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**SUBMISSION TO THE INDEPENDENT REVIEW OF HEALTH AND  
MEDICAL RESEARCH IN AUSTRALIA**

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## **Introduction**

The Australian Women's Health Network is pleased to be able to contribute to thinking about the crucially important future directions of health and medical research in Australia. In this submission, identified questions three and four will be addressed, covering terms of reference 4, 5, 8, 9, 10, 11, 12 and 13.

In relation to the question concerning health and medical research strategic directions and priorities, while recognising the importance of treating diseases once they have developed, the Australian Women's Health Network holds the view that increased effort should be put into discovering more effective mechanisms for the prevention of disease, particularly diseases that have their origins in social arrangements. The small body of research that we have demonstrates that much of the Australian disease burden is preventable and that we have an enormous number of unnecessary, preventable and expensive hospitalisations. In particular, a short supply is research about the prevention of socially determined ill health, including the impact of gender.

*The Australian Women's Health Network recommends an equal division of the health and medical research dollar between individual and social causes of illness, including gender. We urge that achievement of this outcome be given top priority status.*

An answer to the question about how Australia can optimise the translation of health and medical research into better health and well-being assumes that we have in our possession an adequate body of research information, not only about the biological causes of ill-health and their treatment but also about the social causes of poor health outcomes and information about how to respond appropriately. Armed with such information, health research dollars should then be expended to discover a) what sort of health system structures can best provide access to prevention and support services as well as treatment services and b) what kinds of changes outside the health system are necessary for improved population health.

*The Australian Women's Health Network recommends that significant amounts of research funding be devoted to the study of how the Australian health system can be reformed to provide prevention and support services as well as treatment services and that research be undertaken into the most important factors outside the health system that have a deleterious impact on health outcomes.*

## **The Importance of Research into the Social Causes of Poor Health (as well as into biomedical causes).**

The Australian Women's Health Network views health from a social perspective, in keeping with the main thrust of the work of the World Health Organisation. This perspective has recently been endorsed in Australia in the final report of the Health and Hospitals Reform Commission, in the report of the National Preventive Health Task Force, in the *National Disability Strategy* and by most State and Territory governments. Stephanie Bell, Director of the Central Australian Aboriginal Congress, captured the essence of the social health perspective nicely in 2001 when she said

*A person's physical health is like a frozen moment taken from the social and economic environment.*

Evidence of the social causes of poor health provides an underpinning for critiques of conventional medical care systems, in the sense that a treatment focus alone is unnecessarily narrow and misses a great deal that is critical for optimal human health. In a social view, the focus is on population as well as individual health. It is concerned with 'the causes of the causes'. In Australia, the women's health movement, the Aboriginal health movement and the new public health movement have all argued that *more information about the social causes of poor health is urgently needed.*

International research shows that health outcomes emerge from complex interactions between social, economic, cultural, environmental and biomedical factors, rather than arising from biological determinants alone. Furthermore, many women researchers argue that biology is not given and unchangeable, as it tends to be in a medical scientific perspective, but is influenced by multiple factors. Therefore, biomedical processes *need to be understood in their social context.* In this view, 'there is a close interplay between social and biological factors, which means that biology must be problematised' (Hammarstrom 1999:243). *Such evidence demonstrates that health and medical research must be informed by a social determinants as well as a medical model in order to produce a rounded picture of the determinants of health outcomes.*

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

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

Such arguments fit with the findings of earlier studies. For example, Kawachi et al. (1999) studied men and women in 50 American States and found that both smaller wage gaps between the sexes and higher levels of women's political participation were 'strikingly

correlated' with lower female *and male* morbidity and mortality. Status, the authors concluded, reflects 'more general underlying structural processes associated with material deprivation and income inequality'. The arguments of Australian Aboriginal people, for example, who point to the devastating health consequences of colonisation and racism are corroborated by these findings. It follows that it is in the interests of all members of society that comprehensive research into all the causes of poor health is produced.

In the case of the health of the most disadvantaged, the close association between poverty and very poor health outcomes holds both between countries—some rich, some poor—and within countries, whether they are OECD countries or those that are less well off (WHO 2008a). Moreover, women in Australia, as everywhere, are over-represented amongst the poor, thus highlighting the need for a gender lens to be applied to all health and medical research.<sup>1</sup> Australia's gender pay gap, for example, contributes to economic insecurity, increasing the number of low-income families, especially female-headed families, with a negative impact on health, including the health of children. It also contributes to financial vulnerability for women, especially women in retirement. The effects of the pay gap are exacerbated by socially prescribed caring responsibilities, which reduce the workforce participation rates of women, whether they be mothers, daughters, friends or neighbours.

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

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

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

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<sup>1</sup> This is not generally the case for Aboriginal women, who point out that they often have better jobs and higher education levels than Aboriginal men.

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

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

From these brief pieces of evidence, it can be seen that a biomedical approach to health and medical research cannot alone capture more than a partial view of the causes of outcomes. It can only illuminate the immediate or direct causes of ill health, as located in individual bodies in interaction with outside causal factors, such as germs, toxins and injuries. The human body is not a contained system and ill health is not merely a failure of one of the parts. Disease unfolds within individuals in day-to-day interaction with broader social and physical environments (Doyal 1995:15–16).

Therefore, a top priority for Australian health and medical research over the next decade should be to move towards a system where health research funding is divided relatively evenly between research into the social and individual causes of poor health outcomes.

### **Optimal Translation of Health and Medical Research into Better Health and Well-Being Outcomes.**

If both the social and biomedical 'causes of the causes' of poor health can be known and understood and if healthy outcomes are to be optimised, it follows that health and public policy should focus on prevention as well as cure and on the reduction of glaring social inequalities. International evidence demonstrates that where countries have made substantial investments in primary, community-based health care to complement medical and hospital services, health outcomes are improved. Ideally, of course, in order to optimise health and well-being, extensive public intervention is necessary, both inside and outside health systems. A comprehensive program would require investment in economic security, physical security, affordable housing, accessible education, food security and so on. Such a broad approach might be considered outside the scope of this enquiry. However, to provide a comprehensive picture of what is needed to optimise outcomes, health and medical research must provide evidence about the conditions of people's lives that make them sick and about what needs to be done to modify or eliminate the most pernicious forces.

To return to the medical care system, as presently structured, there are a number of crucially important structural barriers to improved population health. These include serious access barriers to conventional treatment services, as well as high access barriers to preventive health and support services. Population health outcomes can only be optimised if these structural barriers are addressed and removed.

## **Structural Barriers to Improved Population Health**

Australia exhibits a number of entrenched structural barriers that impede full access to hospital and medical treatment. These include (but are not limited to) the fee-for-service system of doctor remuneration, the Australian preference for small medical practices, increasing user charges and imbalance in the geographical spread of services. Financial barriers also inhibit access to allied health services, including dentistry, physiotherapy, dietary advice and the like. Further, there is still excessive emphasis on a medical model of care in medical and nursing education with insufficient emphasis on training to increase awareness of prevention and of cultural, sexuality and gender differences. Culturally inappropriate services constitute a serious barrier to access.

## **Fee-For-Service Medical Services**

Although Medicare is a type of national health insurance, it provides only partial coverage against the cost of medical services outside hospitals. Australian user charges—that part of the cost of a service paid for by the user—have been allowed to increase steadily since 1984 and are now among the highest in the world (Schoen et al. 2010:2327). There is a large international literature showing that user charges constitute a serious financial barrier to access, especially for low-income people (reviewed in Gray 2004:65–77). In 2009, 22 per cent of Australians went without care because of cost, 21 per cent paid user charges of \$1000 or more and 8 per cent reported being unable to pay medical bills or having serious problems paying (The Commonwealth Fund 2010). Moreover, the cost of accessing the services of allied health professionals, including dietitians, physiotherapists, psychologists, counsellors, podiatrists, dentists, midwives and alternative therapists, is beyond the financial capacity of a great many Australians and is especially difficult for low-income people, especially women.

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

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

The inverse-care law also operates strongly in relation to residents of rural and remote areas, where services of all types are in short supply, despite evidence that rural people suffer poorer health than people living in metropolitan areas.<sup>2</sup> If we were to take the optimisation of population health seriously, reforms would be implemented to modify and, in an ideal world, eventually eliminate, all of these structural barriers.

Australian health policy has failed to deal with the overt barriers that impact adversely on access to hospital and medical treatment. These fundamental shortcomings must be addressed as a preliminary step towards improving health outcomes. The provision of up-to-date and apposite research is needed to inform policy processes.<sup>3</sup> In addition to the problems of access to conventional medical care, to optimise health outcomes, structural changes are needed to strengthen the primary health care system.

## **Structural Barriers to a Stronger Primary Health Care System**

The important barriers weighing against the development of a more comprehensive healthcare system include cultural factors, financial forces and the stake that powerful groups have in preserving the system as it stands. Ideas about what is appropriate and necessary in a health system take a long time to change. The century-old idea that a health system provides hospital and medical services and not much else is taking a long time to fade. Because there are so few comprehensive primary healthcare centres in Australia, most people have no experience of the kind of care they could be offered and are probably unfamiliar with what is done in other countries in the name of holistic primary health care. What we do know, however, as the experience of women's health centres clearly demonstrates, is that when people have an opportunity to access such services, they are prepared to line up for hours all wait many weeks to do so.

The fee-for-service method of payment works against the provision of comprehensive, preventive, primary health care.<sup>4</sup> It operates as an economic incentive for doctors to see as many patients as possible, as quickly as possible, producing high turnover, curative medicine. It discourages the longer appointments necessary for thorough check-ups, for the management of complex and chronic conditions and to engage in primary prevention work. Internationally, fee-for-service remuneration has come under heavy criticism. One OECD assessment argues that it gives physicians 'full discretion' over the level and mix of services and creates incentives 'to expand the volume and price of the services they provide' (OECD 2003). Policy in a number of European countries is moving away from fee-for-service towards other forms of payment. Fee-for-service has been replaced completely with contract and salaried payment in New Zealand. Recent research shows that the percentage of New

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<sup>2</sup> We do not have geographical access problems of such magnitude in education because education is do not operate as private business entrepreneurs.

<sup>3</sup> It is instructive that the best evidence we have about access to services is not produced in Australia but rather emanates from overseas work. We cannot begin to optimise health outcomes without Australian evidence as a basis for appropriate political and policy action

<sup>4</sup> There is a distinct contrast between primary health care and primary medical care. Whereas primary health care focuses on the provision of a comprehensive range of community based services, including prevention, primary medical care is mainly concerned with the delivery of conventional treatment services to individuals.

Zealanders who go without care because of cost has fallen since 2004 when this change came into operation (Schoen et al. 2010:2327).

In the 1970s, government members and committed bureaucrats ‘talked up’ the value of comprehensive primary health care, whereas in the twenty-first century, most health debate focuses on hospitals and their waiting lists. Despite acknowledgement of the importance of preventive health care in recent health documents, there is not enough Australian-based evidence that demonstrates the value of comprehensive, community-based health care. A preference for solo or small group practice, supported by the financing system, is another structural barrier to comprehensive, primary health care. When women talk about gaps in services, they have in mind such services as prevention advice, counselling and support which are in such short supply under present Australian arrangements. Evidence from overseas shows that teams of health professionals are necessary to deliver an integrated and comprehensive range of preventive, educational, counselling, caring and social advocacy services, alongside conventional medical services. Australia's National Health and Hospitals Reform Commission acknowledged this body of overseas evidence. It also shows that the sharing of ideas and the collegiality that comes with teamwork is beneficial to providers and clients alike. Health teams have been introduced in some European countries and in New Zealand and Canada.

Finance is another factor militating against greater investment in strong primary health care and presents Australian governments with a circular dilemma. Hospital and medical costs have increased faster than other prices for decades and, even for the Commonwealth, which controls most of the Finance in the Australian Federation, they are a large budget item. Under these circumstances, it is difficult for governments to find new money to invest in new prevention oriented services. Yet the only effective way to control hospital and medical cost increases is to improve population health. Under the circumstances, delaying investment in comprehensive primary health care ensures the continuation of a destructive spiral: low spending on primary health care results in avoidable illness and unnecessary hospitalisation, which leads to unnecessarily high expenditure on hospital and medical services which, in turn, manifests in low spending on primary health care.

The National Health and Hospitals Reform Commission drew attention to this quandary, commenting on the lack of any nationally coordinated mechanism to deliver preventive health care. In relation to chronic disease, it argued that Australia spends less than 2 per cent of the health budget on ‘a problem which consumes a major proportion of health expenditure’ (Commonwealth of Australia 2009c:51). Meanwhile, highly expensive practices are not only maintained but are expanding. For example, Australian rates of Caesarean section are high by international standards and growing (although they are defended by certain groups of professionals). Indeed, all the English-speaking industrialised countries have high rates, except for New Zealand, which, since the important reforms of the 1990s expanding the roles and responsibilities of midwives, is now placed about the middle. The OECD country with by far the lowest caesarean section rate is the Netherlands, where medicalisation has always been lower than anywhere else and where approximately one-third of babies are born at home (OECD 2011).

The mainstream Australian health system must embed ‘prevention and early intervention into every aspect’ of the system, as recommended in 2009 by the NHHRC (Commonwealth of Australia 2009c:95).

*Strengthening the Australian evidence base to demonstrate the value of comprehensive, community-based primary health care is a necessary part of producing a situation where the translation of health and medical research into better health and well-being will be increased.*

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