Submission towards the development of a new
National Women’s Health Policy

on behalf of

The Royal Australasian College of Physicians

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Executive Summary
The arena of women’s health needs continuing investment and strong policy direction in order to adequately address and improve the health status of Australian women. Such improvements will flow on to benefits in the health and well being of families and communities. This will align with the Governments social inclusion agenda, along with international developments. Other benefits will include greater participation and productivity in paid and unpaid work which is crucial to the economy. Access Economics has estimated that an increase in women’s participation could increase national output by around $100 billion by 2040.¹

This policy should seek to address the broad needs of all Australian women, including Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds (including migrants and refugees), women from disadvantaged backgrounds (including women experiencing homelessness), women from rural and remote areas and women with a disability including mental illness. This policy should emphasize prevention, address health promotion, health inequalities and the social determinants of those inequalities.

The College welcomes the Preventative Health Taskforce’s proposal to develop a National Prevention Agency (NPA) as a move that will comprehensively improve the health of the nation, and will therefore positively impact upon the health of women.

The Royal Australasian College of Physicians (RACP)
The Royal Australasian College of Physicians (RACP) is a Fellowship of more than 10,500 specialist physicians and 4,000 trainees who practise in more than 25 medical specialties including paediatrics, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, rehabilitation medicine, palliative medicine, geriatric medicine, sexual health medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the well-being of patients. The College works to establish and achieve the highest standards of contemporary knowledge and skill in the practise of medicine and promote the health and well being of the community and of its members. The College, in collaboration with affiliated specialty societies, is the provider of frameworks and standards of education for specialist physicians and trainees.

In 2009, the RACP identified three key areas of policy focus – Indigenous health, the prevention and management of chronic disease, and workforce. These issues all cut across the arena of women’s health. The College is a key stakeholder in the Australian health system, and it advocates for improving the health and wellness of individuals and communities and reducing disparities across population groups relating to women’s health.

Introduction
The purpose of the proposed National Women’s Health Policy is to improve the health and wellbeing of all women in Australia, and especially to those with the highest risk of poor health.² It sets out to encourage the health system to be more responsive to the needs of women, to
actively promote the participation of women in health decision making and management, and to promote health equity among women. In everyday practice many female patients are referred to physicians, many of whom are suffering from female-only illnesses or illnesses which affect women disproportionately.

Marketing health to women is a crucial component of any successful program which seeks to improve women’s health. Campaigns such as awareness weeks are seen as effective ways of raising the profile of women’s health issues and should be targeted to specific groups to achieve the best outcomes. There is a need for comprehensive gender relevant evidence and the current literature provides clear evidence of the health problems that exist for women in Australia.

Particular female sub-populations are more likely to experience poorer health and poorer health outcomes. These populations include:

- Aboriginal and Torres Strait Islander women (ATSI);
- Women from cultural and linguistically different backgrounds (CALD);
- Women from socioeconomically disadvantaged backgrounds;
- Women who live in rural and remote Australia;
- Women with a disability and/or chronic illness;
- Older women
- Women living alone and in residential aged care facilities

There are several conditions which require attention when considering women’s health. Including:

- Breast cancer (predominantly women)
- Cervical and ovarian cancer
- Menopause
- Reproductive health including gestational diabetes and pre existing diabetes in pregnancy
- Antenatal and postnatal depression
- Endometriosis
- Polycystic ovary syndrome
- Osteoporosis
- Dementia & Alzheimer’s disease
- Women as carers

Changes in the leading causes of death as a woman grows older reflect the ageing process and longer exposure to risk factors. For girls and young women, injury and poisoning are the major causes of death. Among women aged 25 to 64, cancer is the leading cause of death, and for women aged 65 and over, cardiovascular disease is the leading cause.  

Gender Equity

The Government's approach to developing the National Women's Health Policy should be based on a principle of gender equity. To achieve gender equity in health, both women and men need health policies that target their specific or unique needs. The leading causes of death and burden of disease in Australia demonstrate that there are differences in the conditions experienced by women and men. Disparities exist with women experiencing more of the burden of disease in the following illnesses: anxiety and depression, breast cancer, cardiovascular disease, dementia and Alzheimer’s disease and musculoskeletal disorders.

Musculoskeletal (MSK) disorders combined are the common cause of disability in the Australian population and the majority are more prevalent in women than men. Osteoarthritis and knee pain is one of the major factors influencing quality of life and physical activity among obese women, and women are almost twice as likely to report a diagnosis of rheumatoid arthritis.
Osteoporosis will affect 1 in 3 women in their lifetime, with the most significant implications being hip and other fractures. It is estimated that in Australia, approximately 60% of women over the age of 60 years will suffer an osteoporotic fracture in their remaining lifetime. Data is often based on self report and is therefore likely to underestimate the actual prevalence, as osteoporosis is often not diagnosed until a fracture occurs. Fractures in post-menopausal women cause significant loss to quality of life and increased mortality. It is estimated that in Australia by the year 2025 fractures will more than double due to the expected aging of the population and correspondingly costs will escalate. Prevention measures that include minimising falls risks, medications and education surrounding lifestyle choices are all essential in the prevention of osteoporosis. Improved detection, treatment and education programs will also need to be facilitated in rural and remote areas of Australia.

The National Service Improvement Framework document identified the following key priorities for MSK conditions in Australia - early diagnosis and treatment of rheumatoid arthritis (including juvenile arthritis); chronic disease management strategies for people with all stages of osteoarthritis, including orthopaedic waiting lists to facilitate timely access for hip and knee joint replacement surgery; and identification and treatment/prevention for people who have sustained an osteoporotic fracture. Education to improve knowledge of MSK disorders and raise awareness was considered to be a priority for: the general community, those affected by MSK disorders, as well as health professionals in undergraduate and post-graduate training.

Health Inequalities and Socioeconomic Disadvantage
The evidence for the existence of health inequities in Australia is substantial and long standing. The underlying causes of such disparities are complex, and include unemployment, low income, poor educational achievement and geographical location. Typically specialist physicians deal with more serious and complex health conditions. These conditions are overrepresented in people who are socioeconomically disadvantaged. As there is currently no Australian data on specialist service utilisation according to socioeconomic status, the implications from overseas research need to be considered by the Government and by specialist medical bodies such as the College. The College recommends that funding and effort is deployed in addressing the social determinants of health in order to rectify the health inequalities that exist.

Life expectancy for Australian women is increasing and now ranks equal second in the world. Australian women have a higher life expectancy than men (83.7 compared to 79 for males in 2005/6). However, while the average life expectancy for women continues to rise, significant health inequalities exist between different groups and there are worrying levels of risk factors responsible for causing chronic illness, injury and premature death. In addition, much of the gain in women’s life expectancy is being spent with disability and disease.

In 2000–02, women living in the most disadvantaged geographical areas had a 29% higher death rate from coronary heart disease than people living in the most advantaged areas. Socioeconomically disadvantaged women report greater use of doctor and outpatient services, but are less likely to use preventive services. They are likely to have a higher rate of health risk factors that include tobacco smoking and being exposed to violence. Participation in preventive health screening programs is lowest for the most disadvantaged groups.

Changes in the leading causes of death with increasing age reflect the ageing process and longer exposure to risk factors. These tend to be more prevalent among disadvantaged and vulnerable groups of women. Addressing these inequalities will require new approaches to provide a basis for coordinated action and a focus on preventive strategies will have the potential to improve the health and well being of health for Australian women.
Aboriginal and Torres Strait Islander Women
Aboriginal and Torres Strait Islander women experience poorer health across almost all areas compared to non-Indigenous women and the life expectancy is 17 years less than for non-Indigenous women. It is known that Aboriginal and Torres Strait Islander women experience:

- higher rates of mental health conditions, in addition to hospitalisation and mortality for these conditions;
- hospitalisation as the victims of assault at a rate 33 times higher;
- a higher proportion of deaths due to disadvantage, particularly for circulatory diseases, diabetes and kidney diseases;
- more than double the rate of cervical cancer in 2000–04 and more than four times the death rate for this cancer;
- higher rates of chlamydia and hepatitis C in young Indigenous women.

High body mass and tobacco smoking are the most important risk factors contributing to the burden of disease in Aboriginal and Torres Strait Islander women, and over half of Indigenous women reported their level of physical activity as "sedentary" compared to a third of non-Indigenous women. While Indigenous status is not collected for cervical screening, it is known that Aboriginal and Torres Strait Islander women access breast cancer screening (BreastScreen Australia) less than non-Indigenous women.

The National Women’s Health Policy needs to address the needs of Indigenous women if the Australian Government is committed to closing the gap between Indigenous and non-Indigenous Australians by tackling disadvantage and improving the health of Aboriginal and Torres Strait Islander women.

The College recommends that in order to address the health issues and risk factors faced by women from different cultural and ethnic backgrounds, health services and preventive programs should take into account the diversity of cultural and ethnic backgrounds and work with Indigenous communities and agencies to ensure that approaches are developed that are culturally and linguistically appropriate. Efforts also need to be increased to support ATSI women who are carrying an immense burden in caring for family and community members affected by mental or physical health disorders as well as children of those affected. Also we believe that the Women's Health Policy should endorse, support and aim to achieve the Targets set by the Close the Gap Coalition.

Women in Remote and Rural Communities
The College is conscious of the specific issues confronting women living in rural and remote areas of Australia, predominantly centred around social and physical isolation, and a consequent lack of access to services. The RACP recommends that the National Women’s Health Policy pays particular attention delivering better health outcomes for this significant group within the population.

The development of a viable and sustainable rural workforce implies adequate funding, the provision of appropriate infrastructure, communication and resources, and the ability to address the maldistribution of health professionals within Australia. It is important to promote the training of general physicians and paediatricians so that rural populations have access to specialists in complex chronic disease and multisystem illness.

The College particularly supports the recommendations pertaining to increased utility of eHealth initiatives to improve rural and remote health. Implementation of such resources will not only improve patient accessibility but can also play a key role in education and support for medical practitioners, allowing rural and remote specialists to engage in peer review programs and continuing professional development activities without the necessity of travel and consequent time lost.
Maternal Health
The RACP supports the recent review of Australia's maternity services, and calls for policy to ensure access to safe, high quality care to women before, during and after birth. The RACP believes that to achieve the aim of safe, high quality care to all childbearing women the following principles need to be considered:

- All roles support the safety of the woman and family;
- Clarity over who leads in any particular case;
- Planned unambiguous handover between care providers and good ongoing communication;
- Training and ongoing education of those involved in the care of women and babies that is accessible, relevant, feasible and affordable;
- Care is aligned with training and experience of staff and back up is available in a timely manner;
- Infrastructure is aligned with the level of care to be provided in that facility;
- Indemnity covers all care provided by each team member to the extent that they provide in alignment with training, experience and back up;
- Women agree with proposed management strategies.

There have been dramatic changes in Australia in the last 20 years with regard to the age and weight of women embarking upon pregnancy. Pregnant women are now older than ever before. In 2006 21.4% of pregnant women were aged 35 or older, up from 15% in 1997.14 These changes have been linked with an increase in the representation of medical problems in the pregnant population. It is now an everyday occurrence and these women require specialist medical and obstetric care due to their high complication risks.

Compared with normal weight, maternal overweight is related to higher cesarean delivery rates and a higher incidence of anesthetic and post-operative complications in these deliveries.15 The average cost of hospital pre and post natal care is higher for overweight mothers than for normal weight mothers. Infants of overweight mothers require admission to neonatal intensive care units more often than do infants of normal weight mothers.

Both maternal overweight and advanced maternal age are associated with increased risk of developing gestational diabetes (GDM).16 Prior to pregnancy all women should be assessed and counselled about their risk of developing gestational diabetes, and be tested for GDM during pregnancy. There is a very high rate of progression to diabetes in the years following gestational diabetes so healthy lifestyle advice and regular follow-up of women who have had GDM is critical.17 Women with pre-gestational diabetes (both Type 1 and Type 2) continue to have poorer pregnancy outcomes than the general antenatal population with approximately 4 times higher rate of congenital anomalies and perinatal mortality.16,19 There is a need to improve professional advisory and counseling skills for women with pre-existing medical conditions before, during and after pregnancy, as well as a need for expert supervision and combined care with a specialist physician.20

Exposure to maternal diabetes in utero has been associated with higher rates of impaired glucose tolerance and overweight in the offspring. Optimal management of diabetes in pregnancy, including GDM, is an important strategy in primary prevention of overweight and diabetes for the next generation.21,22

The RACP favours a team based approach to maternity care in Australia. Team based models of care should respect and appropriately utilise the skills of all members of the team efficiently by involving them at the appropriate level of service delivery. It is important to maximise use of the present system and make improvements to it ensuring that any changes to maternity care policy continue to provide safe care for mothers and their babies. The RACP cautions against approaches
that could lead to unintended consequences such as reducing access to care or safety of mothers and babies.

**Breastfeeding**

Breastfeeding is an important process to assist with the bonding between mother and infant, along with speeding maternal recovery from the birth process through increased contraction of the uterus. Breastfeeding is the biological norm. Breastfed infants when compared to formula-fed infants have improved neurodevelopmental outcomes\(^23,24,25,26\) and a lower incidence of infections,\(^27\) obesity\(^28\), and diabetes.\(^29,30\) Breastfed infants also have better feed tolerance, less physiological gastroesophageal reflux\(^31\) and a lower incidence of necrotising enterocolitis.\(^32,33\) Most of these benefits have been demonstrated in randomised clinical trials although there remains the possibility that some are due to factors associated with the choice to breastfeed rather than breast milk itself. Other benefits are social, economic and environmental and improved maternal health including some protection against breast cancer.\(^34\)

The College supports the World Health Organisation’s recommendation of exclusive breastfeeding to 6 months with introduction of complementary foods and continued breastfeeding until 12 months of age, and beyond if mother and infant wish.

**Sexual Health Services**

There is a need for policy around possible initiatives to address access in rural communities, with particular emphasis on Indigenous and immigrant women. Women from CALD communities have special sexual health needs. They may come from societies with greater gender inequality, and lack basic sexual health education. This issue is not acknowledged in directives regarding the role of sexual health services, and in general practice, these women often see doctors who reflect and reinforce the inequalities. Regional & rural access to specific women's reproductive health services is an important issue which requires addressing.

Access to good family planning services allowing women from all socioeconomic backgrounds an equal opportunity of choice, and ability to carefully plan their family, thus to reducing the burden of unplanned pregnancies in rural and remote areas of Australia is vital. At the present time such access is either totally lacking, or is at least severely limited, in many parts of regional Australia. In these same areas, there is limited access to services providing unbiased counseling and a range of options for women when unplanned pregnancies do occur. It is a major inequity in this country that urban women should have relatively easy and affordable access to services for termination of pregnancy when women living in many parts of regional Australia have no services at all or have to travel considerable distances to access these services. This issue, although controversial, must be addressed in any policy which seeks to better women’s health in Australia.

There is a lack of a clear strategy to address these issues, with fragmented services particularly in rural areas. There is a lack of recognition of the level of service provision with sexual health services seen as an alternative provider for primary screening/treatment only, rather than as a provider of primary services for certain high risk groups as well as a secondary provider to support the work of primary care (and other specialist) providers.

The College recommends a strategic and coordinated planning of sexual health and reproductive services. Increasing access by funding more primary care services without specialist support is not likely to be successful.

**WOMEN AND RISK FACTORS FOR DISEASE**

**Tobacco Smoking**

Tobacco smoking is the equal fourth highest risk factor identified as contributing to the total burden of disease in Australian women in 2003.\(^35\) The prevalence for females who smoke is highest for those aged 25-34 years (22%).\(^36\) While tobacco smoking has declined over time, 15.2% of females aged 14 and over continue to smoke daily.\(^37\) Tobacco smoking is a major risk factor for
asthma, coronary heart disease, stroke, lung cancer and osteoporosis, and has serious implications for women’s reproductive health, including higher rates of: 37,38

- cervical cancer;
- premenstrual tension, irregular periods, heavy periods and severe period pain;
- decreased fertility; and
- earlier onset of menopause (up to 4 years earlier).

At present disadvantaged groups are more likely to be smokers, and there is a need for intervention effects tailored for those groups. Increasing availability and affordability of effective treatment measures such as nicotine replacement therapy is important.

**Alcohol Consumption**

The proportion of females drinking at risky and high risk levels as classified by the Australian Bureau of Statistics were highest in the middle age groups, with 13% of females aged 45-64 years reporting consumption which would place them in the risky or high risk groups.

As well as its harmful effects across the population, alcohol has particular impacts on women. Alcohol is a common cause of congenital birth defects, and for those women with major alcohol problems it can have a devastating impact on their ability to care for children. Alcohol increases the risk of breast and other cancers for women, and is associated with increased risk of osteoporosis for the elderly.

The RACP recommends a range of strategies to reduce alcohol related harm in this population, including a comprehensive review of Australia’s system of alcohol taxation to improve the role of price as preventive measure in alcohol consumption, public health campaigns, and enhanced early intervention and treatment services for women who may be experiencing alcohol related harm. This is particularly important for women of child-bearing age, for whom hazardous alcohol use raises the risk of fetal alcohol spectrum disorders (FASD) in their babies, contributing to another generation of disadvantaged Australians. Women caring for children with FASD affected children may need extra help to cope with their very challenging behaviour. Levels of community awareness about the risk of fetal alcohol effects may be low, particularly among disadvantaged groups. Appropriate targeted approaches to gauge and improve knowledge are likely to be required. The benefits of any increase in alcohol taxation should flow to alcohol related prevention and treatment services. There is a need for increased availability of alcohol treatment services, including both ambulatory treatment for alcohol dependence and residential services which can cater for women caring for their children.

**Obesity**

It is increasingly apparent that there is a need for positive change with respect to the obesity epidemic. At the Australian Health Ministers Council meeting in 2008, obesity was endorsed as a National Health Priority Area. The Australian Bureau of Statistics (ABS) found that over half (55%) of Australian women were overweight or obese. When looking at the age pattern of obesity in adults, the highest proportion were in the age group 55-64 years for women (68%), however, evidence shows that younger women are gaining weight at a much higher rate than previous generations. 39,40 The Australian Longitudinal Study on Women’s Health (ALSWH) found that obesity is now the primary cause of chronic illness in women, and that the risk of developing a range of diseases increases as excess weight increases. 40 The risk of developing type 2 diabetes in women of normal weight is 17.1%, and increases to 35.4% in overweight women and escalates to 74.7% for very obese women. 41 Depression and anxiety are also known to increase in women that are overweight. 42,43

**Physical Inactivity**

Approximately one third of Australian women do not exercise. 44 A lack of regular physical activity was the third highest risk factor identified as contributing to the total burden of disease in Australian women in 2003 and it is a major risk factor for all the major health priority areas and
increasing physical activity not only assists with weight loss but it also known to reduce stress, anxiety and depression.  

**High Blood Pressure**

High Blood Pressure is experienced by 27% of Australian women (aged 25 years and over) and was identified by Begg et al. in 2007 as the equal leading risk factor contributing to the burden of disease in Australian women. It is a major risk factor for coronary heart disease, heart failure and stroke. Lifestyle (non biomedical) causes of high blood pressure include being overweight, physical inactivity, alcohol consumption, high intake of saturated fat and salt, and low intake of fruit and vegetables. The risk of heart attack and stroke increases threefold in people who smoke tobacco and have high blood pressure.

**Violence**

Violence against women is associated with many negative health consequences for women. Living with violence contributes to factors such as smoking, poor nutrition, substance abuse and stress. In association with this is the significant harmful effect on the psychological and physical health of any children witnessing this violence. Rigorous debate surrounds screening and mandatory reporting and there is scant evidence regarding effective interventions for those experiencing violence. There is a danger that the patchy evidence base for how clinicians should respond to issues of abuse and violence can result in their inaction. However, it is possible to articulate an appropriate response for health professionals when faced with disclosure of abuse, or when they suspect that abuse is occurring. This will empower clinicians to act appropriately when dealing with patients suffering past or present abuse.

The issue of violence and abuse involves many services in our community, including children’s services, education, health, and police, as well as the legal and court systems. This is an issue that is often difficult to confront and discuss. It is reflected in the difficulties clinicians have in asking about violence and abuse, and the difficulties our patients have in telling their stories. It could be said that at times abuse and violence is a hidden part of the consultation. Because evidence suggests that abuse and violence may have a very damaging effect on patients’ health, this guideline will help health professionals play their part in responding to abuse and violence within the community.

**WORKING TO IMPROVE WOMEN’S HEALTH IN AUSTRALIA**

**Education**

Education is one of the central measures of socioeconomic status and a crucial determinant of health, employment and income. According to *Australia’s Health*, higher levels of education provide better employment opportunities and higher income, and can provide the knowledge and skills necessary to access health services and to live a healthy lifestyle.

**Prevention**

The policy needs to identify key priority groups of women in the community that are most at risk of poor health for preventive action. By doing so, the policy can help to improve the health and well being of those women most at risk. Australian women have greatly benefited from preventive health measures, such as the National Cervical Screening Program. Breastscreen Australia aims to reduce mortality and morbidity from breast cancer by actively recruiting and screening women aged 50-69 years for early detection of the disease. The National Cervical Screening Program aims to reduce incidence and death from cervical cancer in a cost effective manner, through a more organised approach to cervical screening.

However, there is a need to target our preventive health programs and strategies better. Factors such as the availability of services, sex and gender differences, disadvantage and cultural differences can impact on the success of population health campaigns. For example, cervical cancer incidence and mortality has remained high for ATSI women.
A recent assessment of Australian Government prevention programs indicated that ‘public health campaigns to reduce tobacco consumption, increase childhood immunisation, tackle HIV/AIDS, and prevent road trauma and heart disease not only averted deaths and reduced the disease burden but yielded significant returns on the investment’.

The College also welcomes the Preventative Health Taskforce’s proposal to develop a National Prevention Agency (NPA) to lead coordinated action for prevention.

The College has significant concerns that the details of 2009 Federal budget project a myopic vision for this vital agency. We recommend that the NPA be responsible for the following:

1. Powers granted to NPA to ensure that all relevant governments agencies, across jurisdictions, are coordinated, engaged and active in prevention strategy
   - Cross-sector commitment of State and territory government agencies, acknowledging that primary prevention goes far beyond health departments, and requires support and leadership from multiple agencies.
   - To ensure ‘all of government’ action
   - Alignment of government ‘areas’ across different agencies to avoid areas slipping through the net
   - To include evidence gathering on current jurisdiction programs so that effective measures can be rolled out nationally

2. Instigation and coordination of Annual National Public Health Week
   - Based on US model
   - Supported by Australian Public Health bodies, but requires government backing

3. The allocation of specific funding to local areas for prevention activity
   - Targeted funding proportional to the likelihood of incidence of chronic disease within that population (e.g. considering ATSI population, rurality)
   - NPA to coordinate and support local action on national strategies
   - Funding tied to health agreements with states / territories

4. Support an assessment mechanism for prevention
   - Evaluation of cost-effectiveness of prevention programs
   - Individual and population level
   - Model based on Pharmaceutical Benefits Advisory Committee

   - Focus on targeting high risk groups
   - Early disease detection through health checks / screening with follow up for problems detected
   - Intervening for people with established problems such as hypertension, diabetes and cardiovascular disease where the value of treatment is well established but under-utilised

   - High quality guidelines need to be available for all aspects of prevention of chronic conditions

7. Closing the life expectancy gap for Indigenous people
   - The College welcomes the Taskforce’s commitment to “Closing the Gap”.
   - Recommend the adoption of the interim targets set out in “Close the Gap -National Indigenous Health Equality Targets” to ensure a long term structured approach to reducing the gap in health outcomes.
   - Coordination of, and accountability for programs to achieve these targets

8. Development of Interim Goals and Targets for each priority ‘risk-factor’
   - Need for sets of coherent, realistic, achievable, time-limited interim goals and targets for each priority set by the Taskforce
   - Allow staged working towards the goals for prevention identified by the taskforce

9. Joining the International Association of National Public Health Institutes
   - International data and evidence-sharing.
10. Development of ‘Health Report Cards’ for Australian localities
   - Based on Trust for America’s Health model
   - Provides breakdowns of health by locality to allow comparison and clarity

11. Provision of prevention research grants in partnership with universities to develop and evaluate new interventions and existing programs

12. Use of branding to communicate a consistent message to the public across all programs addressing risk factors (e.g. Australia: The Healthiest Country by 2020).
   - Across all programs, jurisdictions and government agencies
   - Increase public acceptance, recognition and cohesion

A Lifecourse Approach
The College recognises that more gender focussed research is required and that The National Women’s Health Policy should identify key priority areas to guide future research. Areas that will be important to consider will involve addressing the understanding of why women take up unhealthy behaviours and the perceived barriers to change so that these barriers can be adequately modified.

The Government needs to move toward an integrated approach to the health and social inequalities that exist by joining up activities across different departments. This approach should be strengthened and encouraged because health departments alone have little control over the underlying determinants of social and economic disadvantage.

OTHER ISSUES
Women and Medicines
With regards to medicines there are some important difference between women and men.

Physiological differences with respect to medicines:
   - Pharmacokinetic differences: Women have on average lower drug clearance than men, thus at a given dose of most drugs women are at greater risk of toxicity then men.\textsuperscript{47,48,49}
   - Pharmacodynamic differences. These are physiological differences between men and women that result in difference in drug effects. This is most apparent in the sex steroids but other differences are found.\textsuperscript{50}
   - Clinical Pharmacology is a specialised area of practice, concerned with physiological differences in between individuals and groups with respect to medicines, and training and employment of appropriately qualified staff are required.
   - Aging is a risk factor for physiological differences in women due to multiple co-morbidities and polypharmacy, especially with respect to psychotropic medications.

Reproductive differences:
   - During pregnancy the fetus is exposed to most medicines taken by the mother. Drug prescribing during the reproductive years must take into account potential for pregnancy and the consequent fetal risk.\textsuperscript{51} This is also applicable to breast feeding, although this risk is lower.\textsuperscript{52}
   - During pregnancy there are substantial changes in the pharmacokinetics of medicines and physiological changes in the woman that alter drug effects.\textsuperscript{51}
   - Maternal and fetal medicine is a specialised area of practice and training and employment of appropriately qualified staff are required.

Behavioural and outcome differences:
   - Poisoning is a major cause of death and morbidity in women.\textsuperscript{54}
Clinical Toxicology is a specialised area of practice and training and employment of appropriately qualified staff are required.

The College recognises that quality use of medicine principles and the National Medicines Policy are core material in the development of a National Women’s Health Policy. Further, that the above differences in pharmacokinetics, pharmacodynamics, reproductive biology and behaviour with respect to medicines are considered in the development of a National Women’s Health Policy.

Women and Genetics
Genetic influences were identified by the Australian Institute of Health and Welfare (AIHW) as playing an underpinning role in an individual’s health. Genetic factors as a determinant of health are common to all women, regardless of their socioeconomic or ethnic status. Genetic conditions affect not only women but their families, and in particular their children. Genetic conditions may be present throughout life and so a lifecourse approach for women and their children needs to be considered.

Increasing knowledge of the role of genetic factors in disease will enable women at increased risk of a variety of conditions to be identified. Identification of those at high risk will enable preventive health measures to be put in place to minimise harm and reduce the possibility of adverse occurrences. By identifying women at increased risk of some conditions, it will enable targeted planning of service to those in rural and remote communities (eg surveillance of those women at increased risk of bowel cancer to enable early identification and treatment of pre-cancerous lesions). Access to genetic testing and subsequent preventative health strategies is not equally available to all women because of socioeconomic factors.

There are a number of key areas identified in the consultation discussion paper in which clinical genetics plays an important role in women’s health. Any planning of a Women’s Health Policy needs to consider genetic issues and how best to manage them. As other causes of morbidity and mortality are addressed, genetic factors will become more important. Genetic research is increasingly identifying genetic risk factors for a wide variety of common diseases and strategies to use this information will need to be developed.

In the discussion document, the top causes for death in females (2006) include ischaemic heart disease (16.6%), breast cancer (4%) and colon and rectum cancer (2.6%). All of these conditions may have a significant genetic component and by identifying those at high risk preventative care can be put in place. For example, familial hypercholesterolemia can be identified and treatment put in place for those at high risk, reducing long term morbidity and mortality.

Access to testing:
It is internationally agreed that genetic testing should be done within an appropriate counselling framework given the family, medical and ethical issues associated with such testing. In Australia there are significant workforce shortages in clinical genetics and it is important that these are addressed to ensure appropriate high quality care be available to all women regardless of the ability to pay.

Prophylactic surgery:
Some women at high risk of cancers choose to have prophylactic surgery (eg bilateral mastectomy). This is difficult to access through the public health system, and those women who can access the private sector have choices that those who are socioeconomically disadvantaged do not. Access to any screening and surgery may also be more difficult for women in rural and remote areas.

Similar issues apply to women with some inherited cancer syndromes where bowel cancer is a significant component. For example, in the condition Lynch syndrome (hereditary non-polyposis
colorectal cancer), regular colonoscopy is recommended for those with a mutation in one of the associated genes. Accessing colonoscopy in the public sector can be very difficult. Although asymptomatic, these women are at high risk of colon cancer. Early detection and treatment of polyps could reduce their risk. Endometrial cancer and ovarian cancer may also be seen in this condition and access to screening and prophylactic surgery is again an issue.

Breast and bowel cancer:
Breast cancer is a particular issue for women’s health and clinical genetics has an increasingly important role in its management.
- Breast cancer can run in families due to an inherited mutation in a gene (BRCA1 or BRCA2)
- Women who have inherited such a mutation have a high risk of both breast and ovarian cancer
- Evaluation of a woman’s family history can identify those women in whom genetic testing would be useful
- Genetic testing can then identify those women with a mutation in one of these genes. Identification of a mutation means other family members can be tested to see if they are also at high risk
- Those who do not have the family mutation are not at high risk and require population screening only
- Those who have inherited the family mutation are at high risk and need to access specific recommended screening, can consider prophylactic surgery and can be considered for chemoprophylaxis trials
- The information also empowers women to choose how to manage their health and to plan for their family’s future

Antenatal care:
There are a number of clinical genetics issues relevant to women’s health in the area of antenatal and pregnancy care:
- Family history; many women are concerned about the risk of having a baby with a condition known in the family. Access to genetic services enables this to be investigated and the woman provided with information to inform her choices
- Genetic testing in pregnancy; some women with a family history of a genetic condition wish to access testing in pregnancy. In most cases, there is no federal funding for genetic testing and this is met at a state level. Some tests are extremely expensive and are not offered
- Antenatal screening: it is recommended screening tests for Down syndrome are offered to all women in pregnancy. Counselling about the test and the outcomes is important for women to understand what the screening is and their options around this, particularly if the result demonstrates a high risk. Clinical genetics services play an important role in counselling and diagnosis in pregnant women.

Women and Sleep
Healthy sleep is integral to a healthy life. Failure to obtain sleep of sufficient quality or duration is associated with impairment of cognitive and psychomotor function adversely affecting safety, productivity, intellectual capacity, learning and social interactions. Inadequate sleep duration is often a lifestyle choice and public education is required to remind the community of the ill effects we suffer as a result, with fatigue and inattention related motor vehicle crashes being a striking example. Sleep disorders impact significantly on the health of our nation. A recent Access Economics Document estimated the cost to the Australian community of sleep disorders to be $10 billion per year.55

Insufficient sleep may lead to:
- Increased risk of obesity (increased 50% in those sleeping less than 5 hours/night)56
• Decreased workplace performance, described in recent New England Journal of Medicine papers showing increases in medical workforce errors amongst sleep deprived doctors. 57,58
• Significantly increased risk of moderate-severe depression in those not getting enough sleep.59

Obstructive sleep apnea, a common sleep disorder, can be significantly decreased by weight reduction, reduction in alcohol consumption and reductions in tobacco smoking.

The College congratulates the Government on its initiative to consult broadly regarding the development of a comprehensive National Women’s Health Policy, and looks forward to the opportunity to contribute further in the progress of this significant project.

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