Women's Community Health Network WA

WOMEN'S COMMUNITY HEALTH NETWORK WA

2018-19 Pre-Budget Submission

Sustainable Health Outcomes: Gender Matters

JANUARY 2018

About the Women's Community Health Network WA

GENDER BASED INEQUITIES GIVE RISE TO POOR HEALTH OUTCOMES FOR WOMEN

The Women's Community Health Network WA (WCHN) represents women's health and community services across Western Australia. We act to improve women's health, safety and wellbeing through leadership, advocacy, research, knowledge translation and collaboration.

Together with health, community and government organisations, and with (particularly disadvantaged) women across Western Australia, WCHN is a strong sector voice, leader and partner for women's health, safety and wellbeing. WCHN's evidence-based practice is directly informed by women's experiences, research and data.

Community based women's health services work across sexual and reproductive health; mental health; family, domestic and sexual violence; alcohol and other drug use; health promotion and prevention; and employment and education. Services work to address the cultural, social and economic factors that affect the health, safety and wellbeing of women and their children.

Key Facts

GENDER IS A POWERFUL SOCIAL DETERMINANT OF HEALTH AND WELLBEING, ECONOMIC AND HOUSING SECURITY, AND LIFE CHOICES AND CHANCES

Gender inequity has differential impacts on women, depending on the intersection of factors such as race, ethnicity, immigration and visa status, disability, rurality, socioeconomic circumstances, age and sexual identity. For example, women from low socioeconomic, Aboriginal and culturally and linguistically diverse backgrounds, those with disability and long-term health conditions, and those living in regional and rural Australia, may experience multiple and intersecting forms of discrimination, disadvantage and barriers to accessing health and support services.

Beyond Blue[i] notes that women experience anxiety, depression and post-traumatic stress disorder at higher rates than men. Women's susceptibility to mental illness is exacerbated by a range of factors, including pregnancy (up to 10 per cent of all pregnant women will experience depression or anxiety); early parenthood (1 in 7 women are likely to experience some form of postpartum depression); intimate partner or family violence and/or sexual assault; the burden of care and emotional labour that is left to women; and hormonal fluctuations (such as menopause). It is not unreasonable to suggest that the gender inequality that informs the society we live in is also responsible for provoking mental unrest in women, particularly in light of how it also teaches women to question their own interpretation of events and stay silent on issues like sexual harassment, assault and discrimination. Women are three times more likely than men to attempt to end their lives by suicide.

Improving health outcomes for all women requires a focus on women with least access to health resources and who are most at risk for poor health.

Community based women's health, sexual assault and unplanned pregnancy services receive less than 1% of health funding.

Women suffer a higher burden of chronic disease	• Women live more years with disability [ii] • Women have a higher burden of chronic disease • Cardiovascular disease - including heart attack, stroke and other heart diseases - is the leading cause of death in women [iii]
Domestic, family and sexual	• The inpatient costs to WA Health alone for FDV is close to $52 million every 7 years [iv]

violence has high personal and economic costs to health and other systems	• 2016 'victims of crime' figures, showing WA with 5 years of continuous increase in the number of sexual assault victims [v] • Violence remains the leading contributor to death, disability and illness for women.[vi] • 12% rise in family and domestic violence related assault in 2016 in Western Australia) • Aboriginal women hospitalised for FDV 27 times more than non-Aboriginal women. [vii]
A gendered approach is needed to improve women's mental health	• Mental health issues are the leading cause of disability and highest burden of non-fatal disease for Australian women. [viii] • 30% of women aged 16–24 report mental illness – the highest rate for any population group. [ix] • Women experience higher rates of depression, anxiety, eating disorders and self-harm than men.[x] • **Women are almost twice as likely as men to report post-traumatic stress disorder**.[xi]
Caring responsibilities affect women's life chances and health outcomes	• **Women head 83% of single parent families** [xii] • **More likely to be primary carers of children** [xiii] • **Do a larger share of unpaid domestic work** [xiv] • **Women are 2 of 3 primary carers of seniors; their median income is 42% lower than non-carers** [xv]
Women are poorer than men – this worsens their health and mental health	• **Women are poorer – earning 28% less income than men overall** [xvi], **and more likely to be in low paid, part-time and insecure work** [xvii] • **Women's superannuation is 56% of men's at retirement** [xviii] • **Many health issues and diseases experienced by women are closely tied to disadvantage, with research showing that women from low socioeconomic background have a much higher exposure to risk factors for poor health.** [xix]

Strategic and Sustainable Health Policy: Gender Matters

GENDERED DIFFERENCES IN POPULATION HEALTH STATUS MEANS THERE REMAINS SIGNIFICANT SCOPE IN 2018 TO IMPROVE THE HEALTH OF WESTERN AUSTRALIAN WOMEN

The growing costs to Western Australia's health system are an urgent problem. A doubling of health spending, a 49% increase in emergency department presentations and a 39% increase in hospital admissions [xx] paint a clear picture of a system under increasing pressure.

The WCHN welcomes the government's Sustainable Health Review (SHR) and its focus on prevention, early intervention, community based care and patient centred approaches. A key theme emerging from the SHR's consultation workshops is the need for a stronger focus on the social determinants of mental health. The need for increased focus on prevention and upstream interventions through addressing the structural, systemic and social issues that fail to promote positive and sustainable health and wellbeing outcomes for women is widely supported. [xxi]

Community based women's health services have expertise in delivering health services which tackle the key themes arising from the SHR – increased delivery of community based services, earlier identification of health problems, improved partnerships within health and related sectors, and engagement with health services by disadvantaged populations.

RESEARCH HAS SHOWN THAT IMPROVEMENTS TO WOMEN'S UNIQUE HEALTH STATUS ADD SIGNIFICANT BENEFIT TO THE WIDER SOCIAL, POLITICAL AND ECONOMIC OUTCOMES FOR BOTH MEN AND WOMEN[xxii]

A recent systematic review identified the strong economic benefits of investing in women's health:

- healthier women contribute to better-educated and more productive societies;
- ensuring women's control over their own fertility can boost the pace of economic growth and development; and
- maternal health is crucial to the health and economic wellbeing of subsequent generations through intergenerational spill overs. [xxiii]

The most robust evidence of cost savings is in relation to the impact of violence against women. In addition to the serious physical health, mental health and social impacts on the individual, violence against women gives rise to enormous preventable 'downstream' costs to the policing and justice systems, housing and homelessness services, health system and child protection services.[xxiv]

A recent study commissioned by Our Watch and VicHealth, and conducted by PriceWaterhouseCoopers, estimated that violence against women costs $21.7 billion a year, including $7.8 billion a year in direct costs to governments.[xxv] Other research found that for every woman whose experience of violence is prevented, $1,154 in health costs can be avoided. [xxvi]

ACHIEVING GENDER EQUITY REQUIRES REMOVING UNFAIR, UNJUST AND AVOIDABLE DISPARITIES IN HEALTH[xxvii]

There is strong consensus that women's health is a priority. The Australian Medical Association's (AMA) position paper on Women's Health states that:

> "Considering health through a gender lens recognises the ways in which gender roles, resources and perceptions can impact on women's and men's health. Integrating gender considerations into policy planning and delivery can therefore help to pinpoint areas of need, allocate resources and tailor interventions, and identify barriers or enablers to achieving better health outcomes". [xxviii]

The AMA further argues that many determinants of gender inequities in health can be influenced by health promotion and risk reduction strategies, such as interventions which build the knowledge and skills of women to manage their health; targeted health screening and detection programs; and macro-policy measures that address the economic and social determinants of ill health.[xxix]

The WA State Government has a clear and ongoing commitment to women's health, evident in its current development of *The Western Australian Women's Health Strategy 2018-2023 (draft)* (the Strategy). This sets out the gendered responses needed to reach its purpose of:

- Ensuring substantive equality for women through appropriate service models;
- Identifying priority health risks for women to enable targeted prevention, early identification and effective treatment; and
- Promoting collaboration to support broader action on gender as a social determinant of health. [xxx]

The WCHN supports these objectives of the Strategy. The WCHN further welcomes the appointment of a Minister for Women's Interests and Minister for the Prevention of Family and Domestic Violence by the WA Labor Government. A range of positive policy, legal and funding measures to better prevent and respond to family and domestic violence have been implemented over the past year.

However, despite a commitment to strategic women's health policy and the emerging increased focus on family and domestic violence, Western Australia's long-term investment and planning in women's health and associated intractable social issues, remains seriously inadequate.

Community Based Women's Health Services – Experts in Gender Informed Health Care

Evidence shows that women achieve better health outcomes where strong and well-resourced women's health services exist. It is in the interests of the state government to partner with community based women's health services in the development of strategies and actions to improve the health of Western Australian women. This will, in turn, improve the health of the Western Australian population and reduce the burden of ill health and disease across the state.

Community based women's health services in Western Australia provide significant value for money through community based prevention, early intervention and engagement of women with complex needs. Smart investment in growing this sector would make a substantial contribution to the sustainability of WA's health system.

AN INTERNATIONAL STUDY FOUND THAT WOMEN'S HEALTH CENTRES HAVE THE GREATEST BENEFIT WHEN SUPPORTING WOMEN WITH COMPLEX OR MULTIPLE NEEDS[xxxi]

The AMA acknowledges the important role of community based women's health services in the primary healthcare system: they support women's health needs; provide outreach to socially and economically disadvantaged women; provide a focus for support groups, nursing and other ancillary health services; and provide an accessible entry point to a range of health and social services. The importance of partnering with community health providers is also recognised in the reform of primary health care, with the Western Australia Primary Heath Network commissioning a significant proportion of services from not for profit (NFP) organisations.

More broadly, NFPs are recognised for having unique experience in achieving outcomes in complex health and human services,[xxxii] with governments increasingly seeing that the NFP sector provides efficient, effective and flexible service delivery.[xxxiii] The state government identifies NFPs as having closer engagement with the communities they serve and as an important source of social innovation.[xxxiv]

Community based women's health services have more than 30 years' experience in delivering quality, woman-centred health care and human services to Western Australian women and their families. As a sector, these services have reach into metropolitan and regional areas, are well positioned to implement government responses and prevention initiatives, translate evidence into practice and lead coordinated and consistent strategies across the state.

As regionally located organisations, community based women's health services engage with health and community planning, and lead area-based prevention and community based initiatives in tandem with community, local, state and federal governments, and other organisations.

Community based women's health services straddle the health, human services and development sectors. Their partnerships with local government, community health, community organisations and peak bodies, as well as with the acute sectors in health, family violence, sexual assault, crime, emergency relief and mental health, result in alliances and expertise that enable effective responses and prevention across sector siloes.

Community based women's health service models align with the objectives of *The Western Australian Women's Health Strategy 2018-2023 (draft)*, with its focus on gender informed, accessible and integrated services that respond to women with the highest needs.

Evidence suggests that services should include women-only spaces; address highly gendered factors affecting women's health outcomes; attend to clients' presentations in an integrated way; provide better social and community support; and increase overall responsiveness to the person, not just the illness.[xxxv] Community based women's health services report high attendance and engagement of women experiencing significant disadvantage and those not accessing mainstream health and community services.

Our Asks

The problem: in a context of an existing funding shortfall, no new funding has been identified to deliver additional services in regions of very high need.

Commitments sought

1. ***Maintain the existing funding pool, with additional funding for population growth and CPI, for allocation only to the regions currently serviced***
2. ***Provide new, growth funding of $1.2 m for the Peel and Kimberley Services in the State Budget 2018-19***

The Western Australian Women's Health Strategy 2018-2023 (draft) identifies the need to ensure substantive equality for women's health through appropriate service models.

The Community-based Women's Health Stakeholder Group was established by the Department of Health's Women and Newborn Health Service in early 2017. Key stakeholders were included in the Group, including:

- Women and Newborn Health Service
- Women's Community Health Network WA
- Mental Health Commission
- Family and Domestic Violence Unit (Department of Communities)
- Health Consumers' Council
- Regional SARC representative
- Sexual Health Quarters

The Stakeholder Group was formed to reach agreement on leading health issues for women, areas of need/priority, non-negotiables, and minimum standards of practice and to put forward recommendations regarding the procurement of community based women's health services in Western Australia.

The WCHN strongly supports the Stakeholder Group's identification of women living in regional and remote areas and Aboriginal women as priority groups. The WCHN also supports the Group's determination that new services in the Peel and Kimberley regions, where women cannot currently access community based women's health services, are required. However, several members of the the Stakeholder Group expressed strong concerns regarding the redistribution of the existing funding of $4.34 million for community based women's health services across both existing and new regions when current services are re-tendered (current contracts are due for extension or retendering in December, 2018).

SPREADING THE EXISTING FUNDING POOL ACROSS ADDITIONAL SERVICES WILL IMPACT ON SERVICE QUALITY, ACCESS AND OUTCOMES FOR BOTH EXISTING AND NEW SERVICES

HIGH NEED AND DEMAND COUPLED WITH LOW CORE FUNDING

Community based women's health services operate in a context of high unmet demand and need, and increasingly complex service delivery. All services report significant waiting lists and the need to triage, prioritising services for women with the highest needs.

Very significant challenges in servicing their whole region exist; particularly for rural and remote services that often service a vast region. Most of these services offer some outreach, with some also offering telehealth. However, the current funding amounts preclude equitable access for women in rural and remote areas.

Service demands and pressures are also occurring in a landscape of significant change facing the whole NFP sector. These include the imperative to shift to an outcomes focus, personalised service delivery, changes in procurement, a tightening funding environment and an increasingly casualised workforce. Those NFPs providing much-needed holistic services must meet multiple quality standards. These changes are strongly supported by the WCHN, but we emphasise the additional challenges they pose, particularly for small providers.

COMMUNITY BASED WOMEN'S HEALTH SERVICES RECEIVE LESS THAN 1% OF WA HEALTH FUNDING

Existing community based women's health services receive very limited funding for the services they provide. The metropolitan and regional services, except for the Perth City service, receive core DOH funding of between $120,000 to $460,000 per annum. Nine services receive between $260,000 to $330,000 core funding per annum. Most services also seek funding from multiple sources to provide a more holistic integrated service, which delivers significant additional benefits to women and value for money. However, non-core funding is vulnerable to the changing priorities of funders, including state and federal governments; as a result, these additional services that support core funding are not consistently available.

For most community based women's health services, the funding received from the Department of Health is their main funding: core funding of $120,000 - $460,000 per annum is entirely inadequate to the task of meeting the health and support needs of, particularly disadvantaged, women.

Whilst CPI has been applied to these contracts for the past two years, there appears to be no intention to increase the total funding available to account for unmet need and historical or future population growth.

NEW SERVICES REQUIRED IN HIGH-NEEDS RURAL AND REMOTE REGIONS

In addition to the challenges for existing services, the Community-based Women's Health Stakeholder Group has DOH has identified both service gaps and very high needs in the Peel and Kimberley regions, with high numbers of women experiencing a range of complex and interrelated health and social problems. [xxxvi]

Many women in rural and remote areas face multiple disadvantages that impact on their health and wellbeing. Compared to their urban counterparts, they experience poorer health, lower life expectancy and greater difficulties accessing a range of health services.[xxxvii] [xxxviii] Levels of alcohol consumption, and rates of obesity, chronic disease, family and domestic violence and fetal alcohol syndrome are higher. [xxxix, xl] Women in these communities' report fewer visits to GPs and specialists, and are more likely to be admitted to hospital for conditions which could potentially have been prevented through the provision of non-hospital health services and care.[xli]

Women living in some rural and remote communities have limited access to services that are gender and trauma informed. As a result, some women living in such communities may not always seek health advice and treatment in sensitive areas such as the prevention of cervical and breast cancer, fertility control, menopause, sexual health and family and domestic violence.[xlii]

The WCHN strongly supports the Stakeholder Group's recommendation to address the gap in community based women's services through the funding of new women's health services in the Peel and Kimberley regions. However, it would be deeply concerning if the Department of Health decided to fund new Kimberley and Peel services without an increase in the total funding envelope, through reducing the funds provided to existing community based women's health services. This will naturally result in significant cuts to existing services, already running with very low core funding. The Kimberley service will cost 20-30% more than a metropolitan based one, meaning that the impact of shifting funding around between centres is disproportional. This will compound the high rates of unmet demand and need at existing services, resulting in reduced access to women with high support needs within currently serviced regions. The small amount of funding available for each service under forthcoming tender arrangements will create significant challenges for effective service delivery in both new and existing areas.

The remote nature of the Kimberley, with its high proportion of Aboriginal women and high rates of very complex health and social problems, means that town-based, outreach and e-health services will be required across vast distances. This has significant implications for venue, transport, travel assistance, staffing and other on-costs. The Kimberley service therefore warrants a higher funding rate than received by the majority of community based women's health services, if the service is to meaningfully support improved health outcomes for women in this region.

Very high needs in the Peel region have been identified, where there is currently no community based women's health service. Identified needs include high rates of mental health issues, suicides amongst young people, and very high rates of family and domestic violence in the South

Metropolitan area including Peel. WAPHA found that Peel has higher rates of risk factors for poorer health outcomes and potentially preventable hospitalisations than other localities in the Perth South Primary Health Network region. These include a higher proportion of single parent families than the state average, and very high levels of problematic alcohol consumption.

The high needs and relative lack of services compared to other metropolitan areas, combined with the intent of the Strategy to prioritise need, warrants additional funding to the insufficient amount currently being provided to existing services.

Although core funding for existing services is inadequate, the WCHN realises in the current economic climate a funding increase for existing services is unlikely to be supported. We instead request adequate funding for new services; rather than the redistribution of existing funds. As was noted earlier, this would spread resources too thinly such that their impact is likely to be ineffectual.

BUDGET ALLOCATIONS SOUGHT:

1. **Maintain the existing funding pool, with additional funding for population growth and CPI, for allocation only to the regions currently serviced**
2. **Provide new, growth funding of $1.2 million for the Peel and Kimberley Services in the State Budget 2018-19**

The problem: the DOH currently does not contribute any funding to ensure the sustainability of the Women's Community Health Network WA

Commitments sought

3. Commit to the provision of the Women's Community Health Network WA by providing a basic level of core funding to enable its autonomy and sustainability as per other comparable Western Australian peak bodies. An allocation of $229 900 is required for the ongoing viability of WCHN

The Role of the Women's Community Health Network WA

Research, policy development, advice to government and relevant sectors

The Women's Community health Network WA makes an important contribution to the development of inclusive and innovative public policy. The close relationships that WCHN holds with organisations engaged in direct service provision places it in a unique position to undertake research in relation to client and industry needs, best practice, and innovative models of service provision. WCHN has the skills, capacity and flexibility to conduct research which provides the knowledge base upon which to develop effective local solutions.

WCHN presents a unique and cost-effective opportunity for government to access robust and innovative advice from a single point of contact, representing the allied interests of its membership group and the interests of particularly disadvantaged women in Western Australia.

WCHN is able to provide policy input in a number of ways, through:

- Participation on government reference groups and meetings
- Formal and informal consultation
- Formal policy submissions (government-commissioned or independent)
- Preliminary research and recommendations to government on policy reform
- Final comment and submissions to government on policy reform
- Formal analysis of, and recommendations regarding existing policies
- Sector research, data collection, collation and presentation

WCHN also enters into partnerships and consultation with key stakeholders, including other peak bodies, industry experts, universities and researchers.

In this way, WCHN also provides a cost effective conduit for government to access research, views and issues of disadvantaged or marginalised women in Western Australia. This contributes to and improves the development of social policy and programs.

Presentation to government and other decision makers

WCHN provides a low cost mechanism for government to access the knowledge and expertise of the sector to improve the quality, efficiency and relevance of their programs and services;

- Acting as a repository of sector knowledge and expertise in relation to the needs and circumstances of specific population groups of women in the community, through specialist knowledge and contributions from members;
- Instigating and promoting public debate which assists in fostering participatory democracy while contributing to sound social policy development;
- Assisting government to be accountable to, particularly disadvantaged, women in the wider community, by providing information and feedback on the impacts of policy and programs on women in the community.

WCHN acts to give a voice to minority and disadvantaged groups of women who often remain unconsulted during the policy development process. Furthermore, the work carried out by WCHN can, in effect, 'get the ball rolling', initiating interest and opening doors for smaller organisations to build broader platforms to create change locally.

Facilitation of information flow within the women's community health sector and to the community

WCHN plays a key role in disseminating information on changes to policy, government programs or the broader environment that will impact on the sector and/or their clients. This is an efficient way for government to communicate with the sector.

WCHN also facilitates the flow of information between its members or from the community to the members via the sharing of research, opinion and practice experience.

WCHN sifts through the many issues faced by its represented sector and flags the most poignant and urgent issues, and then disseminates information to the necessary communities and organisations.

WCHN also plays an important role in providing community education. This may include raising the profile of issues predominantly affecting women in the community. The community support that results enables governments to act more progressively.

Consultation and coordination within the women's community health sector

WCHN has an important role as a sector coordinator and in bringing organisations and people together around common goals and issues.

Sector consultation is a core part of the role of WCHN. Consultation can be either in response to issues that member groups raise or they may be in response to specific government processes or requests. In the latter case, approaching WCHN may be much more efficient for the government than instigating its own inquiries around the sector.

POLICY COMMITMENT AND BUDGET ALLOCATION SOUGHT

3. **Commit to the provision of the Women's Community Health Network WA by providing a basic level of core funding to enable its autonomy and sustainability as per other comparable Western Australian peak bodies. An allocation of $229 900 is required for the ongoing viability of WCHN**

Service design and costings Peel and Kimberley services

This section contains *approximate costings* for the development and delivery of effective services in the Peel and Kimberley regions, and is included to provide a general indication of service outputs, outcomes and costings. The WCHN notes the development of appropriate service models will need to be region-specific and in accordance with the tender process and Delivering Community Services in Partnership Policy.

The remote nature of the Kimberley, with its high proportion of Aboriginal women and high rates of very complex health and social problems, means that both centre-based and outreach services will be required across vast distances. This has significant implications for venue, transport, travel assistance, staffing and other on-costs. The Kimberley service therefore warrants a higher funding rate than received by other services (except Perth City), if the service is to successfully improve women's health outcomes in this region.

KEY ELEMENTS OF SERVICE PROVISION

Community based women's health services offer a combination of medical, general health, counselling, mental health, and family, domestic and sexual violence support, promotion, information and referral, and wellbeing services.

Service outcomes, outputs and activities should align with those recommended by the Community-based Women's Health Stakeholder Group.

Outcomes:

1. Women have improved access to support services / programs
2. Vulnerable women experience improved health and wellbeing and have opportunities to address their health challenges.
3. Women have greater awareness of resources that can be accessed to assist in meeting health challenges, make health choices and have greater awareness of social determinants of women's health.
4. Consumers have input into the development of programs (consumer informed practice).
5. Emerging issues for women in the region are recognized and responded to.
6. Clients / women have increased knowledge, confidence and skills to manage their health.

Funded services:

Stage	***Service***	***Other***
PREVENTION	***Health Promotion***	***Stakeholder engagement***
	Exercise and support groups	***Staff training***

	Clinical appointments	***Child Care***
		Information and referral
EARLY INTERVENTION	***Counselling***	***Information and referral***
	Group work	***Training to health professionals***
	Clinical appointments	
	Case Management / Advocacy	
POST-VENTION	***Advocacy***	***Information and referral***
	Groups	

Key principles:

- Service operates within a trauma informed care and practice framework
- Service delivery incorporates a woman-centred approach to healthcare
- Service operates in a manner underpinned by the social determinants of women's health
- Service operates in a manner underpinned by the Cultural Determinants of Health (as defined in the WA Aboriginal Health and Wellbeing Framework 2015-2030, Department of Health)
- Service demonstrates consumer input in the service development and delivery
- Services must be non-directive in their approach to service delivery
- Service operates in keeping with the Consumer Principles of the WA Health Consumer Charter

Budget

PEEL				
Staffing				
Manager	130,000			
Reception and admin	50000			
Health promotion	80000			
Counsellor	120000			
Support worker (FDV, AOD, MH)	80000			
Creche	20000			
Bookkeeper and accountancy	20000			
GP is Medicare funded	0			
Nurses	115000			
Sub total salaries	615,000			
Superannuation	58425			
Total staffing expenses	**673,425**			
Overheads including:	20%	25%	30%	Based on % of staffing costs. Should we go with 25% as middle ground?

Premises (new services will not be centre based so a contribution to use premises of other orgs)	**134,685**	**168,356**	**202,028**	
HR, reporting, quality etc				
accreditation, licences				
IT				
finance				
bills				
	at 20% overheads	at 25% overheads	at 30% overheads	
Total costs	**808,110**	**841,781**	**875,453**	
KIMBERLEY				
Same staffing		$673,425	$673,425	
Same overheads		$168,356	$202,028	
Remote staffing costs including:		$168,356.25	$202,027.50	
	20% N/A	25%	30%	
Salary on highest increment, to be competitive and attract suitable applicants				
Staff remote area allowance (approx. 15%), and which ideally will include or have an extra allocation for a housing subsidy (eg, $10K)				
Extra leave, though not usually included as a line item				
Recruitment and possible re-location costs ($3K)				
Interstate travel to join WH networks etc ($5K)				
Remote service delivery additional costs				
4WD vehicle		40,000	40,000	
Regional travel		20,000	20,000	
Higher costs: rent, supplies, utilities etc 20%		42,089.06	50,506.88	

TOTAL KIMBERLEY		**$1,112,227**	**$1,187,987**	
WOMEN'S COMMUNITY HEALTH NETWORK WA				
Staffing				
Executive Officer	110,000			
Admin.& communications	80,000			
Overheads	39,900			
TOTAL WCHN			**$229,900**	

References

[i] Beyond Blue https://www.beyondblue.org.au/who-does-it-affect/women

[ii] Australian Bureau of Statistics.(2013) Australian Demographic Statistics, June 2013. Cat. no. 3101.0. Canberra: ABS

[iii] *AIHW. (2010). Women and heart disease: cardiovascular profile of women in Australia. Cardiovascular disease series 33. Cat. no. CVD 49. Canberra: AIHW. www.aihw.gov.au/publication-detail/?id=6442468369 [Viewed 15 July 2013]*

[iv] Women and Newborn Health Service (2017) 'The WA Health Costs of Responding to Family and Domestic Violence'

[v] Australian Bureau of Statistics (2016) Victims of Family and Domestic Violence Related Offences [Viewed 18 January 2018] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4510.0~2016~Main%20Features~Victims%20of%20Family%20and%20Domestic%20Violence%20Related%20Offences~6

[vi] Examination of the burden of disease of intimate partner violence against women in 2011: Final report / Julie Ayre, Miriam Lum On, Kim Webster, Michelle Gourley, Lynelle Moon. Sydney: ANROWS, 2016.

[vii] Government of Western Australia, Department of Health, Epidemiology Branch. (2017) Analysis of WA Hospital Morbidity Data 2015 (customised unpublished data).

[viii] Western Australian Women's Health Strategy 2013-2017. Department of Health, Perth, Western Australia.

[ix] Australian Bureau of Statistics (2012) 1310.0 Year Book Australia Health. [Viewed 25 February 2016] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~About%20Year%20Book%20Australia~2

[x] Australian Institute of Health and Welfare (AIHW) Johnson S, Bonello MR, Li Z, Hilder L & Sullivan EA. 2014. Maternal deaths in Australia 2006– 2010, Maternal deaths series no. 4. Cat. no. PER 61. Canberra: AIHW. Viewed February 25th 2016. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548375

[x] Ibid.

[x] National Eating Disorders Collaboration 2012, Eating Disorders in Australia, viewed 16th January 2016, http://www.nedc. com.au/eating-disorders-in-australia

[x] Australian Institute of Health and Welfare (AIHW) Johnson S, Bonello MR, Li Z, Hilder L & Sullivan EA. 2014. Maternal deaths in Australia 2006– 2010, Maternal deaths series no. 4. Cat. no. PER 61. Canberra: AIHW. Viewed February 25th 2016. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548375

[xi] Australian Bureau of Statistics. *National Survey of Mental Health and Wellbeing: Summary of Results, 2007 [Internet]. 2008 [cited 2017 June 19]. ABS* Cat. No. 4326.0 Available from http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf

[xii] Richardson, D, Denniss, R. (2014) Income and Wealth Inequality in Australia, Policy Brief No. 64 [Internet] The Australia Institute. http://www.tai.org.au/system/files_force/PB+64+Income+and+wealth+inequality+FINAL.pdf

[xiii] Ibid

[xiv] Ibid

[xv] Australian Bureau of Statistics. (2016) Disability, Aging and Carers, Australia: Summary of Findings, 2015: Carers [Internet]. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0

[xvi] Richardson, D, Denniss, R. (2014) Income and Wealth Inequality in Australia, Policy Brief No. 64 [Internet] The Australia Institute. http://www.tai.org.au/system/files_force/PB+64+Income+and+wealth+inequality+FINAL.pdf

[xvii] Australian Bureau of Statistics. 4125.0 - Gender Indicators, Australia, Feb 2016: Economic Security http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~Feb%202016~Main%20Features~Economic%20Security~6151

[xviii] ABS (2015) Gender Indicators, Australia, Aug 2015, Cat. No. 4125.0, Earnings, Income and Economic Situation'. http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~Aug%202015~Main%20Features~Earnings,%20income%20and%20economic%20situation~120

[xix] Australian Women's Health Network. (2013) Women's Health: Meaningful Measures for Population Health Planning, Australian Women's Health Network

[xx] Sustainable Health Review Infographic file:///C:/Users/Popsi/Downloads/Sustainable%20Health%20Review%20infographic.pdf [Viewed 11 January 2018]

[xxi] For instance, Australian Medical Association (2014) 'Women's Health Position Paper' https://ama.com.au/position-statement/womens-health-2014 [Viewed 18 January 2018]; and Department of Health, Western Australia. (2017) *The*

Western Australian Women's Health Strategy 2018-2023, (consultation draft.) Perth: Women's Health Strategy and Programs, Women and Newborn Health Service, Department of Health, Western Australia.

[xxii] Department of Health, Western Australia. (2017) *The Western Australian Women's Health Strategy 2018-2023, (consultation draft.)* Perth: Women's Health Strategy and Programs, Women and Newborn Health Service, Department of Health, Western Australia. p. 5

[xxiii] Husøy Onarheim, K., Iversen,J. Bloom, DE (2016) 'Economic Benefits of Investing in Women's Health: A Systematic Review'. PLoS One, 11 (3) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4814064/ [Viewed 18 January 2018]

[xxiv] Our Watch, ANROWS and VicHealth (2015) Change the story: a shared framework for the primary prevention of violence against women.

[xxv] PricewaterhouseCoopers Australia (2015) A high price to pay: the economic case for preventing violence against women, p. 10.

[xxvi] https://www.dss.gov.au/our-responsibilities/women/publications-articles/reducing-violence/national-plan-to-reduce-violence-against-women-and-their-children/economic-cost-of-violence-against-women-and-their-children?HTML#health [Viewed 12 January 2018]

[xxvii] Whitehead, M, (1990). *The concepts and principles of equity and health.* WHO document EUR/ICP/RPD 414. WHO Office for Europe: Copenhagen. http://whqlibdoc.who.int/euro/-1993/EUR_ICP_RPD_414.pdf [Viewed 27 November 2012]

[xxviii] Boerder, C, Santana, D, Santillàn, D, Hardee, K, Greene, M, Schuler, S, (2004). *The "so what" report: a look at whether integrating a gender focus into programs make a difference to outcomes.* Interagency Gender Working Group Task Force Report: Washington.

[xxix] Australian Medical Association (2014) 'Women's Health Position Paper' https://ama.com.au/position-statement/womens-health-2014 [Viewed 18 January 2018]

[xxx] Department of Health, Western Australia. (2017) *The Western Australian Women's Health Strategy 2018-2023, (consultation draft.)* Perth: Women's Health Strategy and Programs, Women and Newborn Health Service, Department of Health, Western Australia.

[xxxi] Duffy, S. and Hyde, C. (2011) *Women at the Centre: Innovation in Community*. The Centre for Welfare Reform

[xxxii] Gilchrist, D. J. and P. A. Knight, (2017), *WA's Not-for-profit Sector 2017: The First Report on charities and Other Not-for-profits in WA*. A Report for the Western Australian Council for Social Service. Perth, Australia.

[xxxiii] For instance, see the Delivering Community Services in Partnership Policy (DCSP) (WA Government 2011) at: http://www.finance.wa.gov.au/cms/content [Viewed 15 January 2018]

[xxxiv] Ibid

[xxxv] Richard Wilkinson and Michael Marmot (2003) *Social Determinants of Health: The Solid Facts*. Second Edition. International Centre for Health and Policy.

[xxxvi] Department of Health, Western Australia. (2017) 'A Snapshot of Women's Health in Western Australia'. Perth: Women's Health Strategy and Programs, Women and Newborn Health Service, Department of Health, Western Australia.

[xxxvii] Dobson, A, Byles, J, Dolja-Gore, X, Fitzgerald, D, Hockey, R, Loxton, D, McLaughlin, D, Pachana, N, Powers, J, Rich, J, Sibbritt, D, Tooth, L, (2011). *Rural, remote and regional differences in women's health: Findings from the Australian Longitudinal Study on Women's Health.* Report prepared for the Australian Government Department of Health & Ageing.

[xxxviii] AIHW, (2008). *Australia's Health 2008*. Cat. no. AUS 99. AIHW: Canberra.

[xxxix] National Rural Women's Coalition [NRWC], (2005). *Healthy women – healthy communities.* Policy research paper prepared for NRWC.

[xl] National Rural Women's Coalition [NRWC], (2005). *Healthy women – healthy communities.* Policy research paper prepared for NRWC.

[xli] National Rural Women's Coalition [NRWC], (2005). *Healthy women – healthy communities.* Policy research paper prepared for NRWC.

[xlii] Rural Doctors Association of Australia [RDAA], (2009). *Development of a new National Women's Health Policy: Response to the discussion paper and guidance consultation questions.* RDAA: Canberra.