

# National Strategy to Achieve Gender Equality: Consultation – Health and Wellbeing Meeting Summary

1 December 2022

*The government is developing a new* [*National Strategy to Achieve Gender Equality*](https://www.pmc.gov.au/office-women/national-strategy-achieve-gender-equality)*. The National Strategy will guide whole of community action to help make Australia one of the best countries in the world for equality between women and men.*

*Consultation with diverse stakeholders is key to developing a strategy that speaks to the experiences and ambitions of women and girls around Australia. The first phase of consultation took place in late 2022 and summaries of these discussions are shared to support further consultation and input into the development of the National Strategy.*

*This note summarises a consultation meeting held on 1 December 2022 focused on health and wellbeing, which included representatives from peak bodies, academia, not-for-profit organisations, non-government organisations, community service organisations, and state government. The consultation drew on a* [*discussion paper*](https://www.pmc.gov.au/sites/default/files/2023-02/Roundtable-Discussion-Paper_Health-and-Wellbeing.docx) *prepared by the Office for Women. This summary note reflects the discussion amongst the participants. These are not the views of Department of the Prime Minister and Cabinet.*

### Summary of key points raised by participants:

* 1. There is a systemic and long-term undervaluing of the health and wellbeing workforce, which is dominated by women.
  2. Women’s experience of cumulative and compounding systemic inequalities across their lifetime means women have poorer health, wellbeing and safety outcomes.
  3. There is a need for targets and reforms to support an increase in leadership diversity and improved culture to in-turn improve outcomes for the workforce and patients.
  4. Lower access to, and affordability of, appropriate preventative care, reproductive care, and medical gender affirmation is a driver of the health outcome gap. This is also a symptom of intersectional issues related to age, financial inequality, caring roles, and cultural background.
  5. Non-inclusive education, biases, and operating systems used by medical professionals create barriers and outcome gaps, particularly for the LGBTIQ+ communities.
  6. There is a need to provide Medicare and appropriate services to all people in Australia including migrants, refugees, international students and women on longer-term visas.

### Discussion at this roundtable focused on four questions.

### What are the drivers of gender inequality?

Participants discussed systemic inequalities in the health system, as well as conscious and unconscious biases, that mentors and supports men into leadership positions. The conscious and unconscious biases of medical practitioners include stereotypes about women’s behaviours, stigmatisation of women with disease, illness and addictions, and stigmatisation of reproductive health. The absence of women and diversity in leadership perpetuates the subconscious belief that women are not suited to leadership.

Representation of women in media and advertising is a significant driver of gender inequality. Sexist advertising conspires with perpetrators to justify their beliefs and attitudes. These representations also contribute to body images issues, contributing to mental health and eating disorders, and perpetuate outdated gender norms and roles.

Australia’s healthcare and social assistance has the biggest gender pay gap which has increased over the last year. Multiple factors drive a persistent gender pay gap in the health sector. For example, the systemic long-term undervaluing of feminised sectors and associated skills, and women General Practitioners commonly taking longer patient consultations and charging less for it.

Women’s experience of cumulative and compounding systemic inequality across their lifetime mean women have poorer health, wellbeing and safety outcomes. Women are often in lower paid and less secure employment and they retire with less superannuation.

Unequal distribution of care labour has flow-on health impacts for women. Women are often primary carers and may use their sick leave when children or other dependents are sick. This means that women may delay or not seek medical attention and preventative checks, such as cervical screening and mammograms, to preserve their sick leave.

### What are the barriers to improving gender equality?

Lack of available data in service provision and research to inform change and decision-making. This includes gender disaggregated data, intersectional data, and medical research data on women and their different health circumstances such as pregnancy and menopause. Many government forms also do not adequately capture gender options and other intersectional factors, and patient forms do not distinguish between sex and gender.

Access and affordability of appropriate preventative care, reproductive care and medical gender affirmation is a driver of health outcome gaps and a symptom of intersectional issues. This is more prevalent in rural and remote locations. Women carers and parents are time poor and access preventative care less. There is also insufficient public funding and focus on preventative care. Health needs and issues grow alongside impacts of age and financial disadvantage, and the specific health needs of older women living in financial hardship need to be considered.

Women’s socio-economic situations drives poorer health outcomes for themselves and their families and children. Preventative treatment is rarely accessed by women living on the poverty line or in financial hardship, health services are generally only accessed when health issues are acute and urgent. Participants noted that during COVID-19 there were reports that women who received the coronavirus supplement were able to access health and wellbeing services that were previously out of reach.

Transgender and gender diverse people experience stigma and discrimination across multiple social structures throughout their lifetime and this leads to poorer health outcomes. Often transgender and gender diverse patients take on the role of the educator and share their personal story, which may impact on their mental health. Intersex people may be encouraged to have surgery when young to fit into the gender binary. Women aged over 55, including transgender women, are the fastest growing group experiencing homelessness.

The lack of medical practitioner education reduces access to gender inclusive and trauma informed care. This can exacerbate mental health issues and isolate LGBTIQ+ people from care.

There are low levels of health literacy and digital literacy particularly for culturally and linguistically diverse women in understanding and accessing care options. Many digital health services and information are available online and on apps that are in English. Health information is also best delivered by trusted and adequately trained community leaders.

General pressures on the health care workforce, including lack of support offered to employees, can result in women leaving the workforce. Current reductions in staff numbers strains remaining staff and compromises patient care. Workforce mental health support is needed throughout their employment.

### What are some concrete policy options that should be considered as part of this Strategy to achieve greater gender equality?

Focus on gender equity in health and wellbeing, rather than gender equality. Equity of outcomes accounts for different patient needs and different levels of care required to achieve equally good health outcomes for all.

Participants discussed the following options to support all women (staff and patients):

* Targets and reforms to support a substantial increase in diversity of leadership and cultural change to improve outcomes for staff and patients in the healthcare and medical sectors.
* Clearer discrimination legislation to minimise grey areas of Australia’s laws and regulations.
* Effective engagement in schools to challenge discrimination and bullying.
* Reproductive health leave.
* Social security system reforms, with appropriate income support to ensure women are not living below the poverty line and can access adequate and stable housing.
* Respectful Relationships programs in schools.
* Government working with private sector and industry on improving online safety.
* Consider further workplace reforms to support women balancing work and care responsibilities, and alternative models of workplace flexibility.
* Gender equity training and culturally sensitive practice in health qualifications.
* Increased focus and funding for preventative health.

### Participants raised options to support patients:

* Provide access to Medicare and childcare support initiatives for all women in Australia including migrants, refugees, international students and women on longer-term visas.
* National affordable or free reproductive care for all genders.
* Strengthen standards and affordability of gender sensitive and appropriate care, including better reflecting sex and gender markers on medical forms and undertaking trauma informed practice.
* Improve women’s safety through community initiatives, focus on primary prevention of violence to address the drivers of gender equality.
* Reform medical research funding to support new research that includes women.
* Expand the role and scope of nurses and midwives to improve health outcome gaps, including nurse-led clinics and nurse practitioners who can prescribe medicine, and grow the number of mid-wives and scope of access to support reproductive health.
* Improve health and digital literacy and communicate in a culturally appropriate way, through digital literacy training, health websites and resources in other languages, and educating trusted cultural community leaders.

Participants raised options to support healthcare workers:

* Recognise international qualifications so skilled women can fill shortages, and so their career path is not shifted into lower paid jobs.
* Fair and equal pay reforms through legislative and industrial relation changes.
* Greater secure employment options and valuing of ‘women’s work’.
* Improvements to parental leave and access to childcare.
* Medical training placements that are more flexible to support taking sick leave, carer’s leave, and account for families that are not in a nuclear arrangement.

**What will success look like and how can that be measured?**

Participants discussed the need for a collaborative approach across Government in measuring success and taking accountability for policy. This needs to be supported by increased and more inclusive data collection and forms of measurement, such as expanded intersectional Census questions.

New measures of success should be developed through a co-design process. Co-design can be a purposeful targeted process that identifies cultural discrimination overtones and options to mitigate these issues.

An increase in accessing mainstream medical services, and patients receiving the care they need in an inclusive and appropriate way. For example in reproductive health, see an earlier diagnosis of endometriosis and reduction in infertility.

Narrowed gender pay and gender diverse representation at all levels – 40 per cent women, 40 per cent men and 20 per cent any gender.