

## Women's Health

2014

### Introduction

All women have the right to the highest attainable standard of physical and mental health.

While women and men share many health challenges, they also differ in certain patterns of illness, disease risk factors, and access to and use of health services. These differences are shaped by biological, social and cultural factors. Gender is used to describe those characteristics of women and men that are socially constructed, while sex refers to those that are biologically determined. Together, gender and sex, in interaction with socioeconomic circumstances and other determinants of health, influence exposure to health risks, access to health information and services, and health outcomes.

Although women as a group have a higher life expectancy than men, they experience a higher burden of chronic disease and tend to live more years with a disability.<sup>1,2</sup> Cardiovascular disease - including heart attack, stroke and other heart and blood vessel diseases - is the leading cause of death in women.<sup>1,3</sup> For women under 34 years of age, suicide is the leading cause of death.<sup>4</sup> Because they tend to live longer than men, women represent a growing proportion of older people, and the corresponding growth in chronic disease and disability has implications for health policy planning and service demand. In general, women report more episodes of ill health, consult medical practitioners and other health professional more frequently, and take medication more often.<sup>5</sup> In addition, while chronic conditions contribute to mortality and morbidity across the population, men and women may differ in their experiences of certain diseases, and this can have implications for diagnosis, treatment and recovery.<sup>6</sup>

While there are some overall differences in the patterns of illness and use of health services between women and men, there are also pronounced disparities among women. These health disparities are in turn shaped by wider social determinants such as socioeconomic status, ethnicity, age, disability, employment status, and geographic location.<sup>7</sup> Aboriginal and Torres Strait Islander women experience poorer health across almost all areas compared to non-Indigenous women, and have a significantly lower life expectancy than the wider population.<sup>8</sup> Social and economic disadvantage, limited access to services and inadequate housing are also directly associated with reduced life expectancy, premature mortality, injury and disease incidence and prevalence, and behavioural risk factors. Women living in rural or remote areas, women with a disability, and women from migrant or refugee backgrounds also tend to experience particular health challenges and inequities.<sup>9</sup>

### Guiding Principles

The AMA's position on women's health acknowledges the role of sex and gender in shaping health outcomes, and is informed by an understanding that health is "*a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity*".<sup>10</sup> The following principles inform the AMA's policy position on women's health:

**Social model of health.** A social model of health acknowledges the social, economic, political and environmental factors that influence women's health outcomes. Addressing these underlying determinants of health requires working across various government sectors, including health, housing, education, employment, social welfare and justice.

**Gender equity.** Achieving gender equity requires removing unfair, unjust and avoidable disparities in health.<sup>11</sup> 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 men and women from realising their potential for health.

**Health equity between women.** The health status and behaviours of women may be influenced by a range of factors including income, ethnicity or Aboriginality, sexual orientation, disability, education, geographic setting, and age. Acknowledging this diversity and removing systemic discrimination in health policies and strategies is vital in securing more equitable health outcomes.

**A focus on prevention and upstream interventions.** Addressing structural and systemic issues that affect women's capacity to adopt and maintain healthy behaviours.

**A life course approach to health.** Health policy planning and services need to address women's health across the life span, recognising the differing health issues that arise at different stages and the cumulative effects of experiences over time.

**Strategic coordination and leadership.** Improving women's health requires sustained commitment and coordination within and across different sectors, and at all levels of government. This includes national policy leadership to drive and support improvements across the different tiers of government.

**Building the knowledge base.** Women's health policy needs to be grounded in accurate data and research. Improvements in policy planning, implementation and monitoring require investments in strategic information systems for the collection and the use of data disaggregated by sex and age, and in the tracking of progress toward targets and other indicators relevant to women's health.

## Gender mainstreaming in health

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.<sup>12</sup>

Considering health through a gender lens recognises the ways in which gender roles, resources and perceptions can impact on women's and men's health. Integrating gender considerations into policy planning and delivery can therefore help to pinpoint areas of need, allocate resources and tailor interventions, and identify barriers or enablers to achieving better health outcomes.<sup>13</sup>

Gender specific policy and gender mainstreaming are dual and complimentary approaches to support gender equity in health. Mainstreaming gender in health does not preclude interventions that are specifically targeted to men or women, but recognises that such interventions are necessary and complimentary to broader approaches that integrate gender into health policy.<sup>i</sup>

- ***The AMA recommends that gender mainstreaming is adopted in national, state, territory and local health policies, and that a gender perspective is integrated into areas of policy that impact 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 gender mainstreaming into practice is system-wide and requires ongoing monitoring and accountability for outcomes.***

## Health promotion, disease prevention and early intervention

Many determinants of gender inequities in health can be influenced by health promoting measures and risk reduction strategies, ranging from interventions that enhance the knowledge and skills of women to manage their health; targeted health screening and detection programs; through to macro-policy measures that address the economic and social determinants of ill health.

Health promotion strategies aimed at reducing risky behaviours, such as smoking or physical inactivity, require consideration of the social and cultural conditions within which the targeted behaviours are embedded.<sup>14</sup> Such health promotion strategies can be more effective if combined with measures to change the social environments in which the health damaging lifestyles are embedded.<sup>15</sup>

### Health education and promotion

The impact of the biological and social contexts of women's and girls' lives should be considered in prevention and health promotion activities. In addition to influencing behavioural risk factors for preventable diseases, gender can affect how women and men experience and respond to health promotion programs or activities. Cultural and language differences, levels of health literacy, and socioeconomic circumstances are also key considerations in the targeting and design of health promotion interventions. Different health issues may also be more relevant to women's lives at different stages, and age-appropriate health information and health promotion is important.

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<sup>i</sup> This formulation of gender mainstreaming draws up the World Health Organisation's Madrid Statement, which describes mainstreaming gender equity in health as "a strategy that promotes the integration of gender concerns into the formulation, monitoring and analysis of policies, programs and projects, with the objective of ensuring that women and men achieve the highest health status. A mainstreaming strategy does not preclude initiatives specifically directed toward either women or men or towards equality between them. Such positive initiatives are necessary and complementary to a mainstreaming strategy."<sup>12</sup>

- ***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.***

#### Screening, health risk assessment and immunisation

Screening, immunisation, and the identification of disease risk factors are key preventive health interventions. The uptake of preventive health interventions is consistently lower among women from disadvantaged backgrounds, who report greater use of hospital outpatient services and increased morbidity and mortality from preventable diseases.<sup>1,16,17</sup> Socioeconomically disadvantaged women are also more likely to have a higher rate of health risk factors, such as being overweight or obese, smoking tobacco, and being exposed to violence.<sup>1,18</sup>

- ***The AMA affirms the value of population-based screening programs for the early detection of diseases and associated risk factors, and where there is a strong evidence base showing long-term reduction in the morbidity and mortality from the diseases concerned.***
- ***The allocation of funding to screening and immunisation programs should be informed by considerations around affordability, equity and access, the likely reach and size of impact, and the quality of the evidence base. Particular consideration should be given to improving the uptake of screening and immunisation interventions among women who are underscreened, at high risk of particular health conditions, or who face systemic barriers to accessing essential screening or preventive medicine interventions.***
- ***The AMA supports effective interventions for the prevention, screening and treatment of cervical cancer, include routine vaccinations against the human papilloma virus (HPV) and a national program for cervical cancer screening. Additional measures should be adopted to improve screening rates among groups of women who experience heightened mortality rates associated with cervical cancer, including women from Aboriginal and Torres Strait Islander backgrounds. The AMA also supports and encourages HPV vaccination for boys and men as part of an effective vaccination policy to reduce the incidence of cervical carcinoma in women. An evidenced-based approach should be taken in reviewing the appropriate screening intervals, age at first screen, impact of HPV vaccination, and the role of new technologies in the national cervical screening program.***

#### **Chronic disease and ageing**

Managing the increased burden of chronic disease and age-related disability is a fundamental public health and policy challenge, with implications for the sustainability of health care spending and the design and delivery of health services. It is important that the social context of this demographic shift, in which women and men are affected in different ways, is recognised. Men and women show differing patterns in the prevalence, manifestation and treatment of many chronic diseases, including cardiovascular disease, dementia, arthritis, osteoporosis, diabetes, and various forms of cancer.<sup>19</sup> Women not only have a longer life expectancy than men, but also experience higher rates of chronic disease and severe disability in older age cohorts, particularly in relation to dementia and musculoskeletal diseases.<sup>19,20</sup> As the chronic disease burden increases with an ageing population, the need to consider gender in the design, delivery and planning of health services and programs is a policy imperative.

The development of chronic disease among adult and older women is shaped by the impact of risk exposures across the life cycle, and the cumulative impact of these exposures as women age. Among women from the most socioeconomically disadvantaged backgrounds, the rate of premature mortality from chronic disease is 60 per cent higher than the rate for the least disadvantaged women.<sup>21</sup>

- ***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.***

### **Domestic and family violence and sexual assault**

Domestic and sexual violence are significant public health issues, and have serious and long-lasting detrimental consequences for women's health.<sup>22</sup> Across Australia, it is estimated that more than half the total population of women have experienced some form of physical or sexual violence in their lifetimes.<sup>23,24</sup> This rate is elevated among certain populations and, in particular, among women from Aboriginal and Torres Strait Islander backgrounds.<sup>25</sup>

Associations between domestic violence and poor physical and mental health of women have been consistently demonstrated in studies from both Australia and overseas.<sup>22,26,27,,28,29,30,31,32,33,34</sup> Using a burden of disease methodology, VicHealth determined that domestic violence is the leading risk factor contributing to death, disability and illness in Victorian women aged 15 to 44.<sup>35</sup> The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal ideation, and substance misuse.<sup>36,37</sup> Domestic violence is also associated with poor physical health, including injury, somatic disorders, chronic disorders and chronic pain, gastro-intestinal disorders, gynaecological problems, and increased risk of sexually transmitted infections (STIs).<sup>22,27,28,29,31,32</sup>

Women who have experienced sexual or physical violence tend to use primary care services more often, yet relatively few are identified in health care settings.<sup>38,39</sup> Screening, backed up by appropriate treatment and referral options, provides a unique opportunity for identification and early intervention.

- ***The AMA supports initiatives undertaken by federal and state governments that recognise and address issues relating to domestic violence within the community. The AMA recommends that the National Plan to Reduce Violence Against Women and Their Children be implemented and that it is adequately funded at both federal and state levels.***
- ***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.***
- ***The AMA acknowledges the widespread underreporting of domestic violence perpetrated against women and by women (to other women and to men). It supports ongoing programs to make reporting of such violence easier, and in so doing start processes to gain help to make domestic circumstances safer for all.***
- ***The role and extent of domestic violence, as a determinant of medical and psychiatric morbidity, should be included in undergraduate curricula, postgraduate training programs, and continuing education of medical practitioners. Continuing education of the profession is also necessary to highlight the critical role of primary health care providers in the early detection of victims of domestic violence, and to support the provision of trauma-informed care.***
- ***There is a need for continuing research into the emotional and social aetiology of domestic violence. Development and evaluation of intervention programs for both offenders and victims should be significant components within that research. Strategies to prevent domestic violence must incorporate recognition, understanding, and management of the underlying problems of the perpetrator, and the potential long-term impacts for victims of domestic violence or sexual assault.***

### **Mental health and suicide**

Mental disorders represent the leading cause of disability and the highest burden of non-fatal illness for women in Australia.<sup>40,41,42</sup>

Women's mental health needs may also differ at different times of their lives. Early childhood experiences play a significant role in determining future mental health. Adolescent and young women are more likely to have negative body image or body image dissatisfaction, which is in turn linked to a range of physical and psychological health concerns and risk-taking behaviours, including the development of eating disorders, depression, self-harm and suicide.<sup>43,44,45,46</sup>

Pregnancy and the postnatal period are also a time of vulnerability to poor mental health, and high quality care is needed for women before, during and after birth, particularly for women with existing mental illnesses. Women in mid-life have a higher prevalence of mental illness than other age groups,

and women's role as primary carers can also have a significant impact on their mental health and wellbeing.

Suicide in a family affects the mental health of all members. Although men have higher rates of suicide, women are frequently left to deal with the effects on remaining family members. This role requires significant support and specific measures to maintain the surviving woman's mental health.

- ***The AMA recommends that mental health policies should incorporate a gendered approach. Mental health policies and strategies adopted at different levels of government should be linked into and informed by national policies addressing women's health and domestic violence.***
- ***The AMA strongly supports special mother/baby units adequately resourced to deal with mental health issues in the peripartum period that enable mother and child to remain together in an appropriate facility should inpatient care be required.***
- ***Psychiatric inpatient facilities should provide areas of sex segregation and ensure safety and privacy for female inpatients.***

### Sexual and reproductive health

Access to comprehensive sexual and reproductive health services, screening, and information is critical to safeguarding and promoting the health of women. Sexual and reproductive health should be promoted within the context of women's health across the lifespan.

Contraception can prevent psychological distress and premature deaths of women from the consequences of unwanted pregnancies, particularly for women with a history of certain psychiatric and medical conditions.<sup>47</sup> In addition to reliable, reversible long-term contraception, emergency hormonal contraception should be an option available for all women through registered medical practitioners.

The non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies.<sup>48,49</sup> In addition to ensuring access to safe and legal termination services, women should also have access to appropriate support to maintain a pregnancy to term and subsequently to raise a child, and access to services for adoption where a woman chooses to continue the pregnancy to term but not to raise (or care for) the child. Access to such services should be on the basis of healthcare need and should not be limited by age, socioeconomic disadvantage or geographical location.

Child and maternal health outcomes are influenced by experiences in the journey from pre-conception through to antenatal care, delivery and postnatal care. Although maternal and fetal mortality and morbidity rates are relatively low in Australia, child and maternal health outcomes for Aboriginal and Torres Strait Islander peoples and some culturally and linguistically diverse populations remain poor.<sup>50,51,52</sup> Limited access to maternity services also contributes to inequitable maternal health outcomes in certain regions, including rural and remote Australia.<sup>53,54</sup>

Support for the health of mothers and babies should be provided throughout pregnancy, birth and the post-natal period, and should be coordinated and integrated throughout pregnancy and beyond, and across healthcare settings. Expectant mothers should have access to timely and relevant antenatal screening. Medical professionals play an important role in supporting pregnant women to make fully informed health care decisions, including the provision of advice on the risks and benefits to both the woman and the fetus of lifestyle and medical treatment options.

Mental health problems, including peripartum depression, can affect the wellbeing of mothers, and their babies and partners, during a time that is crucial to the future health and wellbeing of children. It is imperative service systems and healthcare providers support early detection and intervention to improve the outcomes for mothers who experience mental health conditions.

- ***The AMA supports the development of a national sexual and reproductive health strategy, which should address the social determinants of sexual and reproductive ill health, and work in conjunction with the National Women's and Men's Health Strategies.***
- ***Women should have access to legal and safe abortion; reliable, safe and affordable contraception; information and services to support adoption or maintaining a pregnancy; and appropriate sexual and reproductive health and information. Health services and policies should support women's health throughout pregnancy and birth. Critical recognition should be given to improving access to such services and information in rural and remote areas,***

*and to ensuring that services, information and targeted programs are available and appropriate for women with limited language literacy, women with disabilities, women from cultural and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander women.*

- *Sexuality education should be implemented in schools, and include areas such as healthy relationships, negotiating sex and contraception with a partner, and risk-taking behaviour. Sexuality education should be comprehensive, evidence based, age appropriate, and accessible to all young Australians.*
- *Health promotion strategies to support the prevention and treatment of STIs should be implemented and include targeted approaches for 'at risk' groups.*
- *Awareness of the underlying and gendered risk factors for infertility should be promoted.*
- *Health services and policies should support the health of women and their babies throughout pregnancy, birth, and in the post-natal period. Maternity services should be proactive in engaging all women, particularly women from disadvantaged or culturally diverse communities, early in their pregnancy and maintaining contact before and after birth. A system of clear referral pathways should also be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified.*
- *The detection, management and treatment of perinatal mental disorders should be supported by screening and access to appropriate services and supports. The AMA supports specific services for the management of peripartum depression and peripartum health issues, including in-patient access to mother-baby units.*

## **Addressing the needs of specific population groups**

### Aboriginal and Torres Strait Islander women

Aboriginal women have poorer physical and mental health in almost every dimension compared to non-Aboriginal and Torres Strait Islander women.<sup>8</sup> These disparities in health stem largely from social determinants of health and exposure to the risk factors for poor health.

Aboriginal and Torres Strait Islander women are 35 times more likely than non-Indigenous women to suffer family violence and sustain serious injuries requiring hospitalisation, and 10 times more likely to die due to family violence.<sup>25</sup> The tendency to have children much earlier, higher rates of pregnancy complications, and limited access to or uptake of early antenatal care are also critical factors in shaping health outcomes.<sup>55,56</sup> Aboriginal and Torres Strait Islander women experience higher rates of mental health conditions; have higher rates of morbidity and premature mortality associated with diabetes and other chronic conditions; and experience significantly higher rates of mortality associated with cervical and ovarian cancers.<sup>57</sup> Aboriginal and Torres Strait Islander women have lower uptake rates of preventive medicine and screening, and are twice as likely to present at hospital and outpatient services as non-Indigenous Australians.<sup>58</sup>

- *Addressing the disparities in health experienced by Aboriginal women is critical and requires a range of interventions and strategies targeting the social determinants of health; access to affordable and culturally appropriate health care; improving screening and early detection of health conditions; targeted interventions to increase health literacy and overcome the risk factors contributing to chronic disease and ill health; and mechanisms to enhance the numbers of Aboriginal and Torres Strait Islander women working and studying in the health workforce, particularly in the area of women's health. Such measures should be developed in partnership with Aboriginal and Torres Strait Islander women and agencies to ensure that they are culturally and linguistically appropriate and relevant.*

### Women from refugee and culturally and linguistically diverse backgrounds

The health needs of women from culturally and linguistically diverse (CALD) backgrounds are shaped by a range of factors, including their cultural background, language skills, socioeconomic circumstances, education levels, pre-arrival experiences, length of time in Australia, support networks, and possible experiences of torture and displacement. The health advantages that some immigrant women experience upon arrival in Australia often diminishes over time, and the rates of obesity, cardiovascular disease, and diabetes is disproportionately high among a number of culturally and linguistically diverse groups of women.<sup>59,60,61,62</sup> Immigrant and refugee women are at greater risk of

poorer maternal and child health outcomes, are less likely to have adequate information and familiarity with contraceptive methods, are less likely to access antenatal care, are at greater risk of contracting sexually transmitted infections, and are less likely to use preventive health services.<sup>63,64</sup> A small proportion of women from CALD backgrounds have been subjected to female genital mutilation/cutting, with potentially profound implications for their psychological and sexual and reproductive health.<sup>65</sup>

These health disadvantages tend to be most pronounced among women from refugee backgrounds.<sup>64,66,67</sup> Poorer health upon arrival can be compounded by difficulties accessing appropriate services, communication barriers, a lack of familiarity with local health systems, and the complexity of health needs that confront the practitioners providing health care. Asylum seekers or newly arrived women from refugee backgrounds often grapple with a range of social and economic factors that impact on their health and their capacity to access health services. This includes housing insecurity, unemployment or financial insecurity, disrupted education and limited language literacy, and social isolation.<sup>64</sup>

Access to culturally sensitive and relevant health care and information is vital in supporting the health of women from diverse cultural and linguistic backgrounds. Some people who have migrated may have come from social and cultural contexts in which gender roles and expectations differ from those that are widely accepted in Australia. In some instances, engaging the family may be critical in treating women from cultural backgrounds in which participation in healthcare is a family concern rather than an individual responsibility.

- ***The AMA supports measures that increase the capacity of the health system to serve the needs of women experiencing socioeconomic disadvantage and reduce inequities in access and outcomes, including reducing financial barriers and high out-of-pocket medical costs, and ensuring health information and preventive health programs are relevant.***
- ***Health promotion and service delivery should be culturally safe and sensitive, and take into account the social, cultural and linguistic factors that impact on the health of women from diverse cultural and linguistic backgrounds.***
- ***Health professionals should be supported in utilising interpreting services, and accredited interpreters should be used wherever possible rather than family members. Measures should be in place to support interpreter use in hospitals and community health services.***
- ***Upon arrival, all women from refugee backgrounds should be given comprehensive and culturally appropriate health assessment and screening. Particular consideration should be given to strategies to increase the engagement of refugee women with sexual and reproductive health services, preventive screening, contraception and mental health services.***

#### Women from socioeconomically disadvantaged backgrounds

Women experience greater rates of poverty, underemployment, and homelessness.<sup>68,69</sup> Socioeconomic disadvantage can be both a cause and a consequence of ill health. Women who are socioeconomically disadvantaged are more susceptible to poor health, including reduced life expectancy, injury and disease prevalence, higher rates of disability, and biological and behavioural risk factors.<sup>1</sup> Women from socioeconomically disadvantaged backgrounds report a greater use of hospital outpatient services, lower uptake of preventive health services, and lower rates of participation in health screening programs for breast, cervical and bowel cancer.<sup>1,17</sup> The risk of obesity is also 20 to 40 per cent higher in women who have low incomes and are experiencing food insecurity.<sup>70</sup>

Sole parent families, most of which are headed by women, are the most likely of all households to be living in poverty.<sup>71</sup> Single mothers experiencing socioeconomic hardship are particularly vulnerable to poor mental and physical health, and may struggle to meet the healthcare costs of their children.<sup>72, 73</sup>

A challenge for health promotion is to achieve a balance between focusing on the most disadvantaged and population-wide approaches. Health promotion services and messages are often taken up more by those who are socioeconomically advantaged, thereby exacerbating health inequities.<sup>74,75</sup> A strategic approach is necessary to ensure health promotion and preventive health programs are relevant and accessible to women from lower socioeconomic backgrounds, and are undertaken in conjunction with other measures that reduce the barriers to adopting and sustaining health promoting behaviours.

- ***The AMA supports measures to improve the affordability and accessibility of services for women experiencing socioeconomic disadvantage, including reducing financial barriers and alleviating high out-of-pocket medical expenses.***
- ***Actions to improve the health outcomes of women who are socioeconomically disadvantaged require engagement with a range of sectors, including social services, housing, education, homelessness, and domestic violence services. Policy responses need to consider both the influences of adverse socioeconomic factors on health, and the influence of ill health on the socioeconomic status of women.***

#### Women in regional, rural and remote areas

Many women in rural and remote areas face multiple disadvantages that impact on their health. Compared to their urban counterparts, women in rural and remote Australia experience poorer health, lower life expectancy and greater difficulties accessing a range of health services.<sup>59,59</sup> In addition, levels of alcohol consumption and rates of obesity and chronic disease are higher.<sup>76</sup> Remote and rural areas have disproportionately high rates of domestic and family violence, as well as fetal alcohol syndrome.<sup>77</sup> Women in these communities report fewer visits to GPs and specialists, and are more likely to be admitted to hospital for conditions which could potentially have been prevented through the provision of non-hospital health services and care.<sup>76,78,77</sup> Women living in some rural and remote communities have limited access to female or appropriately trained doctors that women feel comfortable with. As a result, some women living in such communities may not always seek health advice and treatment in sensitive areas such as the prevention of cervical and breast cancer, fertility control, menopause, and domestic violence.<sup>79,80,81</sup>

- ***The AMA supports a combination of policy approaches to improve the availability of health services in regional, rural and remote areas, including recruitment and retention incentives; supportive health funding models; improved health infrastructure; and medical specialist outreach assistance programs, including outreach maternity and women's GP services for communities that lack such services. Investment in mental health and domestic and sexual violence services is vital to improve access to these services in rural and remote areas.***
- ***Policies that seek to improve the health of women should take into account the health disparities and access barriers that exist in regional, rural and remote areas.***

#### Women with a disability

Women with a disability can experience multiple disadvantages that impact on their mental and physical health. They are less likely to use primary preventive healthcare services, such as cancer screening, and are significantly more likely to experience intimate partner violence.<sup>82</sup> There is often limited adaptability of health services towards the specific needs and rights of women with disabilities, especially in the area of sexual and reproductive health.

- ***Australian laws and regulations on sterilisation procedures performed on girls and women living with disabilities should ensure these procedures are only carried out in cases of medical necessity or where they have been mandated by a court.***
- ***Women with a disability have the same right as other women to safe, reliable and personally suitable contraception.***
- ***Women with a disability have a right to safe and adaptable access to sexual and reproduction health services and information.***

#### Lesbian and bisexual women

While lesbian and bisexual women are a diverse group, discrimination and marginalisation can impact on their health and wellbeing in multiple ways. Women who identify as bisexual or lesbian are more likely to have experienced violence, higher rates of depression and higher risk behaviours, and lower rates of cervical cancer screening. For some same sex attracted women, the fear or experience of insensitive treatment can be a barrier to accessing appropriate and acceptable health care.<sup>83</sup>

#### Carers

Women comprise over 70 per cent of primary carers, and primary carers who are women are more likely to provide more intense levels of care.<sup>84</sup>



Carers make a valuable social and economic contribution to society, and many report personal satisfaction from their caring role. However, carers also consistently experience poorer physical, mental and emotional health and wellbeing because of their caring responsibilities. Depression, emotional and physical exhaustion, disturbed sleep, and general poor health are common among carers, with rates of depression being particularly pronounced among women carers.<sup>85,85</sup> Many neglect their own healthcare needs due to limited time or the ability to afford appropriate treatments. Many women carers experience a significant economic burden due to limited labour force earnings, less access to superannuation savings, and limited or no access to income.

- ***Policies and programs should support carers to enjoy optimum health and wellbeing, and to minimise the adverse health burdens that can arise due to their caring responsibilities. This includes access to affordable respite services; financial support to maintain health and wellbeing; access to information to support their caring role; peer support programs; and, where necessary, supplementary home support services to help them continue to provide care at home.***

## Health services and workforce

### Access to health services

Women tend to use primary care services more than men, however the access and uptake of such services varies considerably among different groups of women. Access to primary care services is an important health determinant, and the range of barriers women may face in accessing these services can prevent them from fully enjoying their fundamental right to health. These barriers to access may stem from factors within the health system itself, such as high costs; geographic factors or lack of infrastructure; organisational factors, such as waiting lists or opening hours; or insufficient or inappropriate information. They may alternatively relate to the circumstances or characteristics of the potential service user, such as education, age, language, and disability. Some women prefer to have access to a female primary care worker, and this can impact on women's health service utilisation patterns.<sup>83</sup> As 57 per cent of Australian general practice consultations are with women<sup>86</sup>, the gender specific primary health needs of women constitute a significant proportion of the general practice workload.

- ***The AMA acknowledges that access and equity to affordable, timely and quality primary care health services is critical for women to allow prevention, early detection and treatment of illness, and management of chronic disease. Particular consideration should be given to identifying and reducing inequities in access.***
- ***The AMA acknowledges the important role of community-based health centres that support women's healthcare needs, provide outreach to socially and economically disadvantaged women, and provide a focus for support groups, nursing and other ancillary health services. Such services should not be a substitute for mainstream health services, but can provide a complementary service system.***

### Workforce planning, training and development

In the context of population ageing, sustaining levels of healthcare provision and addressing emerging areas of needs is a fundamental challenge. The proportion of women with chronic or long-term health conditions is growing at a faster rate than men, with implications for the distribution and role of the health and medical workforce, as well as implications for long-term planning in terms of the structure, service delivery model, and education and training of the health and medical workforce.<sup>87</sup>

While there is an overall shortage of doctors in rural medical practice, women are even less likely to practice in rural areas.<sup>88</sup> Lack of access to female doctors for women living in rural and remote communities means that women may not always obtain health advice and treatment in sensitive areas such as the prevention of cervical and breast cancer, fertility control, menopause, domestic violence and many other health issues.<sup>89</sup>

- ***The AMA supports a combination of initiatives to provide regional and rural areas with a more equitable share of the medical workforce. This should include recruitment and retention initiatives for medical practitioners, and flexible work arrangements all owing a better balance between work and personal/family commitments. Outreach programs to provide funding assistance for specialists visiting rural and remote areas are a valuable means to enhance the delivery of services in these areas. These programs should be adequately funded and directed to communities where an unmet need is established.***

- **Medical education and training should incorporate principles relating to gender awareness and equity.**<sup>90,91,92,93</sup>

### **Research, data collection and evaluation**

Accurate and comprehensive data, sound research and ongoing evaluation are essential for effective policy, planning and service delivery for women.

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.<sup>94,95,96</sup> 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, 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.***

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## REFERENCES

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