and borne the brunt of family responsibility stressors (including domestic violence).

The AMA is supportive of measures that:

1. Recognise the disproportionate and negative impact of COVID-19 on women in workforce.
2. Ensure that strategies to achieve gender equity are at the centre of national COVID-19 recovery plans.
3. Commit to support gender equity by providing funding to increase access to:
   a) equal and reasonable paid parental and carers leave entitlements for each parent to empower men to seek an equal share of the parenting responsibility;[18]
   b) flexible work arrangements for each parent, so that women can participate in the workforce without comparative disadvantage;[19]
   c) domestic and family violence support (including 10 days paid leave); and
   d) flexible and affordable childcare so that parents can return the workplace.

[14] Collie, E et al (2022). *Merging motherhood and medicine: A qualitative study exploring barriers and enablers to motherhood among female doctors in Australia*. Womens Health (Lond).
[15] Royal Australasian College of Surgeons (2022) *36 per cent of female doctors have suffered a pregnancy loss*
[16] Workplace Gender Equality Agency. (2020) *Gendered impact of COVID-19.*
[17] Jones Y, et al. (2020) *Collateral Damage: How COVID-19 Is Adversely Impacting Women Physicians*. Journal of Hospital Medicine Vol 15 No 8
[18] AMA (2021) *Position Statement Medical parents and prevocational and vocational training*
[19] AMA (2015) *Position Statement Flexibility in Medical Work and Training Practices*

Women in healthcare leadership

Prioritising gender equity in leadership is vital for improving healthcare. Research shows that the transformational and collaborative leadership style, more characteristic of women, has direct and positive impacts on health care outcomes.[20]

Healthcare is a major Australian employer with women comprising 75% of the workforce. Yet nationally women are under-represented in healthcare leadership, failing to reflect the community and workforce. In Australia 30% of Deans, Chief Medical Officers, College board or committee members and 12.5% of large hospital CEOs are women. In some surgical streams only 3-5% are women.[21]

Working with a team of multidisciplinary clinicians and academics, the AMA has partnered with Advancing Women in Healthcare Leadership to co-design, implement and evaluate evidence-based and measurable individual and organisational level interventions to advance women in leadership.

Areas of focus include:

Capacity: Caring responsibilities limit work capacity and often create non-linear career paths, with opportunities and success shifted to later career stages. Lack of workplace flexibility further enhances the impact career disruption and capacity issues.

Credibility: A persistent masculine bias and a lack of gender diversity including cultural diversity in leadership and organisational culture affects leadership credibility, compounded by a lack of women role models. Unconscious bias also presents significant leadership barriers.

Capability: Perceived reduced capability and lack of confidence or self-advocacy stalls progress, leaving women outside strategic networking positions, vital for advancement. Compounded by inadequate leadership training and mentoring at an individual and organisational level.

Intersectionality: Addressing the compounding impacts experienced by women in healthcare leadership who identify with broader diversity attributes.

Meritocracy: Adopting the position that appointments to leadership positions should be based on merit ignores the possibility that gendered norms influence who is considered merited and not.[22]

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[20] Advancing Women in Healthcare Leadership *Why prioritise gender equity in healthcare leadership?*

[21] Teede HJ (2019) *Advancing women in medical leadership*. MJA

[22] Powell S. (2016) *Gender Equality and Meritocracy. Contradictory discourses in the academy*. Department of Urban and Rural Development.

Sexual harassment and gender equality

The *AMA Position Statement on Workplace Bullying, Discrimination and Harassment 2021*[23] recognises that a combination of organisational and professional hierarchies, gender inequity, the competitive nature of medical practice and training, and systems under pressure, has led to a workplace and culture where inappropriate workplace behaviours have become entrenched in many areas of healthcare over time.

The AMA has identified six key areas as essential to support the elimination of bullying, discrimination, and harassment in the workplace[24]:

1. Improving leadership, governance, and accountability.
2. Developing better organisational systems and strategies for prevention and risk management, and for promoting psychosocial health, safety, and well-being
3. Establishing measurable objectives and goals for improving workplace culture and systematic monitoring of psychosocial hazards and psychosocial health, safety, and wellbeing.
4. Building knowledge and capability to prevent, identify and respond to psychosocial hazards.
5. Respecting and enabling diversity and inclusivity.
6. Ensuring confidential reporting and appropriate responses to allegations, as well as effective support during and after reporting.

Further the *AMA Submission to the Australian Human Rights Commission - National Inquiry into Sexual Harassment in Australian Workplaces*[25] highlighted the need to improve leadership competencies and promote diversity. These are fundamental to encourage people to accept legitimacy of difference which in turn norms respect in the workplace and to eliminate sexual harassment in the workplace. The submission also makes recommendations on:

- Drivers of workplace sexual harassment.
- Impacts on individuals and business.
- Existing good practice.
- Current legal framework.

Menopause and work

An increasing number of reports within Australia and globally highlight the impact of perimenopause and menopause on women's employment, retirement decisions and savings.[26] The AMA encourages the Strategy to explore and pursue policy reform in this area in line with the Government's 2022-23 Budget Statement to support women and gender equality in the workplace.

[23] AMA (2021) *Position statement: Workplace bullying, discrimination and harassment*

[24] This is consistent with the Respect@Work: *Sexual Harassment National Inquiry Report* (2020) which outlines seven domains under prevention and response streams.

[25] AMA (2019) *Submission to the National inquiry into sexual harassment in Australian Workplaces.*

[26] Colussi, S et al (2022) *Menopause remains taboo in most workplaces. This needs to change*. The Guardian.

Conclusion

The AMA supports the development of a National Strategy to Achieve Gender Equality. The Strategy should focus on gender equity to recognise the barriers to achieving equality and supporting women and other disadvantaged groups to succeed. Gender inequities should be considered and addressed in the development of all policies, especially those that impact on women's health. The Department should ensure that the Strategy is able to produce measurable outcomes and targets to achieve gender equity that makes a real difference to women's lives. This includes adequate accountability and funding to achieve the Strategy's targets and outcomes.

April 2023