Australian Women's Health Alliance

Policy brief

Addressing intersecting gendered barriers to universal access and equity

Key messages

- While Australia's health system is based on the principles of universal access through Medicare, this is not delivered in practice.
- An intersectional gender lens is critical for identifying and understanding structural inequalities and biases which prevent universal access to health care.
- Achieving the goal of health equity requires universal access to health care and prevention action.
- Addressing biases requires systematic approaches to building awareness, transforming values among policymakers, researchers, clinicians and service providers to improve access to health services, and developing mechanisms for accountability.
- National health strategies must be aligned and recognise women as a priority population requiring tailored approaches which respond to gendered inequities in access to health care.

Purpose of this brief

Australian Women's Health Alliance works to articulate the policies and actions necessary to improve health outcomes for women. The purpose of this brief is to put a gender lens over barriers to universal access to health care and to inform policy, strategy and practice, and is applicable in all jurisdictions.

There is poor understanding and a lack of accessible evidence across health and related sectors, about prevention with an intersectional gender and health equity lens. Further, there is a need to articulate how prevention can be more effectively integrated with health care, social care and social service programs developed for women.

This is a challenge for the National Preventive Health Strategy 2021-2030 (NPHS), the National Women's Health Strategy 2020-2030 (NWHS) and related policies, because without these understandings, it is difficult to identify and disseminate prevention strategies that will achieve health equity.

Why put an intersectional gender lens on universal access and equity?

An intersectional gender lens is critical for identifying and understanding gendered barriers which prevent universal access to health care. Access is generally defined in terms of affordability, accessibility (physical, digital), appropriateness (including culturally safe health services and health care), availability (right place and time), and capacity to meet different population needs.

The right to health is affirmed in the UN's Universal Declaration of Human Rights. Universal health care is fundamental to the right to health because it means that health care in all its forms is affordable, accessible, culturally safe and appropriate:

> Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.[1]

Gendered discrimination in health care, women's disproportionate share of unpaid caring responsibilities, the feminisation of poverty and inequities in paid work are gendered barriers to health care access that infringe on the right to health for women. Access to health care allows women to attain their fundamental right to be full members of society and exercise their social and economic freedoms.

Further, universal access draws attention to equity, and the multiple, intersecting barriers which constrain women's access to health care. An intersectional approach is a lens to understand the ways in which inequalities and discrimination overlap with and exacerbate each other, including those based on gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination.[2] Intersectionality highlights the interrelated dynamics of systemic and structural power and privilege, oppression, and discrimination, which in turn explain the need for a focus on priority populations. These structural inequalities expose women to overlapping forms of oppression and marginalisation that create social, health and economic inequities.

While Australia's health system is based on the principles of universal access through Medicare, this is not delivered in practice. Multiple overlapping structures intersect with gender and women's health needs to create deep access and health inequities. These include colonisation and the enduring impacts of racist and ableist discrimination, the migration system and Medicare waiting periods, the lack in availability of health interpreting and translation services, the lack of culturally competent and safe providers, a lack of available services in rural, regional and remote areas, and homophobia and transphobia.

Migrants subject to the Medicare waiting period and people who are incarcerated do not have access to Medicare. Furthermore, the rising cost of health care means that Medicare rebates are no longer sufficient for many people to be able to access the care they need, especially those who have significant medical costs due to disability, chronic health conditions or carer responsibilities. Low cost and bulk-billed services may not be culturally safe, competent or accessible and Medicare rebates are themselves subject to gender and other biases which disadvantage women and gender diverse people.

Access is only universal, and responsive to women's gendered needs, when it is without discrimination or prejudice, self-determining, addresses intersecting structural barriers and social determinants of health, and recognises women's rights to attain health and social care. The concept of universal access, and the application of an intersectional gender lens, is critical to achieving the goal of health equity.[3]

What does this mean for health equity?

Australian Women's Health Alliance recognises the importance of universal access, equity and agency in health care and prevention. Affordable, culturally safe and appropriate and accessible health care is central to prevention work and evidence building. At present, many health care and prevention programs in Australia lack health equity targets and defined outcomes for priority populations and are neither equitable nor universal.

Addressing biases requires systematic approaches to building awareness, transforming values among policymakers, researchers, clinicians and service providers to improve access to health services, and developing mechanisms for accountability.

The NWHS recognises that different priority populations have different access issues and the importance of addressing gaps in services.[4] The NWHS also recognises the importance of health equity and the need to target population groups of women who experience poorer health outcomes. Access to prevention and health care for priority population groups of women including Aboriginal and Torres Strait Islander women, migrant and refugee women, women who live in rural and remote communities, LGBTIQ+ communities, women with disability, incarcerated women, and women living in poverty is a central focus.

The NPHS highlights the centrality of access to information to prevention, as well as the need to enhance access to appropriate, culturally safe, responsive, and quality health care, but does not recognise the need to provide a gender lens on access. While the NPHS commits to equitable approaches to prevention[5] and the determinants of health, it lacks an articulation of how gender is a determinant of different health experiences and outcomes. Notably, women are not identified as a priority population.[6]

To be effective, national health strategies need to consider the extent to which gender inequities, particularly those resulting from intersectionality, impact on women. Women must be identified as a priority population requiring tailored approaches which respond to structural gendered inequities in access to health care. As the NPHS says, action must focus on the external barriers that impact on health. Those barriers must be understood and addressed for prevention to be effective for women and gender diverse people.

About us

Australian Women's Health Alliance provides a national voice on women's health. We highlight how gender shapes experiences of health and health care, recognising that women's health is determined by social, cultural, environmental, and political factors.

Contact us

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We acknowledge the Traditional Custodians of the lands and waters on which we live and work. We pay our respect to Elders past and present. Sovereignty has never been ceded.

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[1] World Health Organization, *Universal health coverage*, World Health Organization, 2023, accessed on 16 May 2023.
[2] KW Crenshaw, 'From Private Violence to Mass Incarceration: Thinking Intersectionally about Women, Race, and Social Control', Symposium: Overpoliced and Underprotected: Women, Race, and Criminalization: I. Establishing the Framework', *UCLA Law Review*, 2012, 59(6): pp 1418–73.
[3] C Kelly, L Dansereau, J Sebring, K Aubrecht, M FitzGerald, Y Lee, A Williams and Barbara Hamilton-Hinch, 'Intersectionality, Health Equity, and EDI: What's the Difference for Health Researchers?', *International Journal for Equity in Health*, 2022, 21(182) accessed on 16 May 2023.
[4] Australian Government Department of Health, *National Women's Health Strategy 2020-2030*, Australian Government, 2018, accessed on 16 May 2023.
[5] 'Preventive health action considers the inequities that exist across Australia, including gender inequities, and promotes equitable access to health care that is culturally safe and tailored to diverse community needs. Action must focus on the external barriers that impact on health.' Australian Government Department of Health, *National Preventive Health Strategy 2021-2030*, Australian Government, 2021, p 10, accessed on 16 May 2023.
[6] Australian Government Department of Prime Minister and Cabinet, *National Strategy to Achieve Gender Equality – Discussion Paper*, Australian Government, 2023, accessed on 16 May 2023.