



**AUSTRALIAN HEALTH POLICY
INSTITUTE
at The University of Sydney**

Boutique health?

Gender and equity in health policy

Dr Toni Schofield

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For further information regarding The Australian Health Policy Institute or
this publication, please contact:

Dr Rebekah Jenkin
Manager
The Australian Health Policy Institute
Victor Coppleson Building (D02)
University of Sydney NSW 2006
Australia
Telephone: +61 2 9351 7219
Facsimile: +61 2 9351 7218
Email: rebekah@med.usyd.edu.au

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the University of Sydney.

ABOUT THE AUTHOR

Dr Toni Schofield

Dr Schofield works in the School of Behavioural and Community Health Sciences in the Faculty of Health Sciences. She embarked on a career in researching public policy thirty years ago. This began with an Honours thesis in the Department of Government and Public Administration at the University of Sydney that examined the then renascent Australian film industry and the role that public policy had played in its various fortunes! Since then, her research interest has shifted to health policy and politics, and to the role that gender plays in public policy processes. The latter has been a central focus of a large three-year study of gender equity in the New South Wales public sector. It was funded (2001-2003) by the Australian Research Council and NSW Premier's Department, and conducted with Bob Connell and Sue Goodwin.

Dr Schofield has also been an active contributor to health policy-making processes across a range of forums including the World Health Organization, the Office of the Status of Women in Australia, the NSW Health Department, and various community-based, non-government organisations such as the Immigrant Women's Speakout Association, the Family Planning Association, and the Sydney Women's Counselling Service.

Contents

Introduction	00
Part I: Women's health policy	00
Part II: Theorising women, diversity and gender	00
Part III: Men's health policy	00
Part IV: 'Gender and health' policy	00
Part V: Mainstreaming gender in health policy	00
Conclusion and future directions	00

Reviews by:

1. Professor Vivian Lin	00
2. Professor RW Connell	00
3. Ms Helen L'Orange, AM	00

Introduction

Gender has been brought explicitly into public discussion about health, both in Australia and elsewhere, primarily through discourses on ‘women’s health’, ‘men’s health’ and, more recently, ‘gender equity and health’. These have proliferated through a variety of channels including popular media, national and international conferences, academic publications, government reports and public policy. A pervasive feature of these public discussions is the confusion that prevails in relation to the meaning of gender and, in turn, to its relationship to health inequality and equity (Doyal 2000a, Schofield 2002, Krieger 2003). Arguably nowhere is this more evident than in public health policy.

Public health policy is an arena through which claims for public support in relation to health, both financial and symbolic, are made and negotiated. In a democratic society, constituencies are entitled to make claims on public institutions for legitimacy and material resources. Whether their claims are justified and deserving of support, however, is a deliberative process in which conceptual clarification and analysis can make a vital contribution. This paper contributes to this process by examining the ways in which gender has been represented and understood in ‘gender-specific’ health policy discourse. In doing so, it seeks to identify more clearly the nature of ‘the problem’ of gender and health and to recommend directions for improving the way in which it has been represented and addressed in policy to date. To this end, the paper also explores recent international trends towards ‘mainstreaming’ gender in policy and discusses the implications of this development for addressing the goals and ‘outcomes’ identified within gender-specific health policy. This discussion is informed by recent Australian research on the advancement of gender equity goals in public policy-making.

The paper is structured into five parts. Part I analyses representations of gender in Australian women's health policy. Part II explores recent theoretical work on women, 'diversity' and gender, and applies the tools it has generated to critically evaluate representations of gender in Australian women's health policy. Part III draws on the conclusions from the preceding to compare the ways in which Australian men's health policy has represented the problem of gender and health. Part IV surveys internationally-led policy development in gender and health. Part V discusses international trends towards 'mainstreaming' gender and of the implications for the current Australian policy practice of segregating gender from 'mainstream' health policy. The paper concludes with some suggestions on how to begin to support and implement gender equity in health policy.

Part I: Women's health policy

The explicit formulation of a national 'women's health policy' occurred in this country in the late 1980s. After wide-ranging consultations with women's organisations representing over a million women, the then Commonwealth Department of Community Services and Health produced the *National Women's Health Policy*, launched by the then Prime Minister, Bob Hawke in 1989. It was followed shortly after by the National Women's Health Program—a Commonwealth–state funded package designed to implement the main recommendations of the *National Policy*.

As the *National Women's Health Policy* emphasised, it adopted a social rather than a medical approach to women's health. This meant three main things. First, it identified and prioritised women's major health concerns in terms of the frequency with which women themselves reported them in the consultations. Second, it discussed and analysed these concerns in terms of a growing scholarly literature on the gendered material circumstances and social relations of women's everyday lives and the disadvantages that accrue to women as a result (Schofield 1998: 130). And third, the strategy it formulated to address women's concerns focussed on increasing women's participation in

the organisation and management of health services and research (Schofield 1998).

Through this process, 'women's health' emerged basically as what diverse constituencies of women said it was. Intrinsic to this formulation was the assertion of women as the subjects of their health care. This meant that women actively participated alongside and together with others in decision-making relations and negotiations associated with their health care. As such, it involved a demand for women to have a voice in the public provision of their care and to speak their needs in the process. In effect, 'women's health' was a form of political redress for the marginalisations and exclusions that women said they had experienced in relation to the organisation and management of their health care. Central to this understanding was the idea that women had both a collective and plural interest. In other words, while recognising that there are significant differences among women—by class, ethnicity, nation, sexuality and generation, for example—national health policy discourse nevertheless subscribed to an understanding of common or shared ground among women.

Such an understanding did not suddenly emerge in the course of the production of the national policy. Indeed, the *National Policy* was built on foundations laid by almost twenty years of women's community-based activism and the establishment in the 1980s, at both state and Commonwealth levels, of policy machinery that enabled the development of 'women's health' bureaucrats with strong links to grass-roots constituencies of women (Schofield 1998).

In this context, 'gender and health' was virtually synonymous with 'women's health'. Gender was understood as a social relationship of inequality between men and women that stemmed from women's more limited socio-economic and political participation. The health care arena did not simply reflect this relationship. Rather, it played a key role in its constitution. The organisation of health services was understood as being actively involved in producing women's subordination and marginalisation. Such a dynamic was played out through a male-dominated health services structure and culture,

despite the predominance of women employed in the sector (see, for example, Lewin and Olesen 1985, Russell and Schofield 1986, Broom 1991, Miles 1991, Doyal 1995). In a society where the prevailing mode of governance was social democratic and where health services were publicly funded, this was considered unacceptable. Such services were obliged to operate in a pluralistic manner, recognising the heterogeneity of the entire citizenry, including women. A gendered approach to health within public health policy discourse thus involved identifying the extent to which health services were not responding to the needs of women and formulating strategies to redress this situation.

Within a year of the launch of the *National Policy*, the idea that it had been inclusive of the needs of **all** Australian women was challenged by a national organisation representing non-English speaking background (NESB) women—the Commonwealth–State Council on Non-English Speaking Background Women’s Issues. With the support of the Office of the Status of Women, the Council formulated a policy to address the specific health concerns of NESB women. As the resulting document, the *National Non-English Speaking Background Women’s Health Strategy* stated, NESB women *had distinctive and particular health and health service needs that require[d] the development of specific and targeted strategies* (Alcorso & Schofield 1991:xxxii). It supported such a claim with a detailed analysis of NESB women’s health and health services experience. Consistent with the *National Policy*, it focussed on the material circumstances and social relations of NESB women’s everyday lives, providing a comprehensive set of recommendations to address the key issues it identified. One of the most significant recommendations the *Strategy* proposed was increasing NESB women’s participation in the organisation and management of health services.

Discontent with a ‘one-size-fits-all’ women’s health policy was also voiced by Aboriginal women at the Third National Women’s Health Conference held in Canberra in 1995. Aboriginal women called for a health policy that would speak their specific needs in ways that

emulated their NESB counterparts (Davis et al 1996). Such a demand received unanimous support from conference participants.

The demands voiced by NESB and Aboriginal women for policies to address their specific health concerns demonstrated that these constituencies of women believed a generic women's policy was not adequate. That this was endorsed by national women's policy machinery and a major forum within the women's health movement indicated widespread acceptance of the idea. Such consensus, in fact, expressed the longstanding commitment of the Australian women's health movement to the view that women are not a homogeneous group. From the very outset, when the first women's health centre was established in the inner western Sydney suburb of Leichhardt in 1975, one of the basic principles that informed the centre's operation was the 'diversity' of women's health needs (Stevens 1995).

Nevertheless, the demands by NESB and Aboriginal women for specific health policies raised questions about the political relevance and efficacy of a generic women's health policy. If women's health needs were socially heterogeneous, what was it that women shared in relation to health? If they had nothing in common, what was 'women's health'? On what basis could a national women's health policy, accompanied by a publicly funded program, be justified? At stake in such questions is an issue that is at the forefront of current international debate and discussion on gender: how to deal with 'diversity' among women and maintain a politics that subscribes to the advancement of a collective women's interest (Young 1997, Lake 1998).

Conceptual clarification of a collective women's interest is integral to such debate. In this present context it involves the following sorts of questions. Is it still the case that women are united by a generalised relationship of social inequality between men and women? Is health care a major and active arena in which such inequality is generated? If so, in what ways? Do these comprise 'the problem' of women's health? If they do, what are the goals and 'outcomes' that policy would seek to achieve in addressing them? The following section of this

paper explores recent conceptual work in gender in order to answer such questions and to clarify what ‘the problem’ of gender and inequality is in relation to women’s health.

Part II: Theorising women, diversity and gender

By the mid-1980s in the United States, the policies of radical neo-liberalism were nourishing the social and economic polarisations that characterise the world’s richest democracy. It was in this context that ‘women of colour’ proposed that their experiences as women were so vastly and qualitatively different from those of their white counterparts that it was difficult to see much common ground between them. They suggested that women’s diverse identities render the idea of a collective interest among women chimerical (see Walby 1992 for a critical summary of this approach). Advancing women’s interests thus required a pluralistic approach—a ‘politics of identity’.

As North American feminists, Judith Butler (1995) and Iris Marion Young (1997) have commented in relation to this development, that in conceptual terms, ‘identity politics’ necessarily involves the description of the content or attributes of women as a social collective. According to Young, such an approach raises conceptual and political problems because it *either leaves out some individuals who call themselves women or distorts the experience of some of them* (1997:33). Butler also identifies problems with the approach insofar as it involves identity categories that are intrinsically normative, exclusionary and factionalising. For example, the categories lesbian, Aboriginal, housewife, professional, Arabic-speaking and so on not only necessarily exclude women who do not belong in them because they do not meet the ‘descriptors’, they also create emotionally charged divisions among women that correspond with the distribution of social ‘recognition’ associated with such categories (Honneth 1995). In theoretical terms then, an ‘identity politics’ approach to conceptualising gender renders impossible the idea of women as a unity with a common interest.

Butler (1995) thinks this is not such a bad thing because unification of the category 'women' has usually been achieved by reference to universalising categories such as motherhood. (In other words, what enables women to be regarded as a distinctive collective is their propensity for motherhood). For Butler this is significant because gender politics is fundamentally a politics of meaning and how it is played out through human embodiment. Accordingly, universalising categories have tended to restrict the scope of who we understand women to be and, in turn, what they can do. Young, however, has a different response. Hers derives from a concern to secure a coherent, theoretical *basis for a specifically feminist politics* that includes organised collective action for the purposes of making claims on public resources. Such a politics is impossible, she says, *if 'women' is not the name of a specific social collective* (Young 1997: 5-6). This poses a difficult theoretical problem because the formulation of the category women cannot resort to positive identification of attributes or of specific boundaries, for reasons already mentioned above. Nevertheless, without a conceptualisation of women as a unity, an effective feminist politics is seriously compromised. Young's problem is to develop a theorisation of gender that renders the category women simultaneously pluralised and unified. She sets out to solve the problem by drawing on Sartre's concept of 'seriality' which he developed in his theorisation of social class (Young 1997).

Young refers to Sartre's description of people waiting in a queue for a bus. She writes, people in such a situation comprise a:

series. They are a collective, insofar as they minimally relate to one another and follow the rules of bus waiting. As a collective they are brought together by their relation to a material object, the bus, and the social practices of public transportation. Their actions and goals may be different; they have nothing necessarily in common in their histories, experiences, or identity. They are united only by their desire to ride on that route. Though they are in this way a social collective, they do not identify with one another, do not affirm themselves as engaged in a shared enterprise or identify themselves with common experiences. The latent potential of this series to organise itself as a group will become manifest, however, if the bus fails to come; they will complain to one another about the lousy bus service,

share horror stories of lateness and breakdowns, perhaps assign one of their number to go call the company, or discuss sharing a taxi. (Young 1997:24)

Following this logic, Young suggests that common cause is created among women by virtue of a relationship and a set of social practices they all share in relation to particular kinds of material objects. However, this relationship and its associated practices are constituted serially or differentially. In other words, women share nothing in common with each other in positive or descriptive terms but they do in terms of why they are assembled together in the first place. Such an approach provides a conceptually coherent basis for representing women as the 'same but different' in public health policy. It also contributes to explaining what 'the problem' is in relation to current health service provision from a 'women's health' perspective. To explain how, I think exploring the concept of seriality in terms of a health care setting would be useful since health services are the main levers by which public health policy addresses the health needs of public constituencies. Since this paper is concerned with clarifying what is involved in 'women's health', an example that has a substantial impact on Australian women and their families would be most appropriate. I suggest substituting the bus queue with pregnant women and the bus with maternity services in Australia.

Pregnancy, childbirth and maternity care have been major national public policy issues at least since Federation in Australia (Thame 1974, Reiger 2001). Most Australian maternity care relies heavily on publicly funding, and takes the form of medical and hospital services. Applying Young's and Sartre's logic, pregnant women in Australia and in comparable countries may be understood as being brought together as a collective in two main ways. One is through their desire to be assisted by such services. The second involves their relation to these services, in particular, to the material objects—doctors' surgeries and equipment, obstetric hospitals, equipment and technologies, birth centres and so on—and to the social practices required to engage with them.

What is also important in the constitution of this collective is the type of relationship and practices that pregnant women have with maternity services. The work of Australian researchers in this field (Schofield 1995, Reiger 2001) suggests that it is not unlike the one that bus passengers have with bus services! Pregnant women neither drive the bus nor participate in the management and administration of the bus service. They have little or no say over the kinds of buses used, the routes they take or the timetables they run to, for example. Such activities and the decisions associated with them are largely the preserve of bus drivers and managers. Just as members of the bus queue can decide to get on or off the bus, so, too, can pregnant women 'choose' to avail themselves or not of widely available maternity services. Yet this reflects the extent to which they participate in any decision-making involved.

Clearly, some pregnant women have access to social resources such as income, education, experience in professional or managerial occupations—and they may feel confident enough to confront maternity services management for improved services, just as more privileged bus patrons might demand more comfortable buses, more and varied routes, and more frequent service. In doing so, they may bring themselves into being as an identifiable group. Another collection of people in the series might be actualised as a group by the frustration and inconvenience that staff and management experience in dealing with them because they speak a different language and/or are unfamiliar with the customary and routine ways of doing things. Still another group might emerge through their loyal and uncomplaining patronage of the service because they do not have the money and/or knowledge to consider other options. They are generally compliant and grateful that the service exists at all.

Underpinning the differences among the members of this series are their differential responses to, and negotiation of, the material objects and social practices of maternity care. To the extent that they share any specific response or negotiating style, they become a particular group with distinctive needs. Despite these group differences, it is clear that all are members of the same series. What determines their

membership is not only their shared desire for the objects and practices of maternity care, but also their relationship to these. In this case, it is a relationship in which the members do not exercise governance over the organisation and management of the objects and practices involved. All the members are nevertheless required to engage with the service because they need the resources it offers.

At the heart of this conceptualisation of gender is the idea of relationality as our case study on pregnant women and maternity services illustrates. In this scenario, pregnant women are brought into being as a collective through the relationship they share vis-à-vis the material objects and social practices of maternity services. One of the main shortcomings of this approach, however, is that though men play a significant role in pregnancy and maternity services—as partners or husbands, doctors, maternity service policy makers, maternity service planners and managers, and so on—they are not included. Recent developments in gender studies, however, suggest that gender involves both women and men, and that a politically nuanced understanding of the concept needs to address the relations between and among them. A major international contributor to this approach is Australian sociologist, Bob Connell (see 1987, 2002). Like Young's, Connell's view of gender emphasises relationality. Yet it differs from Young's in significant ways. One is the focus on the nature of the relationship between the men and the women involved with a specific set of material objects and social practices, such as those associated with health services.

For Connell, *gender exists where a set of practices brings the reproductive distinction between bodies into social processes* (2002:10). This involves the 'divisioning' of people into men and women and it is intrinsically relational. For Connell these relations can be sources of *pleasure, creativity and other things we greatly value* such as our sexual relationships. However, they can also be *sources of injustice and harm* (2002:143). The latter occur when the process of 'divisioning' goes hand-in-hand with a distribution of resources and political authority such that one group—usually men—accrues benefits or dividends at the expense of

the other—usually women. Apart from a very small minority of women, gender favours men, albeit unequally (Connell 2002).

Let us return to pregnant women and maternity services as a way of exploring this conceptualisation within a health context. It is obvious that a bodily reproductive distinction prevails in relation to pregnancy and childbirth. Clearly, pregnant women's embodiment renders them key agents in the process. Such a fact has been interpreted by some as indicating that pregnancy and childbirth are rightfully the exclusive preserve of women (Arms 1975, Rich 1976). Nevertheless, in day-to-day reality men are integrally involved in the process. In some cases, as already mentioned, they participate as pregnant women's partners. In most cases they are hospital-based, obstetric specialist doctors who entered the field in dramatically increased numbers in most industrialised countries like Australia in the 1960s (Schofield 1995).

This is not to say that all attendants in childbirth are men, or that all specialist obstetric medical assistants are men. Far from it. Much of the work of assisting women in childbirth is in fact performed by obstetric nurses or midwives, almost all of whom are women. And there is a small but significant proportion of consultant doctors in childbirth—around 14 percent in Australia and England—who are women (Pringle 1998). Overall then, assistance to women in childbirth mainly takes the form of institutionalised maternity services managed and staffed by both men and women. However, these are hierarchically organised along gender lines. The apex levels of such organisation are basically occupied by obstetric medicine and other decision-making professionals, and they are male-dominated. It is they who determine the kinds of material objects and social practices used in maternity services. In the process, they exert considerable influence over decision-making that shapes women's access to such services and their experience of them.

In Connell's terms, the social relations of maternity care are gendered not because the women involved have babies and the men don't. Rather, the men and women involved in this set of practices—of birth and care—are brought into being as reproductively distinct groups

through the relationship each experiences vis-à-vis the process. In this case, there are basically two main relationships. One involves the exercise of political and managerial authority over the process of pregnancy and birth—almost exclusively the preserve of men. The other involves direct participation in producing babies, undertaken primarily by women but also by men who attend as supporters. The overall and persistent pattern that emerges is one in which the men involved in the former, and the women and men in the latter, are brought into the process in a hierarchically divided way.

Both derive benefits from the arrangement. For women, these are mainly associated with access to drugs and surgery for pain and complications in labour. For specialist obstetric practitioners, they are primarily material and symbolic gains in the forms of financial remuneration and social recognition. However, the condition upon which each derives their respective gains is a hierarchical and gendered relationship. Such an arrangement, of course, also generates costs. One of the most significant involves the post-natal morbidity and injury that women incur through the increasing application of surgical and chemical obstetric technologies. The astonishing Australian caesarean section rate of one in every four births—one of the highest in the world—is an obvious example. Men who participate in the process suffer no comparable impost. The balance of the benefits and costs involved would suggest, in fact, that the distribution of the dividends generated by the arrangement would appear to favour the men who organise and manage the process (Connell 2002).

Exploring Connell's conceptualisation of gender through the case of pregnant women and maternity services shows that it is important in approaching any sphere of human practice to analyse the ways in which men's and women's relations with one another in the process are structured or configured. It is in this way, by adopting a relational approach, that the gendered nature of a specific set of social practices can be identified and understood. Accordingly, this conceptualisation of gender means that the 'women' in 'women's health' are best understood in terms of the relations between women and men in health services. In relation to the case study of pregnant women and

hospital-based maternity services, it is clear that such relations are far from egalitarian or democratic. Some, in fact, have suggested that hospital-based organisation has displaced pregnant women as the **subjects** (or decision-making participants) of birth (Katz Rothman 1982, Martin 1987, Reiger 2001). Further, those who now occupy this space derive economic, social and political benefits that they would otherwise be denied (Schofield 1995).

Since the advent of what some have called '1990s feminism' (Barrett and Phillips 1992), the conceptualisation of 'gender and health' developed in this case study has attracted significant criticism. Rosemary Pringle's empirical study of gender, power and authority in the medical profession in Australia and the United Kingdom is a notable example. She argues that such an approach represents doctors or medical interests as a 'power bloc' in relation to women (Pringle 1998). Accordingly, women are cast as having no power. Adopting a Foucauldian approach, she proposes that the exercise of medical power is better understood as 'capillary-like' and dynamic. It is diffuse, interactive and productive. This means that women also exercise power in relation to the medical profession and they derive gains for themselves in the process. An obvious example, she says, is women's demand for natural childbirth (Pringle 1998). Further, the massive entry of women into the medical profession and their widespread participation in general practice, has meant that traditional modes of patient-practitioner interactions are being challenged. Thus, the nature of the social relations between women and doctors is such that women do have opportunities to speak their health needs and be heard! In any case, asserts Pringle, medicine is able to identify and address women's health needs in constructive and helpful ways. *It enables [women's health] problems to be recognised and treated. It provides here and now solutions rather than waiting for revolutionary social change in some idealised future* (1998:218).

Pringle is correct to say that medical service arrangements have not precluded women's exercise of power. Women **have** placed demands on obstetric practitioners and service managers for services such as 'natural childbirth', or motel-style labour rooms, and so on. They have

made claims for changes in material objects and practices in childbirth, for example, and these have been introduced into public maternity services. Yet this has been on a very modest scale (Schofield 1995, Reiger 2001). For example, the proportion of women having their babies in birth centres has been estimated to be no more than three percent. Meanwhile, the rates of surgical and other interventions in childbirth suggest that 'natural childbirth' is a far from common experience. And while general practice has become more feminised, childbirth has never been more masculinised in terms of the prevalence of male-dominated specialist medical management (Schofield 1995, Reiger 2001). What this suggests is that despite the exercise of power by women that has effected changes in maternity services, a dominant mode or pattern of service provision still prevails. And while many of the women who use these services derive certain benefits from it, they do not match the substantial economic, social and political benefits that accrue to the male-dominated specialist medical providers and managers of such services.

While women can and do exercise agency in relation to male dominated health services, the evidence suggests they do so within significant constraints. Challenges to medical power, illustrated by demands for birth centres and 'natural childbirth' in hospital settings, for example, are therefore limited. Basically what produces such limits and subverts such challenges in health services are the complex institutional arrangements through which the relations between men and women are played out. Recent Australian analysis of gender and social institutions such as the public sector, the legislature, the family, the economy and so on, suggests that male dominance is an integral feature of them. Moira Gatens (1998), for example, proposes that, contrary to rationalist models of organisational neutrality, social institutions are governed by norms arising from institutional structures and cultures. These norms shape the contours for human action within institutions. They render neutral and taken-for-granted ways of thinking and of doing things that are, in fact, the products of certain interests with specific values. For Gatens (1998), major social institutions are partisan—not rational—human organisations in which

gender norms have come to play a central role in securing male privilege.

This work echoes the assumptions and findings of a now substantial body of international research on gender and organisational culture within corporations and public sector agencies. The resounding finding is that they do not work on the basis of impartial, bureaucratic principles as the groundbreaking research of American sociologist, Joan Acker (1990) and Australian feminist, Clare Burton (1987) demonstrated. Organisations are, in fact, *the bearers of gender relations... They are not gender-neutral structures in which gender is simply a property of the individuals who appear in particular slots* (Connell forthcoming). Such relations invariably take the form of gender hierarchies and, frequently, resistance to them. These dynamics are played out in various ways but certain kinds of practices appear to be more influential than others, especially those associated with the division of labour, the exercise of power and authority, the expression and negotiation of emotion, and ideological understandings involving the relations between men and women (Connell forthcoming, Schofield & Goodwin forthcoming). The result is organisational structures which tend to marginalise women's interests in relation to men's.

With their emphasis on the normalisation of political dominance through the apparently non-coercive medium of organisational culture, these studies evoke the work of the Italian Marxist, Antonio Gramsci (1971) and his idea of hegemony. This was a term he used to describe the generalisation of dominant interests as the common interest. In other words, the interests of a dominant minority come to be seen and widely accepted as those of the majority. According to Gramsci, this happens through the routine, daily practices that prevail in important social institutions including those associated with health and health care. Examples here would be university-based health education and training programs, hospitals, and health policy and service management bureaucracies. Hegemony thus involves the exercise of power associated with enduring divisions within social relations which are naturalised in the process. Indeed, for Gramsci,

hegemony was one of the principal mechanisms by which social hierarchy was secured and reproduced.

What, then, can this recent work on gender tell us about the ways in which women's health policy has represented 'the problem' of gender and health? Is a collective interest that incorporates diversity in health conceptually and politically tenable? What is the mechanism that produces it in health? What does such a representation suggest in the way of answers to the questions posed in the previous section in relation to the goals and 'outcomes' that women's health policy might then address?

As explained in the previous section, national women's health policy in this country has basically operated with an understanding of gender as a social relationship of inequality between men and women that originated in women's more constrained socio-economic and political participation. Health services delivery and research were key sites in producing such an outcome. As a result, mainstream health services were 'inadequate' and 'inappropriate' in addressing women's needs. Indeed, what women themselves frequently reported as pressing health needs were incommensurable with those identified by the technocratic languages of the dominant participants. For example, in studies conducted to determine what women rate as their main health concerns; tiredness, menstrual difficulties, domestic violence, and depression and anxiety topped the list (Brown and Redman 1995, Brown and Doran 1996). This contrasted markedly with the results of structured health surveys based on female rates of diagnosable medical conditions. Not surprisingly, chronic cardio-vascular diseases were top-of-the-pops.

As the analysis of recent theoretical work on gender suggests, the idea of women being united by a collective interest is still both conceptually and politically viable. What supports it in relation to the field of health is the idea that the social organisation of participation in identifying health needs and in managing and providing health services is characterised by a gendered dynamic. This is played out through the organisational processes of health institutions that involve naturalising

or normalising male dominance. This is achieved in often complex and subtle ways that devalue challenges and resistance, often by discrediting, trivialising or marginalising them. As a result, opportunities for mutual partnerships and practices are limited. A logic of hierarchical division shapes the relations between male-dominated specialist service providers and managers, and the women who use or work in providing such services within public health institutions. As such, a 'gender regime' of masculinist hegemony prevails (Schofield & Goodwin forthcoming).

The example of maternity services is again a good case in point. For well over twenty years now, organised maternity groups, midwives and some general practitioners have struggled to establish non-specialist based services with the support of public health institutions (Reiger 2001). They have used a range of policy-making processes to advance such an objective, at both state and Commonwealth levels. And policy makers at both levels have frequently been responsive in acknowledging and supporting the legitimacy of these claims as evident in the establishment of birth centres and the Alternative Birthing Services Program. At the same time, however, specialist medical practitioners in the field have suggested that if they do not manage childbirth, the process is precarious and potentially seriously damaging for mothers and/or babies (Schofield 1995). As a consequence, access to non-specialist medical care is rationed according to criteria specified by specialist medicine.

A further example of masculinist hegemony in public health institutions is evident in the recent crisis in New South Wales involving Campbelltown and Camden hospitals. From February to the end of December 2003, first-time mothers were able to give birth at Camden Hospital's birth centre—an example of non-specialist maternity care that women and their families in the area had sought to establish for almost a decade. Specialist practitioners in birthing, however, refused to work at the hospital and provide back-up care in the event of complications. According to one newspaper report that covered the issue, the former general manager of the hospital had been ordered by the then Minister for Health to employ five

anaesthetists from South Africa because local practitioners refused to do the job (*Daily Telegraph* 19/12/03). Despite such efforts, the birth centre has now been closed and first-time mothers and their families are now required to go to Campbelltown Hospital's specialist maternity wards. In short, the organisation and delivery of specialist, male-dominated medical care has ensured that access to non-specialist maternity services is even more tightly rationed. This was despite recognition and approval by the previous Minister for Health and public health officials of non-specialist maternity services in the Camden region. Paradoxically, this reversal has been achieved in the name of mothers and babies, as a subsequent newspaper report disclosed. The high-level medical specialist who recommended the birth-centre closure stated that it was *the interest of the mothers and babies* that precipitated the decision (*Daily Telegraph* 26/12/03:4).

In terms of the analysis developed in this paper, such a development illustrates the ways in which the interests of a dominant, masculine minority can be naturalised and normalised as the general interests of the citizens—mainly women—whom they are employed to serve. It also demonstrates how these interests were able to prevent the secure foundation and maintenance of a partnership between public service providers and community-based constituencies—a goal that the present NSW State Government has prioritised in an effort to ensure that public human services address the needs of constituencies (NSW Premier's Department 2003).

At this point I want to return to the question I posed at the beginning of this paper in relation to the representation of 'the problem' of gender and health in women's health policy. I think it is probably useful at this point to ask, what might the developments reported in the examples outlined above tell us about this representation? I suggest they robustly evoke the central 'take-home message' of women's health policy. **Women are excluded from participating, especially at the most senior levels, in decision-making processes that determine the kinds of services they need.** So what do we do with such a message in terms of a discourse of goals and 'outcomes' that now prevails within women's health policy? As I

mentioned at the beginning of this paper, 'women's health' and 'women's health policy' are now located within broader public discussions about gender and health. The question of future directions in women's health policy thus needs to be addressed and examined not only in relation to recent theoretical developments and research in gender. It also requires a critical analysis of other policy developments in relation to gender and health. Accordingly, the paper now turns to the emergence of men's health policy in Australia.

Part III: Men's health policy

In 1996, at the instigation of the then Minister for Health in the Keating Labor Government, Carmen Lawrence, the Commonwealth Department of Human Services and Health produced the Draft National Men's Health Policy. A change of government in that year saw no further policy development in 'men's health' at Commonwealth level. However, the new Coalition Minister for Health, Michael Wooldridge, funded a range of initiatives in the area including a national conference and a study to write a background report and national research agenda in 'men's health' (Connell et al 1999).

From the outset, public policy on 'men's health' mobilised the term 'gender'. The *Draft National Men's Health Policy*, for instance, stated:

In the past, it has been assumed that all men's health needs have been covered by the general health system and that they have few, if any, special needs. Now evidence is emerging that many aspects of men's health have been overlooked, particularly in relation to certain groups; for example, Aboriginal and Torres Strait Islanders, men from non-English speaking backgrounds, men with low socioeconomic status, gay men, men with disabilities and rural men. Health policy has been critically examined in the 1980s in respect to women's health and it is time now to undertake the same type of examination in respect to men's health.

The need for a men's health policy arises from the fact that significant groups of men experience poor health with respect to specific diseases (eg. cardiovascular

*disease and significant cancers) and injury (eg. suicide and road accidents) with substance abuse impacting significantly in both these areas. There is also evidence that men's utilisation of health services may be different to women's and that their utilisation patterns are mediated by a range of factors which include socioeconomic status and culture. It follows that if we better understand these **gender issues** [emphasis added]...then more can be done to secure better health outcomes for men, and ensure health services are appropriate to their needs (Commonwealth Department of Human Services and Health 1996:39).*

Clearly, the understanding of gender in health represented in this document bears little, if any, relationship to that articulated in women's health policy discourse. In this text, as in most produced within the field (see, for example, NSW Department of Health 1999a), gender in health refers to **sex differences** in health status and health service utilisation rates. Here, gender in health is constituted by **margins of difference** between men's and women's rates of morbidity, mortality, disability, health services use and certain 'lifestyle' practices identified as being strongly associated with health 'outcomes' (Schofield et al 2000). It is a representation informed by epidemiological imperatives of measurement.

Certainly such a representation of gender in health involves a relationship between the sexes. But it is a binary one of sex-based aggregations of numerical contrasts in health indicators. Such a construction is no mere tool for operationalising gender in health. Rather, it is itself a conceptual mechanism by which a particular representation of gender in health is brought into being (Schofield 2002). Intrinsic to it is the establishment of an association between human groups that are ostensibly mutually exclusive—'males' and 'females'—and their respective 'health chances'.

Such an association functions as a proxy for the collective interests in health of men and women. However, these 'interests' are basically artefacts of an approach based on categorical thinking and quantitative, binary comparison. From such a perspective the respective, collective interests of men and women in health are necessarily exclusive of each other since they are constituted by a

division between sex-based agglomerations of health indicators (Schofield 2002). Further, the actualisation of such interests—that is, their articulation in public policy as warranting action—is contingent on whether the combination of one set of indicators suggests an inferior status vis-a-vis the other.

Underpinning this representation of gender in health is an arbitrary and abstract relation between men and women, as is its relationship to 'health outcomes' (Schofield 2002). Such a conceptualisation does not derive a relation between men and women analytically or empirically. It avoids examination and discussion of their everyday life practices, and of the ways in which these are organised and patterned. It does not explore how men and women are positioned in relation to each other in terms of their capacities to access vital social resources such as employment, income, education, housing, leisure, sexual intimacy and so on. The respective social costs or benefits that men and women experience through their participation in the configurations of practices in which they are located as men and women, are not considered or examined. In short, such a representation:

does not explore the concretely embodied ways in which men and women interact and participate in these configurations, nor the embodied nature of the costs and benefits generated in doing so. It eschews any engagement with the political nature of the relations between men and women that is central to women's health discourse. Rather, [such a representation] designates and prescribes a relation between men and women as one of mutually exclusive correspondents (Schofield 2002:35).

One of the main factors associated with the arbitrary and abstract nature of the relation between men and women in this representation of gender in health is the increasing global currency of a population health approach within public health policy (Lewis and Leeder 2001). As is now widely recognised and understood, the interest in the shape and movement of 'populations' is a relatively recent development that coincided with industrialised capitalism and the rise of the modern nation state in Europe in the eighteenth century (Foucault 1980). Economic growth, nation building, territorial expansion and warfare featured large in these and so, too, an imperative for assessment and

calculation of human resources that could be deployed towards these ends. The 'health' and capacity of these resources to reproduce themselves of course assumed considerable significance in such a project. Indeed, in Australia, such a concern was central to the very constitution of the nation and its destiny (Cass 1983, Gillespie 1991).

In the course of such developments, 'populations' were manufactured—brought into existence, in fact—by the instrumental purposes of nation states. Given the significance of women's sexual and reproductive capacities for these purposes, it is not surprising that methods for counting and auditing human resources created a sex-based category that produced 'men' and 'women' as discrete populations. Nor is it also surprising that the respective, collective interests of men and women in health should involve sex-based aggregations of health indicators. Such interests made perfect sense from the perspective of the utilitarian state, because the state needed to know and understand the capacity of its 'citizens' to reproduce the nation's human and non-human resources. Central to this process was identifying the quantum and robustness of the nation's 'women'—for childbearing—and 'men'—for work and warfare (Lake 1994). Being appraised of sex differences in the population, and of their respective robustness—as indicated by sex differentiated mortality and maternal mortality rates—was a basic requirement of effective national policy and planning.

Since the mid-1990s, population health discourse has strongly influenced Australian public policy in men's health (Schofield 2002). As a consequence, its representation of gender and health has been tantamount to sex differences in health. The representation of these differences is much more detailed and elaborate than those reflected in the early collections of the Commonwealth Statistician. In large part, the current detail is attributable to regular national health surveys conducted in this country since the late 1970s by the Australian Bureau of Statistics, and the growth of epidemiological expertise.

One of the principal effects of an epidemiological approach is to suggest that if the magnitudes of the sex-based aggregates of health

indicators are equal, then men and women experience the same health status. If the magnitudes between the two collections are different or unequal then so, too, are the health statuses of men and women. Indeed, 'women's health' can be regarded as worse or better than 'men's health', and vice-versa, depending on the respective, aggregated magnitudes of the indicators within each sex-based category. Difference or inequality between the two signifies that health status is *gendered* (Schofield 2002:34). As mentioned above, such an interpretation is predicated on the idea that a collection of numerical indicators by sex corresponds with a collective identity and interest produced by its differentiation from the 'other' sex.

Within men's health policy discourse, the pattern of health differences presented generally suggests that men as a whole do not enjoy a health advantage over women. Indeed,

the discourse evokes a strong sense of mutual suffering and health disadvantage between the sexes. It also suggests that men as a sex experience specific health difficulties that require a sex-specific public response, such as men's health policies and services. (Schofield et al 2000: 248).

However, within men's health policy, the idea of a collective interest among men in relation to their health goes hand-in-hand with the idea of a plurality of interests among them. As the *Draft National Men's Health Policy* asserted in its opening statement,

many aspects of men's health have been overlooked, particularly in relation to certain groups: for example, Aboriginal and Torres Strait Islanders, men from non-English speaking backgrounds, men with low socioeconomic status, gay men, men with disabilities and rural men (Commonwealth Department of Human Services and Health 1996: 39).

This representation of plurality or diversity of interests among men differs markedly from that advanced in the representation of gender in health in women's health policy discourse. In the latter, plurality is entirely consistent with a collective interest because of the way in which gender in health is constructed. In short, women's collective

interest in health is brought into being through their relationship to those who are the major arbiters of the nature and distribution of their bodily care, and of the resources allocated in the process. This hierarchical relationship is situated and played out in the plethora of sites and practices that comprise health care organisations and is experienced by women differentially, depending on social factors that shape and deflect their capacity to participate in and negotiate the process.

The plurality of interests that accompanies the collective interest in men's health policy discourse, by contrast, is created by differences in health rates among men by Aboriginality, country of birth, occupation, education, income, geographical location and so on. This creates some tension in the formulation of gender in health (Schofield et al 2000:249). On the one hand, to the extent that there is a shared or collective interest in men's health, all men as a whole have comparable or worse health than women as a whole. Yet on the other, while there are differences among men, only certain groups of men have comparable or worse health than women as a whole. Clearly, both are not tenable. Such a representation is conceptually contradictory, as the following comment explains:

Although all men might appear to be the subject of men's health discourse, the discourse also emphasises some ways in which men's health disadvantage is not generalised among men. Particular groups of men are often identified in bearing a particular burden: indigenous men, men from non-English speaking backgrounds, African-American men (in the United States), men with disabilities, gay men, men of low socioeconomic status, and rural men... The implication here is that social disadvantage produces the margins of difference between men's and women's health patterns.

[But] understanding men's health in this way poses a contradiction for prevailing men's health discourse. If it is the social disadvantage of some men that produces the rates of health differences between men and women, then to what extent is 'men's health' sex-specific at all?(Schofield et al 2000: 248)

The emphasis on sex differences in the representation of gender and health in men's health policy is also associated with a further significant limitation. As the Commonwealth Government-commissioned report of research in men's health concluded, *there is no evidence that the differences exceed the similarities in health* (Connell et al 1999). Clearly, a vast international and Australian literature on sex differences in health exists, as official statistics and extensive project-based research shows. Indeed, an extraordinary diversity characterises the health conditions for which these differences are examined. Typical examples are mortality, average life expectancy, chronic illness, injury and disability from accidents, suicide and substance abuse. But they also include *diet and weight-control practices...snake bites, dog attacks, and infections from eating with chopsticks* (Schofield et al 2000:249).

Yet, as the Commonwealth Government-commissioned report explains, *a finding of sex difference need not imply a difference between all men and all women. In fact, it usually does not. Quite small differences among a minority of the population may produce statistically significant differences in overall rates or averages* (cited in Schofield et al 2000:249). Further, as the report also points out, *in many research reports,...men and boys have similar averages or rates to women and girls; in other studies, men and boys have better averages or rates than women and girls* (cited in Schofield et al 2000:250). As the report was at pains to stress, however, this is not to trivialise or dismiss the serious health trouble that **some groups** of men are in; especially Aboriginal men, working class men, men from non-English speaking backgrounds, some gay men and some rural men. However, men as a whole are not worse off than women.

It is clear then, that the meaning of gender in prevailing men's health policy discourse is characterised by significant flaws in conceptualisation and in the use of empirical evidence. There are no grounds—apart from those associated with men's reproductive biology—for advancing the idea that men as a whole share a set of health needs and that these disadvantage them vis-à-vis women as a whole. There are certainly groups of men with pressing health needs but these are generally related to factors associated with men's class, their indigeneity and, for some, their ethnicity and homosexuality.

It is nevertheless evident that the hazardous and lethal effects on men of class, indigeneity, ethnicity, sexuality, rurality and so on are gendered. For example, the markedly higher rates of occupational mortality and disability among working class men are not simply attributable to the greater prevalence of dangerous and disabling work they perform compared with their more educated and affluent male counterparts in the workforce. They are also the result of greater participation by working men in such jobs compared with their female partners, wives, sisters and daughters. In short, working class employment has been organised in relation to, and constituted by, practices in which *the reproductive distinction between bodies* has been central (Connell 2002:10). This has meant that working class women's employment has been significantly more restricted both in terms of quantity and scope. Consequently, working class men historically have tended to occupy more of the available jobs, especially full-time, and have participated across a wider range of occupations than their female counterparts (Ryan 1998).

Unfortunately, men's greater and more diverse employment has gone hand-in-hand with more exposure to injurious and potentially fatal work (Waldron 1995). One of the most influential factors responsible for such an outcome has been the adoption by both management and unions of aggressively exclusionary approaches to women's employment in these hazardous jobs. This gender segregation has seen a thoroughgoing masculinisation of such work. And so, the excessive burden of occupational illness, disability and mortality that working class men bear is the outcome of a set of employment relations in which gender has played a central role.

However, the current representation of gender in men's health policy does not identify and express the problem in this way. As explained above, 'the problem' is primarily one of sex differences in measurable health 'outcomes', especially men's greater rates of mortality and disability. The principal objective of this policy is to remove the differential and to secure the same rates between men and women. The logic of such policy, however, would suggest interventions that

are not appropriate or acceptable to public health policy makers and institutions. For example, bringing women's participation to parity with men in those occupations and industries that currently maim and kill men would achieve the objective of eliminating the sex differential in occupational illness, disability and mortality. Yet it would increase women's rates of poor health and defeat the overall mission of public health institutions: to protect and enhance the health of all Australian constituents, including women.

As this analysis suggests, the representation of gender in Australian men's health policy differs significantly from that developed by its women's health counterpart. For the latter, the problem of gender and health has mainly involved a social relationship of inequality arising from men's greater socio-economic and political participation and women's correspondingly greater marginalisation and exclusion. According to this approach, women have experienced more diminished opportunities to participate alongside men in decision-making processes that determine health care needs, the kinds of services required to address them, and the amount of resources needed to provide them. Women's health policy has thus framed its major policy objectives in terms of gender inequality, particularly that prevailing within the health sector. Interestingly, however, international developments in 'gender and health' policymaking indicate a departure from this approach. What they disclose is a convergence with the representations of gender in Australian men's health policy as the following section shows.

Part IV: 'Gender and health' policy

In 1996, the Women's Health and Development (WHD) division of the World Health Organisation convened an inter-division Gender Working Group (GWG) to strengthen and coordinate what it described as a gender-based approach to the work of the WHO (WHO.INT 2000). Prior to this, 'gender and health' within the WHO was largely synonymous with 'women's health' and focussed on maternal and reproductive health, especially in 'developing' countries

where reproductive carnage, illness and disability among women were horrifically pervasive and severe—a problem that persists to this day (WHO forthcoming). By the 1980s, such a focus was increasingly informed by what has been termed the '*Women in Development*' or *WID approach* (WHO 1998:7). Its goal was to eliminate women's invisibility in development programs (White 1994, Bacchi & Eveline 2004).

At the Third World Conference on Women in Nairobi in 1985, the WID approach was enthusiastically endorsed by participants as a means of improving women's status across the globe. A range of WID policy initiatives was subsequently implemented. By 1995, however, the Fourth World Conference on Women held in Beijing concluded that women's basic economic, social and political status remained largely unchanged (WHO 1998). The appropriateness of the WID approach was called into question, a trend already underway in the early 1990s (for example, Kabeer 1994, Young 1993). Some of the main reasons proposed were that the WID approach was 'women-centred' and rendered women 'the problem' and 'passive victims' in need of welfare and special treatment to improve their circumstances (WHO 1998, WHO 2003). With a focus on *women as subject* (WHO 2003:11), such an approach was considered overly preoccupied with women's biological and reproductive concerns, and accused of 'ghettoising' women's issues (cited in Bacchi and Eveline 2004). Further, it was criticised for failing to *explore the reasons behind women's subordination and to find explanations for the systematic devaluation of their work or for the continuing constraints on their access to resources* (WHO 2003:11).

When the Beijing World Conference on Women declared 'women and health' to be a critical area of concern and formulated five strategic objectives to address it, it did so in the light of agreements reached at the International Conference on Population and Development in Cairo in 1994. These endorsed both the right of women to control all aspects of their health and also, equal relationships between women and men in matters of sexuality and reproduction. At the heart of the program formulated by the Beijing Conference was integration of *gender concerns into **mainstream** [emphasis added] health policies, and establishing or strengthening institutional mechanisms to support women's*

participation at the levels of decision-making and delivery (WHO 2003:10). As a number of commentators have suggested, this signalled a decisive departure from the WID approach and the adoption of a new understanding about women's health issues—namely, one informed by a 'Gender and Development' (GAD) approach (Bacchi and Eveline 2004, WHO 1998, WHO 2003, Saulnier et al 1999, Rathergaber 1990).

According to the commentaries on GAD, it is the socially constructed relations and divisions between men and women, rather than 'women as subject', that needs to underpin analyses and policy frameworks to address women's issues. This gender-based focus allegedly serves to correct the understanding that it is the biological difference between the sexes that underpins their differential needs. From such a perspective, **gender-based analysis** is the requisite conceptual tool to address women's issues in policy and program development (WHO 2003, WHO 1998, Saulnier et al 1999).

By 1997, the United Nations Commission on the Status of Women announced that it, too, supported 'the gender perspective' and recommended mainstreaming it into all of its programmes and policies. According to the UN, this involved *assessing the implication for women and men of any planned action, including legislation, policies and programmes, in all areas and at all levels* (WHO 2003:11). In the wake of this decision the WHO's Gender Working Group produced *Gender and Health: Technical Paper*. When it was published and distributed in 1998, it made clear in the paper that 'gender analysis' (WHO 1998) was the key conceptual means by which the GWG would seek to realise its basic objective of integrating gender issues into the work of the WHO, including its research, policy and program development (WHO.INT 2000). This would mean that all facets of the organisation's activities would have to address and engage with gender issues in health. Women's concerns would no longer be segregated and marginalised.

This approach was embraced in a range of international health policy making settings but no more vigorously than in Canada (Health Canada 1999). Health Canada announced that it was implementing a gender-based analysis (GBA) to ensure that its *day-to-day*

operations... [were] sensitive to women's health needs and concerns (Health Canada 2002:1). It made clear that the overall goal of the 'GBA implementation' was making the health system more responsive to women and women's health (Health Canada 2002:2). The relationship between a GBA approach and the advancement of women's health was indivisible.

This position received strong support from Canadian feminist health researchers and commentators (Armstrong 1999, Saulnier et al 1999). For example, Christine Saulnier and her colleagues proposed that the purpose of employing a gender-based analysis in health was to facilitate identification of the gender-based inequalities and power relations that underpin women's disadvantage and their health problems. It was a means of getting to the root of the problem. As such, it demonstrated that women were not the problem in need of change or integration (Saulnier et al 1999). Rather, it was the gender relations of organisations and institutions that needed to be transformed to 'empower women' and improve their health. The ultimate objective of GBA and gender mainstreaming, according to Saulnier and her colleagues, was the achievement of gender equity or fairness. The goal of such an objective was for women to *get what they need, whether or not they require the same opportunity or condition as men* (Saulnier 1999:9). To enable women to 'get what they need', gender mainstreaming would promote women's 'strategic interests'. In the health arena these involved enhancing women's control of resources, encouraging women's capacity for leadership and increasing their participation in decision making (Saulnier et al 1999). Advancing women's 'strategic interests' would establish the conditions for women to identify solutions to meeting their 'practical needs' in ways that did not reproduce their subordination.

The explicitly feminist goals of the Canadian approach to 'gender and health' policy were not as clearly replicated and evoked in documents produced by the WHO's GWG. The introduction of the *Gender and Health: Technical Paper* (WHO 1998), for instance, states:

A gender approach in health, while not excluding biological factors, considers the critical roles that social and cultural factors and power relations between men and women play in promoting and protecting or impeding health...

*There has been a tendency to equate gender analysis with the analysis of the situation of women. **The purpose of a gender analysis is, however, to identify, analyse and act upon inequalities that arise from belonging to one sex or the other, or from the unequal power relations between the sexes** [emphasis added]. These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health... Since these inequalities most often disadvantage women, a gender analysis has been used so far mainly to explain and address women's health problems.*

However, the social construction of male roles may also disadvantage men and an attempt has been made in the paper to provide some examples of this. (Gender and Health: Technical Paper WHO 1998:6).

As this passage suggests, it is not women's health that is the explicit concern of the paper or the purpose of implementing a gender-based analysis. Rather, as the very opening paragraph of the introduction states, it is *health and health care issues in general* (WHO 1998:6) that are its central focus. From such a perspective, gender-based analysis is a kind of actuarial tool for devising balance sheets of health 'risk factors' associated with belonging to either the category male or female. The subject—women and their health—is, in effect, erased.

This approach to gender and health has been further elaborated in other papers produced by staff and consultants involved in the WHO's Gender and Health: Technical Paper (see, for example, Vlassoff and Moreno 2002, Doyal 1998, Doyal 2000b). Its key features are determined by a particular understanding of gender that stems from 'sex-role' theory of the 1970s (Connell 2002). First, it emphasises a distinction between 'sex' and 'gender'. The former refers to biologically determined characteristics, the latter to characteristics that are socially constructed. Second, both sex and gender **differentiate** people into men and women. However, as one exponent of the approach states, *[gender] is a term used to distinguish those features of males*

and females that are socially constructed from those that are biologically determined (Doyal 1998:1). Third, in relation to health, the resultant differences—in ‘maleness’ and ‘femaleness’—*are reflected in the patterns of health and illness found among men and women around the world* (Doyal 1998:1). It is these differences that are the problem of ‘gender and health’. Addressing and explaining them requires analysing the impact of the combination of sex and gender differences on health.

This representation echoes the problem formulation of Australian men’s health policy and suffers the sorts of limitations and tensions already explored in this paper. One is that patterns of health by sex are not predominantly characterised by difference. They are as likely to demonstrate no difference. The second—that there is a correspondence between sex and gender—is problematic for the following reasons. In asserting from the very outset the reproductive distinction in human beings—that is, sexual difference—in defining and explaining gender, such an approach immediately suggests that human embodiment is fundamentally dimorphic. Yet, as Bob Connell reminds us, *while humans are mammals with well-differentiated reproductive systems... the physical differences between the sexes in other respects are very modest* (Connell 2002:29). Despite the lack of foundation for a representation of human embodiment as essentially dimorphic, ‘gender and health’ policy discourse proposes that there is a match between social behaviour and this human bodily dimorphism. Accordingly, the social practices of human beings *take the shape of a dichotomy between all-women and all-men* (Connell 2002:36). The behavioural patterns of men and women, however, are far more similar than this view would suggest. For example, despite the popular view that ‘unhealthy lifestyle’ practices such as smoking, heavy drinking and dangerous driving are the preserve of men, in fact, both men and women engage in them. Certainly, the proportion of men overall exceeds that of women who participate in such health impairing activities, but the rate at which some groups of women practise ‘bad habits’ is significantly greater than that of some groups of men. In relation to smoking, for instance, the proportion of women who do so exceeds that of men if we compare young women (aged 20-29) from working class backgrounds with older men (aged 50 and

over) from educated, professional backgrounds (Australian Institute of Health and Welfare 2002).

This is not to suggest that large areas of human practice are not strongly gendered or patterned by the deployment of the bodily reproductive distinction, as we have seen in employment that involves high exposure to hazardous conditions, substances and processes. The care of the sick and disabled in both formal and informal sectors is a further striking example. Here, however, it is the possession of female sexual characteristics that is brought into play in determining access to the practices involved, their organisation and the material and symbolic rewards for performing them. At the level of senior management that involves decision-making practices associated with the care of the sick and disabled, on the other hand, it is the possession of male sexual characteristics that predominates in determining access, organisation and rewards.

What these examples illustrate is that gender is not an analytical tool for sorting human behaviour into mutually exclusive and static categories that correspond with bodily dimorphism. Rather, it is a principle of social organisation in which the reproductive distinction is deployed and enacted to determine who gets to do what, how and with what kinds of symbolic and material consequences (Ferree et al 1998). Understanding gender in this way involves addressing and analysing the social distribution and exercise of power and its consequences. These not only include the distribution of socially valued resources. The social inclusiveness of the process that determines what gets to count as socially valued resources, and the needs and constituencies they should address, is equally important. The fundamental purpose or object of gender-based analysis from this perspective, then, is to contribute to the achievement of equitable resource distribution and democratic participation, especially in positions of influence and decision-making processes.

Understanding gender in this way involves acknowledging and recognising that the reproductive distinction has been brought into play in ways that have yielded significantly greater 'dividends' to men

than women, as illustrated by the gendered organisation of maternity services. As importantly, the persistent repetition of such a dynamic has generated enduring patterns or structures of inequality and inequity that constrain women's participation alongside men in voicing their needs and, in turn, their access to resources to address them. Yet such structures do not exist outside of human practice. As the discussion of recent developments in gender theory and research in the early part of this paper suggests, organisational practice within public institutions is a key mechanism in producing gender relations.

Within public health institutions, it is masculinist and technocratic hegemony in decision-making and service delivery organisations that lies at the heart of the problem of 'gender and health'. This is because such hegemony marginalises and excludes women from participating alongside men and exercising leadership with them in decision making that determines the health needs to be addressed by public health resources, the kinds of resources to be provided in addressing them and the organisation of their delivery. 'The problem', then, involves the organisational foundations of public health institutions. As the participants at the last World Conference on Women in Beijing recognised, these are primarily mainstream services and programs and the public sector policy-making agencies associated with them because this is where the lion's share of public resources is located. Achieving gender equity in health thus depends on empowering women, as the Canadian approach proposes, by enhancing women's participation alongside men in decision making at the levels of management and delivery in mainstream services.

Part V: Mainstreaming gender in health policy

It is important to remember that the understanding of gender and health developed by the WHO emerged in the course of seeking to mainstream gender. In effect, this project has amounted to the production of conceptual tools. The enhancement of gender sensitivity in health policy making, for instance, has produced *frameworks for integrating a gender perspective into national health policies* (Doyal

1998). More recently, the advancement of gender equity in health has involved the development of 'indicators' to identify, map and monitor the impact of sex/gender differences on health and mainstream health services (see, for example, WHO 2004). The principal measure by which the WHO has engaged with mainstreaming gender, then, has been to develop technocratic measures to assist health policy makers to adopt a gender-based perspective in addressing health and providing health services.

In the process of doing so, however, the WHO has commissioned women to do the job and established extensive international consultative forums and networks of women policy makers, health workers and experts in 'gender and health'. Such initiatives are consistent with the kinds of institutional measures that the women at the Beijing Conference had in mind when they resolved that increasing women's participation in decision making was a top priority. At various international gender and health forums conducted since 2000 by the WHO Centre for Health and Development in Japan, for example, one of the four key streams of discussion is about enhancing women's capacity for leadership in health and decision making (WHO 2003). Such forums may be understood as empowering women through organisational practices that are generally 'women-centred'. Yet, they are certainly not part of mainstream decision making and organisational practice.

What these developments suggest, paradoxically, is that the project of mainstreaming gender in health at the international level has been taken up in ways that contain and marginalise the goals implied by the Beijing Conference resolution. The focus on the formulation and dissemination of conceptual tools for measuring and checking, for instance, renders the process of mainstreaming a professional and technical exercise. The rationalist character of the process is further consolidated as the relevant technical experts within policy-making agencies in national public health institutions are expected to apply these tools.

Meanwhile, it is 'business as usual' in mainstream health policy making and the organisational processes associated with it. Mainstream policies that determine which constituencies get what in relation to public health resource distribution and what those resources will involve, for example, inevitably involve decision-making about the kinds of needs that will be addressed and the types of services and programs that will be used to do so. In most states in Australia the latter are overwhelmingly hospital-based services that address medically diagnosable conditions. The main question for policy makers becomes which constituencies will get more or less of them. In NSW Health, a statistically based formula has been devised and deployed to assist policy makers to come up with the answers. In this context, 'gender issues' are addressed largely in terms of sex differences in hospital service utilisation rates (see, for example, NSW Health Department 1999b). Inequalities generated by the ways in which the bodily reproductive distinction is played out in decision-making associated with resource distribution, or in the kinds of services that are accorded mainstream funding, simply do not make the mainstream policy-making agenda.

The Australian situation is, of course, not unique. There is no published international evidence of major organisational changes having been introduced into mainstream health policy-making to increase and strengthen women's participation in decision making. Nor is there any evidence that mainstream health policy making is beginning to demonstrate any re-orientation towards enhancing the capacity of women to increase their participation in management and service delivery as subjects alongside men (see, for example, Mackay and Bilton 2000). In fact, there is alarming evidence of the removal of women's policy-making machinery (Mackay and Bilton 2000, Staudt 2003, Bacchi & Eveline 2004). This is evident in Australia, especially in relation to health at the national level where, since 1996, a conservative government has struggled with supporting women's health programs.

Such a development represents a significant reversal in women's health policy and funding. Since the mid-1970s, Australian policy-

making agencies at both Commonwealth and state levels have funded community-based women's health services, both government and non-government. These have afforded providers and users the opportunity to participate together to determine health needs and the kinds of interventions they believe are appropriate for meeting them. In most cases, they have sought to establish a process that places women at the centre of their care, enabling them to 'speak their needs'. Women's health services have also involved collaborations between mainstream stakeholders—health and welfare workers, administrators and policy makers—and community-based constituencies of women. Such collaborations have identified and clarified women's health needs and have usually been characterised by a process that is inclusive, deliberative and consensual—not one informed by professional dominance and privilege.

Much of the funding that women's community health services receive, however, is program-based so there is no guarantee of continuity of service. While this can enhance flexibility and 'fine tuning' in needs identification and service provision, it also imposes a significant cost in the form of participants' time and expertise. Such a cost is, of course, not necessarily burdensome. Indeed, it may be understood as an integral requirement in establishing a participatory, democratic process. Yet it is a very costly practice for women's health services receiving a very small fraction of the total health budget. They are rarely able to employ sufficient staff to meet demand for their programs. In fact, the vast majority of community-based women's health services, especially those in the non-government sector, are chronically under-resourced (Women's Health NSW 2002). For example, the one community-based health centre in New South Wales that specialises in providing counselling services to women with mental and emotional difficulties, especially those related to domestic violence and sexual abuse, is a non-government women's health service that relies heavily on program-based funding. It has a waiting list of over a year (pers. comm.)! The overwhelming majority of the women who use the service, many of whom are from non-English speaking backgrounds, simply cannot afford the non-rebatable fees charged by psychologists or psychiatrists in private practice.

Despite the cool relationship the Commonwealth Government presently maintains with women's health policy and programs, governments within the most populous states continue to support the production of state-based women's health policy and programs, including community-based women's health services. Clearly, however, this commitment and provision are annexed from the mainstream. This separation and distinction underpins the description of women's health services and programs as 'boutique health'. Such a description is, of course, ironic. Community-based women's health services have more in common with 'op shops' than boutiques because of the financial constraints under which they are forced to operate and the dire need of the women who frequently use them.

Nevertheless, women's health services and programs struggle to maintain their democratic character. They encourage women practitioners and community constituents to work together in non-hierarchical relations to identify what is needed and how these needs should be addressed. This fundamental operating principle was established very early in the piece (Broom 1991). To this end, such services undertake regular discussion forums and research to be informed of recent developments in areas that women have consistently identified as major concerns, such as depression and anxiety. This effort is often coupled with evaluation of the effectiveness of the services in addressing such issues (see, for example, Leichhardt Women's Health Centre and Central Sydney Area Health Service 2003). In the course of doing so, one of the main methods adopted involves interviewing individuals and conducting focus groups with relevant 'stakeholders' to maximise women's opportunities to voice their responses.

The problem, however, as already explained, is that this is all done on a shoestring, in a climate of funding uncertainty and with negligible connection to mainstream services. At the same time, to the extent that public health policy-making agencies are adopting and adapting gender-based analysis and producing men's, women's and gender equity policies in health, they apparently believe they are engaged in

mainstreaming gender into health policy and service delivery. As this paper has explained above, this is increasingly associated with an understanding of gender as mutually exclusive sex-based categories, each of which suffers particular kinds and intensities of 'health risks' because of correspondingly divided social worlds that inflict different kinds and exposures of injuries and illnesses on their respective participants.

So how might mainstreaming gender in health policy be implemented in such a way that the goals of the Beijing Conference are achieved? It is probably worth re-iterating at this point that gender-based analysis and mainstreaming were endorsed internationally as mechanisms for redressing the disadvantages that women experience as a result of gender-based inequalities, including their under-representation in decision-making and a wide range of activities across social, political and economic life. Gender mainstreaming, then, was formulated within an overtly feminist context to advance women's 'strategic interests'. Its anticipated 'outcomes' in relation to health were basically twofold: one, to integrate gender concerns into mainstream health policies; and two, to establish or strengthen institutional mechanisms to support women's participation at the levels of decision-making and delivery.

As already mentioned, the published research to date on achieving these outcomes is virtually non-existent. Yet recently completed Australian research on gender equity in public institutions in New South Wales suggests that at least one high-profile public sector agency has been extremely successful in mainstreaming gender and advancing women's interests (see, Schofield & Goodwin forthcoming). The study examined mainstream and gender-specific policy making in a number of public sector agencies. It found that only one agency's policies formulated its objectives in terms of redressing gender inequalities. This was underpinned by representations and understandings of gender that involved the deployment of the reproductive distinction in such a way that women had been historically and systematically disadvantaged. Further, the organisation sought to address and redress this problem through both

its mainstream and gender-specific policies. These were produced almost simultaneously and in relation to each other. The mainstream policy integrated the central gender concerns that were identified, examined and developed more fully in the gender-specific policy.

This mainstreaming of gender into policy occurred through an organisational process involving considerable agency restructuring that established rough parity between men and women at all levels of the policy-making processes. Both an in-house advisory unit and a sector-wide agency specialising in equity and women's concerns were also integrally involved in the production of both policies. This was further supplemented by extensive consultations with community-based organisations and other stakeholders that included organised women's groups. Reports by non-agency based experts with knowledge and understanding of the impact of gender on women in the area were also commissioned and incorporated.

Significantly, the driving force behind this achievement was the Minister—a man who had a sophisticated understanding of gender equity and a vigorous political commitment to advancing it in his portfolio. He appointed a woman to the position of senior executive manager within the department. This senior executive manager, together with most of the staff, recounted experiences of organisational solidarity and feelings of admiration and loyalty in relation to the Minister and the project he oversaw. Concomitantly, the Minister could not speak highly enough of his staff and a small coterie of specialist advisers from outside the agency. Sadly, however, with the policy formulation process all but completed, the Minister has resigned, the CEO has moved on, the agency has been downsized and restructured, and the specialist equity unit all but dismantled. It appears that gender mainstreaming is no longer operating in this agency.

Despite this disappointing outcome, it is nevertheless clear that gender mainstreaming can be done. It actually happened in one of the most hard-nosed, masculinist organisations in the New South Wales public sector! While political leadership was fundamental to its achievement,

it is important to recognise that it occurred in a broad policy context of commitment to social equity espoused by a Labor government newly elected to power. These circumstances undoubtedly shaped the political possibilities for mainstreaming gender in policy making in public institutions. Yet the mainstream policy-making that integrates gender concerns in such a way as to address specific equality objectives involves the establishment of organisational practice that encourages women's participation alongside men in identifying 'the problem' and in formulating strategies to address it. As importantly, it supports 'affirmative action' for women in organisational terms insofar as women's policy machinery and women's community participation and consultation are integral (see Bacchi & Eveline 2004).

In a very recent analysis of the problem of gender mainstreaming in policy making, Carol Bacchi and Joan Eveline (2004) propose that there is also a pressing need to formalise conceptual analysis in policy design, since gender-based analysis in policy making has proved to be so problematic in its conceptualisation of 'the problem'. They have set about developing a procedure called 'deep evaluation'. Basically, it is another conceptual tool for policy makers to use in incorporating a gender perspective into mainstream policy. Yet it differs from its technocratic counterparts insofar as its application requires opening up political discussions about policy options and empowering policy activists in the process. In short, its application demands a more democratic and deliberative set of social relations in policy making. As Bacchi and Eveline conclude, however, any such procedure is unlikely to achieve its intended outcome unless and until it is part of a broader program of women-specific reforms that include women's increased participation in positions of influence (see also, Bacchi 1996).

Conclusions and future directions

'Gender and health', as this paper's analyses of gender-specific policies suggest, is a hotbed of contestation and debate. Confusion about what, exactly, gender and health means, is widespread precisely because of this discursive conflict. This paper has argued, however,

that 'the problem' of gender and health may be best understood in terms of unequal participation in mainstream decision-making at the levels of policy formulation and service management and delivery. Such a disparity in participation constrains women's voices and favours those of men, especially those with specialist professional, managerial and technical expertise. As a consequence, women's capacity to determine what counts as health needs, what kinds of services should be provided to address them, who should receive them and with what degree of public support, is significantly limited.

'Gender and health', then, is a problem associated with democratic governance and its relationship to health policy making and the distribution of public resources. Australian women are the main 'subjects' of the problem because it is their subjectivity as decision-making participants that is more likely to be effaced in mainstream health policy making and service management and delivery.

Therefore the problem of 'gender and health' is essentially one of gender inequality in the mainstream health care arena. Resolving it requires a repertoire of public interventions to advance gender equality. This objective means that such interventions need to be shaped by equity imperatives since equity involves the provision of public resources to assist those who are disadvantaged to participate alongside their more privileged counterparts in social life. Its main objectives are to:

1. integrate gender concerns into mainstream health policies to address the disadvantages that women face as a result of the ways in which the bodily reproductive distinction is played out in their everyday lives, in general, and in health services in particular, and
2. implement organisational changes in public health institutions to enhance women's leadership and increase women's participation alongside men in policy making and in the management and delivery of services.

Accordingly, the major, anticipated ‘outcomes’ of such an approach are:

1. the promotion of explicit gender equality objectives in mainstream health policy making, and
2. the establishment of social relations and processes within public health organisations that are inclusive of both men and women, and that enhance their democratic participation.

Where to from here?

This paper cannot prescribe a comprehensive framework and specific strategies for advancing gender equality in health policy. It can, however, propose some suggestions that may assist in beginning to support a process that will deliver such an outcome.

1. One of the difficulties of formulating ‘future directions’ involves the risk of reproducing technocratic prescriptions. To avoid this outcome, my strongest recommendation is that any future policy developments in health need to be informed by principles of democratic governance. This mainly means increasing women’s participation alongside men in the organisational processes involved in decision making in policy making and service management. Though it is wildly unfashionable and unashamedly ‘PC’, I suggest that one of the most effective strategies here is affirmative action (AA) accompanied by organisational restructuring. But perhaps we need an additional and new kind of AA that involves mandating quotas to limit the proportion of jobs in policy and management decision making that can be full-time. Such a strategy would increase the proportion of permanent part-time jobs at more senior levels within public health organisations. These jobs could then be shared between men and women on a 50/50 basis. Such an intervention would be the responsibility of governments and the public sector as a whole because it involves employment arrangements within the public sector.

2. I suggest that the WHO develops a framework and a set of conceptual tools for undertaking gender-based analysis in health policy making that necessarily increases and enhances women's participation in producing health policy that works towards the achievement of gender equality.
3. Further, I propose that Commonwealth and state health policy agencies examine their most significant mainstream policies in terms of an internationally recognised gender-based analysis that is informed by an understanding of the impact on women of gender-based inequalities. Examples of such policies here might include the Medicare Agreement and the resource distribution policies within the states and territories.
4. Additionally, I propose that gender-specific health policy making should continue but that its production should be co-extensive with mainstream policy making. Both processes should inform each other. Further, the same gender-based analysis adopted in mainstream policy making should be applied to gender-specific policy.
5. Women's policy machinery in health should be maintained and resourced to ensure the availability of organisationally based expertise in gender-specific policy issues.
6. In beginning the project of promoting gender equality in mainstream service management and delivery, I suggest that health policy makers allocate recurrent funding to establish collaborative provision between specialist medical services and community-based women's health services. The groundwork for such a project could be laid through seeding funding to establish and trial pilot collaborations in which evaluations of progress necessarily involve women's participation in design, execution and management.

7. Presently, funding for the National Women's Health Program depends on the Public Outcomes Funding Agreement between the Commonwealth and the states that will end on 30 June 2004. I propose that the NWHIP continues to be funded after this date to ensure that community-based women's health services can be maintained and further developed. Since gender mainstreaming of health services may involve the introduction of innovative forms of service delivery that draw on our existing resources, it is vital that services which have already pioneered some form of democratic *modus operandi* be supported.
8. Finally, it is important that our most senior decision-making officials—politicians and public sector executive managers—understand what gender mainstreaming is and the role of political will in supporting it. To this end, I suggest that the subject of gender mainstreaming in health be addressed and explained at forums such as the Australian Health Ministers' Advisory Council.

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REVIEWS

1. Professor Vivian Lin

Public Health, La Trobe University

Introduction

Toni Schofield has produced a wide-ranging and finely nuanced paper, drawing together sociological theory with a review of the evolution of Australian policies regarding women's and men's health. She examines current developments in mainstreaming gender in health policy, drawing from both some international work as well as research findings in New South Wales. She concludes by offering some policy prescriptions which are predicated on a conscious attempt to avoid producing technocratic prescriptions.

To translate Schofield's sociological and historical complexity into simple terms, the essential argument in the paper appears to be as follows. The history of a generic women's health policy in Australia shows that it is neither politically relevant nor efficacious in the context of a multicultural society. Despite this problem, the *National Women's Health Policy* (1989) and its subsequent funding program attempted to capture women's experiences and bring a women-centred approach to health service delivery. The concept of gender as social relations is translated into participatory structures in women's health services, although male dominance persists in mainstream health care. On the other hand, the development of men's health policy in Australia was based more on the differences between sexes as well as other ways in which populations can be categorised. Schofield views such categorical thinking as essentially epidemiological, and considers that it effaces the notion of social relations that should be embodied in the concept of gender. She also posits the idea that the notion of 'population' was manufactured by the instrumental, utilitarian purposes of nation states.

Schofield's most important argument, from a policy perspective, is that patterns of dominance in social institutions are shaped and reinforced by norms arising from institutional structures and cultures. These institutional structures and norms can be changed, even though gender norms are embedded in everyday practises. Here Schofield cites the apparently short-lived experience of one NSW government department as an example of what can be achieved in mainstreaming gender. From this basis, she suggests that the problem of gender and health is one of democratic governance, and the essential policy solution rests with addressing:

- 1) how to integrate gender concerns into mainstream health policies; and
- 2) how to implement organisational changes that enhance women's leadership and increase women's participation in both policy-making and health services management.

In this commentary, I am drawing on my experiences in the health policy world, and as a student of health policy. First, I would like to reflect on the history of policy-making in Australia on women's and men's health. Then I would like to comment on the processes of health policy making, which will highlight the problem of trying to align a finely nuanced sociological and theoretical analysis with the blunt tools of public policy, together with problems of policy implementation in general. From there, I will comment specifically about the policy prescriptions offered at the end of the paper, including the relevance (if any) of the international context. I conclude with very brief comments on problems of terminology in the paper.

Australian women's and men's health policies

The *National Women's Health Policy* (1989) was developed in the mid-1980s after an extensive process of consultation with women across Australia. It remains a defining document for the women's health field. It is important to note that the 1980s represented a

renaissance period for public health in Australia. During the period of Neal Blewett's ministerial stewardship, Medicare was introduced, public health infrastructure was established (such as the Australian Institute of Health, the Public Health Education and Research Program, and the Public Health Research and Development Committee of NHMRC), and major national strategies and programs were developed. In this latter category, one should include the National Aboriginal Health Strategy, the National HIV Strategy, the National Campaign Against Drug Abuse, the National Better Health Program (with its predecessors the Better Health Commission and the *Health for All Australians Report* (Blewett 1988) the Bicentennial Measles Campaign and the subsequent National Immunisation Program. In other words, the *National Women's Health Policy* was simply one of many policy initiatives that changed the Australian health policy landscape, and the issue of gender and health was not a particularly notable feature in that broad landscape.

The subsequent National Women's Health Program was a Commonwealth-state cost-shared program, much like the outcomes from other national policies and strategies. It was a relatively small funding program, compared to HIV, Drugs, Breast Screening, and Cervical Screening. Each state translated the program into its own framework of health services delivery, but the generally accepted approach was one of a 'dual strategy'—that is, simultaneously providing women-specific, women-centred, and women-governed health services and advocating for change in mainstream health care. Across all states, women's health units were set up within health departments, led by a women's health advisor, and together they constituted the Australian Health Minister's Advisory Council (AHMAC) Subcommittee on Women's Health. The 'femocrats' of this era liaised closely with other women's units in various areas of government (i.e. labour, education, or Premier's). Together, they prepared women's budgets that publicly accounted for the government's total commitment in women's issues, and were also the internal advocates for the women's health community. Women had moved from the fringes

into the centre, or so it seemed. While this could be characterised as the heyday for women's health—as a field of professional practice and politics—it was also seen by many as a period where special interest groups ruled.

In the 1990s, the Australian health system went into a period of reform. It was a period of budget cuts, and of enforcing efficiencies through changes in organisational and financing arrangements. The effectiveness of the 'dual strategy' of the National Women's Health Program was questioned. There were skirmishes across the country to preserve the dollars, to protect the specialist services, and to ensure the continued existence of women's health units within the bureaucracy. In the health policy world, women's health came to be seen as even more of a special interest group. Women-specific services were not seen to be relevant to either the larger health system agenda, nor to women generally—either as carers, or as consumers of health services. Although women's health had, in theory, stood for recognition of diversity and equity, women's health advocates came to be seen as wanting to impose ideological straight jackets on all. Whispers of 'feminist mafia' were heard in the corridors of policy making.

By the time men's health policy came on the health policy agenda in the mid-1990s, the context had substantially changed. In 1996 the government changed, and the Commonwealth followed the footsteps of state governments in pursuing severe cutbacks to the public sector, as well as entrenching the principles of the new public sector management across Australia. Men's health policy had little chance of going anywhere, regardless of how it was framed. Some critics saw it as 'call me a victim as well', some advocates pushed for focus to be on their favourite body parts which were distinctly male, for example, prostate and testicles. In any case, there was little money to be had, and there was the political need to re-engineer the interest-group landscape. On the broader canvas of health policy development, the 1990s saw Australia become the land of the resource-free national health strategies. National health priorities were officially adopted, and many more policy documents

were released, but all these documents had few programmatic outcomes.

There have been some shifts in policy paradigms in recent years—at least rhetorically—at the state level across Australia. Concepts about social cohesion, social inclusion, social capital, community strengthening, community capacity, have come to the fore. Gender has not.

Policy-making and policy implementation

The brief reflection on my own lived experiences in the health policy world suggests that the Schofield has incorrectly placed emphasis on theoretical constructs (such as gender) or even the construction of evidence (such as epidemiological categories) as determinants of health policy. She is right in suggesting that institutional structures and norms shape patterns of thinking and behaviour, but the missing link in the paper's policy analysis is an exploration of the deep culture of policy-making institutions.

An analysis of the *National Women's Health Policy* (1989) would probably point to the importance of a lengthy process of women's engagement with the political process, as well as a particular political context for the policy's development and release. An analysis of the implementation of that policy via the National Women's Health Program might point to the capture of program dollars within certain organisations and by particular community groups. The National Program itself would be seen as synonymous with the *National Policy*. Analysis of both the policy development and policy implementation processes would reveal the extent to which the history of women's health is a series of negotiated outcomes. There are numerous theoretical perspectives from political science and public policy, as well as sociology, that can be drawn upon.

The determinants of health policy are often crudely political, rather than conceptual and analytical. 'Gender' becomes a categorical

concept, and not because of epidemiology. Epidemiological evidence has, in fact, limited influence on policy making. Rather, it is equated with ‘add women and stir’—a switch from the terminology of ‘women’s health’ when it became necessary, politically, to enter into the policy discourse of ‘mainstreaming’. ‘Men’ and ‘women’ are not the categories of ‘population health’, which is a very late comer to health policy discourse, but the demographics of voting patterns. (They have also been the traditional categories for social and economic data collection). For the purposes of health policy, it might be that ‘men’ equates to the self and ‘women’ equates to other members of the family—as a former parliamentarian once revealed in conversation, ‘we see women’s health as what affects our mothers and sisters’.

The instruments used to implement health policy are also blunt. At the Commonwealth level, cost-shared funding and funding agreements (and associated reporting requirements) are the main vehicles. Occasionally, legislation is used to shift public opinion and behaviour. These instruments, which are usually used to spread millions of dollars across a myriad of organisations, are not the instruments to drive culture change in organisations. Culture change requires forces within the organisation, complemented by forces outside the organisation, and may take a long time. Changes in health services delivery at the level of the consumer experience—in that finely nuanced way that Schofield asks for—seldom occur because of policy dictates. The extent to which women’s participation in policy-making and management have impacted on either the labour process of health care delivery, or on the experience of receiving health services, is questionable.

When the Public Health Outcome Funding Agreements were being introduced in 1997, and the National Women’s Health Program was being ‘broadbanded’, the Australian Health Minister’s Advisory Council Subcommittee on Women’s Health commissioned the development of more than 200 reporting indicators. Apparently the view was that this suite of indicators represented a comprehensive monitoring framework that could be used to assess the extent to

which the ambitious aims of the *National Women's Health Policy* had been achieved. The sheer number of indicators, rather than any particular content contained in the suite, meant that no senior decision-maker in the health system was going to contemplate them. In other words, effective tools for policy implementation and monitoring true cultural and institutional change have yet to be found in the contemporary Australian context.

The Australian political and public sector culture in recent decades can be characterised as one of throwing money at the noisy issues of the day. For those seriously committed to long-term change, efforts should not be solely oriented towards getting a policy document accepted or a bundle of dollars appropriated. Prior analyses using such frameworks as 'policy implementation failure' and 'web of institutionalisation' may prove to be invaluable. Implementation failure may be related to problems of professional resistance, inadequate resources, shallow political support, or altered policy priorities. By anticipating potential problems, contingencies can be better developed. By understanding the factors that underpin what it takes to institutionalise change, a co-ordinated and longer-term agenda can be developed that crosses government and civil society. In putting all the women's health eggs into the government funding and policy basket, there seems to be over-reliance on a relatively small quantum of short-term funding as the tool for change. At the same time, the internal advocates (i.e. the women's health units) could never quite penetrate the underlying culture of bureaucracy and political decision-making.

Policy prescriptions for gender mainstreaming

In pointing to the problems of institutional culture, Schofield is right to suggest that principles of democratic governance and equity lie at the centre of policy prescriptions for change. These have been the conclusions reached in other areas of health advocacy—for example, in ethnic health. These concepts, however, are not easy to operationalise and their operationalisation rests in part on the underlying analysis of institutional culture, and an understanding of

the labour processes in producing health care. There is also a more fundamentally problematic assumption about the relationship between policy and institutional change.

Schofield suggests that the cultural problem in health service organisations is one of male dominance. Therefore, the solution lies in some form of affirmative action to bring women into decision-making positions. An alternative construction of culture within health services is that it is ruled by professional hegemony, rather than male hegemony. Professional education in health, including training in clinical settings, is a powerful socialisation experience. The consumer critique of health care culture applies to both male and female health care providers, and to institutions led by managers of either sex. Perhaps the issue needs to be framed more around equity and diversity, rather than gender.

The Medicare Agreement, now known as the Australian Health Care Agreement (AHCA), while the most important tool for financial transfer between the Commonwealth and the states for the health system, has hardly been a tool used to effect change in mainstream health services delivery. In the 2003 negotiation process, for example, emphasis was placed on the states' obligation to guarantee their financial contribution, while matters of health reform were not the mainstay of discussion. Although there were nine taskforces addressing various problems in the health system in the lead-up to the final negotiations, participation was largely from clinicians. Gender was not a dimension considered by these taskforces, nor was it considered by the Australian Health Care Summit, which was held by a broad coalition of clinical and consumer interest groups to lobby for greater consideration of health system reform within the Agreement. If previous Commonwealth-state agreements specific to women's health funding and/or to broadbanded public health programs have yet to deliver change in the mainstream, it is hard to see how AHCA could be an effective instrument.

Schofield rightly points to the need for senior decision-makers, such as members of AHMAC, to become more educated about gender mainstreaming and the necessity for political will. However, a typical AHMAC agenda is comprised of 30 - 40 agenda items and a special forum on gender mainstreaming is not likely to be seen as a priority item, unless so dictated by the political masters. In recent years, AHMAC has held a special forum on Aboriginal health. Gender mainstreaming would have to compete against many other issues on the agenda.

Earlier World Health Organization frameworks, such as Declaration of Alma-Ata, have been given strong support within Australia. But now, it is doubtful whether any conceptual tools developed by the WHO will be seen as relevant for Australia. International agencies—be it the WHO, the World Bank, or other United Nations entities—have been working on a range of analytical frameworks and policy tools to enhance gender analysis and gender sensitivity, particularly for low and middle-income countries. For the moment, Australia seems to have adopted a sceptical position towards the UN system in general, though work within the OECD realm seem to hold more credence.

Schofield supports the continuation or adaptation of a number of current arrangements, such as gender-specific policy-making and women's policy machinery. These mechanisms are probably as effective as they are allowed to be, or as effective as their leaders can make them in negotiating the complexities of policy making. They do not exist outside a larger political context, including the strength of advocacy outside of government. Given her earlier propositions about democratic governance and equity, perhaps further consideration is required about how the women's agenda links more precisely with the new gender and health scenario, as well as with the equity and diversity agenda. Some thought should also be given to the headline items for health reform, and how to 'engender' those developments.

Schofield proposes funding for collaborative service provision between specialist medical services and women's health services. In theory, resources are presently available for new service models to be offered. The barriers to these services becoming reality may relate more to the attitudes and habits of providers, and to any inherent financial incentives in the current system. The challenge, from a system change perspective, is to work on institutional change, rather than defining new funding streams which may not be sustainable.

In a sense, the principles of the dual strategy remain correct. However, the implementation may have been flawed through insufficient resources, insufficient analysis of potential for implementation failure, and insufficient understanding of how to effect institutional change. An old community development principle should suggest that consciousness-raising and change has to start with where people are. That means there is a much greater need to understand institutional culture, at both the policy-making level and in health care delivery institutions. It means simultaneously engaging with technocratic agendas as well as re-framing priority issues; mobilising community and professional efforts to work with multiple institutions; and understanding what current priorities are for decision-makers at all levels and helping to 'engender' the solutions to those problems. An examination of the past 15 years suggests that there is danger in over-reliance on the government for solutions. The development and maintenance of an effective advocacy agenda and approach from outside government is critical.

Some notes on terminology: A postscript

There are some minor points of terminology that should be pointed out.

Schofield uses 'public health policy' to mean public support for health. She uses the term interchangeably with 'health policy'. In Australia, a reference point for defining 'public health' is from the

National Public Health Partnership in Victoria (at <http://hna.ffh.vic.gov.au/nphp/>) and is related to societal efforts to protect and promote health and prevent illness and injury. It does not encompass the funding of public sector health care institutions, and goes beyond both funding and health sector.

Schofield suggests that 'population health' coincides with industrialised capitalism and that the discourse has strongly influenced public policy in men's health. It should be noted that the term 'population health' arose from Canadian health economists who felt that the traditional notions of 'public health', (which did have its origins at the same time as industrialised capitalism), failed to address the question of whether the health care system produced improved health outcomes at the population level, as opposed to the individual level. 'Population health' came into the Australian discourse in the mid-1990s when the conservative government viewed 'public health' as something akin to the Labor Party, and public health advocates began to use the Canadian terminology.

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2. Professor R W Connell

Faculty of Education and Social Work
University of Sydney

The Institute's consideration of this topic is timely. The problem of formulating gender policies in health—and gender policies in other areas, such as education, workplace relations, peacekeeping and violence prevention—is attracting growing attention around the world. A 'gender perspective' is now a familiar term in public policy discussions.

Since the Beijing World Conference on Women in 1995, 'mainstreaming' has become a widely endorsed strategy for overcoming the limitations of previous policy frameworks. But it is often far from clear what a 'gender perspective' really means; what the principle of 'mainstreaming' signifies for practice; and what the consequences of mainstreaming might be for the original goals of gender equity policies.

Dr Schofield does us a great service by placing these questions on an intellectual and conceptual plane. She first asks how gender has been represented in Australian health policy. She shows that the original idea of 'women's health' was by no means a simple descriptive term. The concept not only gave a name to a set of problems **about health services** as well as about women; it also addressed the relationships between women in need of health care and the various providers of health care. This made the empowerment of women (to use more recent terminology) a core issue for the women's health movement in setting health policy and controlling health services.

Dr Schofield then examines the most relevant theories of gender, to establish the sense in which we can speak of 'women' as a group or collectivity with definable interests in the health care arena. Of all the sections of her paper, this will be perhaps the least familiar—in its language and ideas—to most participants in health policy discussions. I commend it to your attention.

Regrettably, most policy discussions of gender—in all fields, not just health—have hardly progressed in their conceptualisation beyond the model of ‘sex roles’ as formulated about thirty years ago. The idea of ‘sex roles’ is certainly an improvement on nineteenth-century doctrines of fixed natural difference. Nevertheless, there are well-recognised weaknesses in the ‘sex role’ framework that gravely hamper policy development. We need to bring our conceptual thinking into the twenty-first century.

Within gender studies, there has been an active development of theory in the last generation (Connell 2002, Alsop et al. 2002). This work includes the development of multi-dimensional structural models of gender; a whole new literature inspired by post-structuralism; treatments of cultural diversity and globalisation in relation to gender; a very interesting literature on embodiment; a conceptual debate about the gender of men and the nature of masculinity—and in each case, another literature applying the conceptual models to practical issues in realms like health, employment and education.

In explaining the formation of gendered interests, Dr Schofield makes very effective use of the example of pregnant women and pregnancy services. At the time of writing (February 2004), this example has become even more relevant as the New South Wales parliamentary opposition has used the ‘birth centre’ dispute to make a bitter personal attack on the NSW government. Strikingly, they did so, not by taking up the cause of women who want non-medicalised births, but by adopting the point of view of male specialists. They then blamed the government, (unbelievably), for specific deaths, i.e. for failing to have a perfect outcome. Since **no** health policy has a perfect outcome, this is not a credible argument for any purpose except producing headlines. However, it illustrates how difficult it is now to break with the dominant medical point of view.

Of course, the same conceptual analysis can be applied to other cases. A notable one is the gender dimension of occupational health. For instance, repetitive strain injury (RSI) from keyboard work became a much-disputed health issue in the 1980s, at a time when electronic

word-processing was coming in on a large scale. It was a women's health question, not because keyboards are involved in fertility, but because the experience and consequences of pain and disablement were implicated in the gender division of labour and the position of women in the society as a whole (Meekosha and Jakubowicz 1986). There was a strong cultural association between femininity and keyboard work, so that the categories 'woman' and 'secretary' overlapped and blurred. Attempts to get recognition for an occupational health issue therefore ran up against cultural interpretations of femininity and the ways men habitually exerted authority over women. Many employers, some doctors at least, and the compensation system, all discounted RSI as a dubious complaint of hysterical women—even as a gendered form of malingering.

In her third section, Dr Schofield looks at the way gender is conceptualised in the recent attempts to produce a 'men's health policy' in Australia. Here she has a depressing message for us. She shows that, far from adding to the sophistication of gender policy analysis (as they might have done), the 'men's health' policy formulations represent a **regression** to cruder and less helpful understandings of gender and health.

In effect, statistical margins of difference (e.g. in rates of injury, health service usage, etc.) become the definition of 'gender'. In this way of talking about health policy, the categories 'men' and 'women', rather than being understood as historically-constituted groupings in practical and changing relationships with each other, become ahistorical categories linked only by an abstract (i.e. statistical) relationship. In consequence, as Dr Schofield puts it, women as the **subject** of health policy then vanished from the health policy discourse.

I would add two points to the analysis here. First, this way of talking about gender and health is partly due to 'backlash' politics. Dr Schofield, generously, talks as if the debate were entirely rational and altruistic. In fact, the debate is shaped by masculinity politics. There are diverse patterns of gender politics among men, comprehensively mapped, for the USA, by Messner 1997. (For an excellent Australian

study see McMahon 1999). Among the various agenda in masculinity politics are backlash movements which are hostile to feminism and anxious to deny the facts of gender hierarchy. In practical terms they are concerned to defend what they understand as 'men's interests'.

In the version of this politics that emerged in the health arena, certain groups of men found it possible to discredit women's health provision by arguing that **men were statistically worse off than women** on a variety of health indicators. (Those that became celebrated in the media were youth suicide rates and average age of death). When the statistics are examined carefully, the position is much more complex (see Connell et al. 1999). Nevertheless, a media image was created of the health money going to women, and the health problems staying with men.

Gender-and-health discussions were thus plunged into what Cox (1995), in the context of education policy, has accurately called the 'competing victims' discourse. This is death to clear policy thinking, in health as in education, but it still goes on.

Second, the model of gender as statistical difference between men and women (i.e. as abstract aggregates) has been acceptable in policy circles partly because it fits with important trends in public sector management. The 'new public management' has a strong affinity with models of the world that allow it to define quantitative goals and to link expenditure with quantitative indices of effects, in order to measure program effectiveness. Managerial professionalism is emphasised. (For an introduction to the debates about the new public management, see Riccucci 2001).

This approach to management is, to say the least, difficult to combine with the messy participatory politics of the women's health movement (or any other democratic movement), or with the varying or even conflicting definitions of women's health needs that come up 'from below' in that movement.

At a deeper level, the idea of gender as statistical difference fits with the rise of the neo-liberal 'market' agenda in the public realm as a whole. In this world-view, which now has a powerful influence across Australia and the rest of the world, the idea of an interactive citizenry collectively making public decisions is replaced by the idea of a population of consumers making individual market choices. As we all know, public sector agencies, from universities to hospitals, are increasingly forced to act as enterprises in a market responding to consumer choices.

In this conception of the world, 'gender' is effectively **a form of market segmentation**, a pattern of difference among consumers that affects their preference schedules. (Men have a low preference for hysterectomies; women have a low preference for hair implants, etc). It is only when there is a clear cut difference in patterns of consumer demand that neo-liberal policy is likely to recognise the existence of a gender issue.

In this framework it makes perfect sense that the funding of initiatives in andrology, (i.e. treatment of the dysfunctions of the male reproductive system) might appear as the centrepiece of a national men's health agenda, since they are services for which women have a very small demand. The fact that men—in the persons of policymakers, specialist doctors, corporate managers and lobbyists—dominate decision-making in the health system as a whole, does not appear in the neo-liberal framework as a gender policy issue at all.

In the final two sections of the paper, Dr Schofield goes offshore and explores the consequences of the inadequate or ambiguous models of gender in current international gender and health policy frameworks and 'mainstreaming' processes. It is interesting, though also depressing, to see how 'gender-based analysis' has evolved from its roots in a social movement to become principally an accounting tool, useful in a managerial approach to health. Perhaps some of this is inevitable in the 'long march through the institutions' that all reform movements at some stage of their history must make.

It is also important, as Dr Schofield reminds us, to remember that other possibilities are open. She mentions examples from Canada and from Australia, where reform processes have taken a different shape, with much more focus on women's agency.

It is not beyond our capacity to imagine and to produce an approach to gender and health that combines the activist concern with women's agency, a conceptually sophisticated understanding of gender relations, and a comprehensive view of public health issues. That is the possibility opened up by Dr Schofield's work, and it is surely the direction that policy discussions in this field will most fruitfully go.

Where does this leave us with the idea of 'men's health' policy? Though Dr Schofield does not develop the argument in this direction, I believe her analysis has strong implications for our view of men's health as a policy field.

First, it is not a simple analogue of, or opposite to, 'women's health', as the margins-of-difference approach would imply. The respective positions of men and women in a society that is marked by systematic gender inequalities are not symmetrical. 'Men' do not need empowerment in relation to the institutionalised health services of modern society. It is men who dominate both public sector decision-making and the corporate health and drug sectors; who draw the greatest economic benefits from these industries; and who hold predominant cultural (for example, scientific) authority, as classically shown in the birth centres dispute.

But not all men. This is the second direction in which Dr Schofield's analysis is very useful for issues about men's health. Her approach provides a model for thinking about the relationship between health services and disempowered groups of men.

Although it is one of the major findings of modern research on gender issues among men and boys that patterns of gender practice and identity are diverse, they are diverse in structured and intelligible ways. As well as diversity arising from the cross-cutting of gender relations,

social class and ethnicity, there are differences and tensions between hegemonic and subordinated masculinities. Issues about men's bodies, including health issues, are caught up in this web of relationships which result in very different levels of empowerment, and different health statuses, among different groups of men and boys (for a guide to this literature see Connell 2000).

For disempowered groups of men and boys we can ask similar questions to those Dr Schofield asks for women. What relationship do disempowered men have to the men who hold authority in the health system; how are they represented in health policy discourse; how are their interests articulated; in what ways (if at all) do they come to act as a collective; and how might their capacity to participate in shaping their own health services be enhanced? In short, how can disempowered men become subjects of men's health policy, not just 'targets'?

The answers to these questions will be different from the answers given for women and girls, but the issues are connected. Therefore, we must also ask; what is the relationship of such processes among men and boys to the empowerment of women and girls, and how can we make sure relevant reforms on both fronts support rather than interfere with each other?

The conclusion that Dr Schofield spells out, that *'gender and health'...is a problem associated with democratic governance and its relationship to health policy making and the distribution of public resources* seems to me an important and true principle. It gives guidance for our thinking about the specific problems concerning men and boys as well as for our thinking about women. I welcome her analysis for the light it casts on the whole policy domain.

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3. Helen L'Orange, AM

Former Consultant to the Women's Health Program, WHO

My aim in this review is to comment on Toni Schofield's findings from the perspective of influencing both mainstream and gender specific health services through the Australian Health Ministers Conference and related fora. I also comment briefly on the implications of the paper for UN/WHO policy and tools development.

Context

As the health system falters and in some spheres fails, effective research transfer from universities to policy advisers and decision makers is becoming increasingly important. It is also important for the reputation and relevance of universities. Dr. Schofield's paper is a valuable resource for the equitable development of Australian and international health services.

Summary of key points from Dr Schofield's paper

1. When established, the *National Women's Health Policy* (1989) adopted a social rather than medical approach to women's health. Women's health services have involved collaborations between mainstream stakeholders and community-based constituencies of women. Such collaborations are characterised by a process that is inclusive, deliberative and consensual.
2. Women's health policy is now located within broader public discussions about gender and health. Gender is a principle for social organisation in which the reproductive distinction is deployed and enacted to determine who gets to do what and how, and with what kinds of symbolic and material consequences.
3. Social disadvantage produces the margins of difference between men's and women's health patterns. However, men on the whole are not worse off than women.

4. Organisational structures tend to marginalise women's interests in relation to men's. Women are excluded from participating, (especially at the most senior levels), in decision-making processes that determine the kinds of services they need. While women do exercise agency in relation to male-dominated health services, they do so with significant constraints. Challenges to medical power are therefore limited.
5. Within public health institutions, it is masculinist and technocratic hegemony in decision-making and service delivery organisations that lies at the heart of the problem of 'gender and health'. This is because such hegemony marginalises and excludes women in participating alongside, and exercising leadership with men in the decision-making that determines the health needs to be addressed by public health resources, the kinds of resources to be provided in addressing them and the organisation of their delivery. 'The problem', then, involves the organisational foundations of public health institutions.
6. **Mainstreaming gender in health policy is crucial to improving women's health** (emphasis added).
7. Gender mainstreaming was formulated within an overtly feminist context to advance women's 'strategic interests'. Its anticipated 'outcomes' in relation to health were basically twofold: one, to integrate gender concerns into mainstream health policies; and two, to establish or strengthen institutional mechanisms to support women's participation at the levels of decision-making and delivery. The published research to date on moving these outcomes forward is virtually non-existent.
8. Gender and health is a problem associated with democratic governance and its relationship to health policy making and the distribution of public resources. The problem of 'gender and health' is essentially one of gender inequality in the mainstream health care arena. Resolving it requires a repertoire of public interventions to advance gender equality. This objective means that such interventions need

to be shaped by equity imperatives since equity involves the provision of public resources to assist those who are disadvantaged to participate alongside their more privileged counterparts in social life. Its main objectives are to:

- integrate gender concerns into mainstream health policies where they address the disadvantages that women face as a result of the ways in which the bodily reproductive distinction is played out in their everyday lives, (in general, and in particular in health services); and
 - to implement organisational changes in public health institutions to enhance women's leadership and increase women's participation alongside men in both policy-making and in the management and delivery of services.
9. Accordingly, the major, anticipated 'outcomes' of such an approach are:
- the promotion of gender equality objectives in mainstream health policy making, and
 - the establishment of social relations and processes within public health organizations that are inclusive of both men and women, and that enhance their democratic participation.
10. In 2002 Health Canada implemented gender-based analysis (GBA) to ensure that its *day-to-day operations [were] sensitive to women's health needs and concerns*. It made clear that the overall goal of the 'GBA implementation' was *making the health system more responsive to women and women's health. The relationship between a GBA approach and the advancement of women's health was indivisible*.

POLICY IMPLICATIONS

1. Urgent need to accelerate cultural change to democratise mainstream health

My suggestion is that a proposal be put to the Australian Health Ministers Conference (AHMC) that the Australian Health Minister's Advisory Council (AHMAC) lead a national, broadly based consultation process to achieve this urgently needed cultural change.

The rationale for this proposal could be based on Dr Schofield's paper but expanded to encompass a broad equity approach. The benefits of change could be highlighted to AHMC and AHMAC by illustrating the point with policy issues which are high on their agenda, for example, scenarios around the cessation of practice by obstetricians. A democratised scenario could show a future where obstetricians stay in practice, mother have healthy safe births and 'the women cease to sue the gods'. Below is an example of the kind of suggestions clinicians can come up with unaided. Imagine what a truly equitable consultative process could achieve. MacLennan and Spencer write:

Initiatives that could be considered to redress the declining numbers of obstetric practitioners

- A 'no-fault' compensation system for neurologically disabled children.
- A scheme of structured awards rather than a single lump-sum payment.
- The selection of expert witnesses by the court rather than the plaintiff or the defendant.
- Payment of indemnity premiums to practise private obstetrics in hospitals or in regions where this is required or desirable.
- Improvement in working conditions for obstetricians, with reasonable rostered hours achieved through group private practice or increased hospital staff appointments.
- Encouragement of team obstetric and midwifery practice.

- Greater public education and realistic expectations of the rates of perinatal and maternal mortality and morbidity, including birth defects.
- Better access to dispute resolution processes before civil litigation.
- The training of specialists specifically to practise only obstetrics or only gynaecology.
- Lowering of the statutory time limit in which litigation can occur after birth. (MacLennan & Spencer 2002)

The suggested consultation process could use a discussion paper proposing broad principles and a set of strategies for comment by a wide range of stakeholders. The strategies could include the use of gender-based analysis (GBA), as is encouraged by the UN and which is in use in Canada. As Dr Schofield's paper suggests, GBA needs to be based on specific gender equality objectives.

A case study from Canada on applying GBA to mental health system performance measurement illustrates how much is missed without GBA. The Canadian material also points out that by including sex, gender, diagnoses and diversity (e.g. race, age, ethnicity, gender identity, ability) as variables, more data are gathered that may help identify how the system is functioning differently (or the same) for diverse groups of men and women. For more information on this please go to Case Study 2 (last updated 4/7/2003).

<http://www.hc-sc.gc.ca/english/women/exploringconcepts.htm>

Another major issue which could be tackled in this context is fostering more realistic expectations of the health system by encouraging citizens to recognise their own agency in their health. It is vital that citizens actively participate in the maintenance of their health and the development of health services they need. Similarly, it is vital that the deliverers of the health system keep their focus on the needs of their customers.

2. The Women's Health Program can contribute to cultural change

The Women's Health Program (WHP) should, after so many years of operation, provide a strong evidence base to support the need to democratise mainstream health. The wider choice provided by the women-specific services appears to have improved women's health services as a whole. Many of us have anecdotal evidence of how women's health services have influenced mainstream services. Contrast Australia with Japan where women specific health centres have only just started. In the mainstream system in Japan women are expected to cover their heads and torsos whilst being examined internally. Here in Australia, some women discuss the ultrasound picture with their gynaecologist whilst she or he proceeds with the examination.

Strategies should be devised to increase the contribution of the Women's Health Program to cultural change in the mainstream. Dr Schofield's suggestion of joint projects is a good one and should be pursued. In addition, an effectiveness evaluation of both WHP services and the mainstream health services women use, would provide an objective comparative analysis in terms of both costs and health outcomes. This could have great benefit in showing the extent to which women's health services are a model for more co-ordinated, responsive and accountable health care systems. Strategies should encourage collaboration and information exchange between mainstream health service organisations and women's health services.

3. Contributing to UN/WHO policy and tools development

Interesting things are happening internationally with regard to the project of mainstreaming gender and other developments in equity. Australia can learn from these initiatives, and conversely, what happens in Australia will be of interest to the international community.

Dr Schofield makes valid points about the danger of gender based analysis tools and indicators being used in limited narrow ways. As she argues, *From such a perspective, gender-based analysis is a kind of actuarial tool for devising balance sheets of health 'risk factors' associated with belonging to either the category male or female. The subject—women and their health—is, in effect, erased.*

It is interesting to note that UN Millenium Development Goals (MDGs) did not include gender sensitive indicators for most of the goals. Only the sex-specific goals like maternal mortality had such indicators. In the past year, groups in the World Bank UN Development Program and the WHO have advocated for gender sensitisation of the MDGs. The WHO is putting a big effort into the use of gender-based analysis to gender sensitise their mainstream health indicators.

In 2002-2003, the WHO Kobe Centre (WKC) commissioned the La Trobe Consortium headed by Professor Lin to evaluate UN system indicators. The aim of this work is to influence and modify the mainstream health indicators system by integrating gender perspectives into a core set of leading health indicators, in order to improve women's health and quality of life. A Health Information Framework (HIF) is being used for this work. The HIF was developed originally by the OECD and the International Standards Organisation (ISO), and adapted by the La Trobe Consortium and further evolved by an Expert Group Meeting at the WKC in late 2003. The HIF has 3 tiers:

- Tier 1 – Health Status (overall health of a population).
- Tier 2 – Determinants of Health (inclusive of individual/household/community level proximate factors as well as national contextual aspects).
- Tier 3 – Health System Performance (design and delivery of health services and how well the system is performing in relation to major goals).

The HIF developed by the La Trobe Consortium is even more comprehensive and has equity fully integrated into the framework. More information on this work and HIF is available at http://www.who.or.jp/women/publications/tf1_report.pdf and http://www.who.or.jp/women/research/Kobe_EGM_recommendation.html

If Australia does proceed with accelerating cultural change to democratise mainstream health, then there would be interest from the UN system and other member states, especially developed countries.

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