Gendered inequalities in policy processes: An illustration of women on the periphery in environmental design and public health policy

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Abstract

Gender inequalities manifest in a number of ways including through policymaking processes. Drawing on critical feminist perspectives, we investigate a recent Victorian Inquiry into environmental design and public health in order to illustrate how policymaking processes serve to reinforce gendered divisions within society. In our analysis, we highlight the ways in which the scope and methods of the Inquiry process, and the outcomes produced, reinforced gendered divisions and confined women’s voices to the periphery. In our critique we make four key points: 1) professional or ‘expert’ knowledge was given privilege over ‘non-expert’ voices; 2) the gender-neutral nature of the report consequently obscures the needs of women which are folded into those of ‘populations’ and ‘families’; 3) the focus on individual behaviour and responsibility for health outcomes ignores social relations and processes and the dynamic between structure and agency and; 4) where specific issues relating to women are highlighted, they are not translated into recommendations. We conclude that the Inquiry report focused on chronic disease prevention and recommended the reorganisation of urban space to further shift the responsibility for population health outcomes onto individuals. This obscured the needs of women and perpetuated a social order referenced to masculine interests. Ultimately, policy processes of this ilk disempower women and legitimise their marginalisation and exclusion from public health discourses in general.

Keywords: urban planning, public health, policymaking, gender, discourse

Introduction

In this paper we examine how the lives and concerns of women were (un)represented within a recent Victorian inquiry into environmental design and public health (Environment and Planning References Committee (EPRC), 2012). Specifically, we critique how the Inquiry recommended urban space be reorganised to further promote individual responsibility for health and prioritised the role of expert knowledge over the voices and experiences of private citizens in general, and women in particular. The emphasis on individual behaviour and responsibility is characteristic of contemporary neoliberal policy approaches: our main concern with the Inquiry is that the gendered neutrality of the investigation reinforced gender
divisions through such policymaking processes. More specifically, we argue that the Inquiry illustrated the operationalisation of masculine discourse in policy that placed women’s issues at the periphery. At the same time, we highlight how the focus on personal responsibility for chronic disease prevention removed women’s health interests from the frame and thus from the policymaking process.

In light of public health’s new focus on ‘environments for health’ (Department of Human Services, 2001), planning policies provide a unique opportunity to examine the way in which individual health problems are framed within policymaking discourses. As critics suggest, “the new public health is, if nothing else, a set of discourses focusing on bodies, and on the regulation of the ways in which those bodies interact with particular arrangements of time and space” (Peterson and Lupton, 1996: 11).

Drawing on the problem representation work of Bacchi (2009), Freidenvall and Krook (2011: 49) note that

the goals of the problem-representation approach, however, go beyond simply documenting the structure of policy discourses. They also entail focusing on the ways in which power operates through discourse to fix certain constructions of gender relations as dominant and to marginalize or exclude counter-discourses. In other words, issues of gender and power are central to the articulation and effects of discourse.

As such, here we examine the Inquiry Report in light of what Monk and Hanson (2008) have identified as key sites for sexism in geographic research, and we contend applies equally to policymaking. Following the classic work of Westkott (1979), in discussing research practice, Monk and Hanson identify how the purpose, methods and content of research may focus attention on issues that reflect the status quo that is created by and sustains a social order referenced to masculine interests. In this analysis, we examine the ways in which the scope and methods of the Inquiry process and the outcomes produced reinforce gendered divisions in public health. In doing so, we identify how the Inquiry process served to ‘write out’ women’s concerns that did not fit within the health focus framed around chronic disease. Women’s concerns were instead ‘folded in’ with those of ‘the population’ and ‘families’ (Jenson, 2008), an elision that served the interests of the masculine discourse in dominance.

**Environmental Design and Public Health in Victoria**

Following the rhetoric of ‘healthy public policy’ (World Health Organization, 1986) embedded within the environmental logic of the Healthy Cities movement (Tsouros, 1990), in 2011 the Parliament of Victoria provided terms of reference for an inquiry into “the contribution of environmental design to prevention and public health in Victoria” (EPRC, 2012: 5). This inquiry sought to “improve the quality and design of the built environment in ways that promote and encourage positive health outcomes for all” (EPRC, 2012: 4). After reviewing 63 public submissions, hearing evidence from 31 organisations and individuals, and conducting site visits to five municipal areas, the Reference Committee produced a report that examined “best practice models in terms of modifying aspects of the built environment in ways that lead to better health outcomes” (EPRC, 2012: 8).
The resultant Inquiry Report was organised into eight chapters. After an introductory chapter outlining the scope and structure of the report, three further chapters reviewed evidence on the links between the built environment and public health, particularly in relation to chronic disease. Chapter 5 then explored “opportunities to promote considerations of planning for health and wellbeing in Victorian legislation, guidelines and policy approaches” (EPRC, 2012: 8). Chapters 6 and 7 focused specifically on best practice models of parks and open public spaces, and active transport, respectively. Finally, chapter 8 described four case studies including three new residential developments and a green wedge preserve.

Analysis and findings

While researchers have drawn on Foucault to critique the regulatory power of new public health discourses (Peterson and Lupton, 1996), we heed the call of Butler (2005) and Moore (2010) who seek to disaggregate gender from Foucault’s web of regulatory power. Like Moore (2010), we acknowledge the deeply gendered nature of ‘new public health’ discourse whereby the operation of power upon individual bodies relies on conventional ideas of women’s roles and their responsibility for family health.

To conduct our critique, we employed Jäger’s (2001) method of critical discourse analysis, as this provided a way of uncovering how practices contained within texts “systematically constitute the subjects and objects of which they speak” (Schwandt, 2001: 58). In the current study, we employed Jäger’s method of examining how language shapes social relations to examine the purpose and method of the Committee’s work, the gender neutrality and specificity of the Inquiry’s terms of reference and data sources in order to identify the construction of gender roles and identities that reflected extant social relations at the expense of women’s ‘public health’. We also examined the content of the submissions to the Inquiry and the Final Report (EPRC, 2012) to make a case for our argument, based on the following four interrelated points.

First, the Inquiry’s Terms of Reference directed the Committee to: evaluate and report on the evidence regarding environmental design and public health; review existing policy frameworks and legislation regarding environmental design and public health; and examine the experience of the international Healthy Cities initiative. In doing so, expert and bureaucratic understandings of the problem were privileged over private citizen and community group interests, and the submissions were therefore primarily from academic, government and service sources. The absence of broader public views and concerns was reflected in the Chair’s foreword, where she noted: “importantly, the committee has heard that there is a strong consensus between the planning and the public health professions on how to approach the problems” (EPRC, 2012: v). We contend that the effect was the marginalisation of issues outside this focus, including those relating to gender.

We argue that this expert focus played out in recommendations calling for “public health specialists” (EPRC, 2012: xii) to inform Precinct Structure Planning processes; and for further research on planning projects to generate “quantifiable evidence” (EPRC, 2012: xvii) regarding health and wellbeing. In these cases, problems were framed by and will continue to inform the existing social order, a consequence of which is the legitimisation of the status quo as ‘non-expert’ voices will continue to be confined to the periphery.
It is acknowledged that the construction of knowledge embedded within the Inquiry process is not limited to gender, and reflects other social divisions including those of socio-economic status, race and class. From a feminist perspective, however, what is of relevance is the ways in which ‘professionalised’ accounts of social problems and their solutions necessarily lie within a social order that buttresses male interest and the role of the professions therein (Davies, 1996; Kuhlmann and Bourgeault, 2008).

A second issue is the use of secondary data and the focus on population-level indicators of public health. As the report indicates, the scope of the inquiry was limited to “populations, not individuals” (EPRC, 2012: 7). While older people, the disabled, adults and children were identified as populations warranting specific attention, the report’s findings and recommendations were not disaggregated by population or gender and research demonstrating gendered factors that contribute to chronic disease were identified, but not addressed (a point we return to below).

Third, there was a focus on individual behaviour and responsibility for health which ignored social relations and processes and the dynamic between structure and agency (Giddens, 1984). As is consistent with recent critiques of the Healthy Cities movement and the new public health (Peterson and Lupton, 1996), the Inquiry essentially failed to understand or act on the social organisation of health. As critics have suggested, “despite rhetoric about the need to develop a new ‘holistic’ framework of analysis and new modes of social organisation, [the Healthy Cities and new public health] philosophies, policies and practice reflect a conventional, modernist understanding of society and of reform” (Peterson and Lupton, 1996: 121); one that supports the existing social order and the marginalisation of women.

This position is evident in the Report’s focus on chronic disease, despite the Inquiry’s terms of reference providing no specific directive to do so. The main body of the Report is organised to address ‘factors’ contributing to chronic disease, such as obesity, physical activity, health eating, and alcohol consumption – all of which can be, and are often, attributed to the behaviour of individuals. The background chapters that set out the nature of chronic disease in Australia provide little justification as to why chronic disease is the focus of the report, other than to state that “chronic disease is the largest burden on Australian health services, yet unlike infectious disease, is often preventable and/or attributable to individual lifestyle and behavioural choices” (EPRC, 2012: 9). We argue this emphasis on individual behaviour diverts attention away from structural contributors to chronic disease and largely removes gender-specific concerns from the frame. For example, the relationships between neighbourhood characteristics and intimate partner violence (Pinchevsky and Wright, 2012), which is the leading preventable cause of death, disability and illness for Victorian women aged 15-44 (VicHealth, 2004), were not addressed.

Although on most occasions the Inquiry’s recommendations ignored the complexity of women’s lives, ironically women were implicitly referenced as those who control family health behaviours, such as food consumption, travelling to and from school, or playing in parks – all of which hint at the highly complex nature of everyday life. For example, the low number of children walking or riding to school was identified as of particular concern and a recommendation was made to “support initiatives to increase the number of children walking and cycling” (EPRC, 2012: 111). While safety concerns were highlighted as the primary reason parents choose to drive their children to school, this obscured the impact of time poverty, especially in outer suburban areas where men were reported as being unavailable for their families due to long work hours and commutes (EPRC, 2012: 44).
Further, the Committee noted that walking or cycling could replace many short trips taken by car, but that this would rely on “providing the necessary walking and cycling paths and networks” (EPRC, 2012: 52). Hence individual behaviour was depicted as dependent on physical infrastructure, rather than occurring within a social context. As we have argued, the removal of the social context disproportionately impacts on women, as “it actually prioritizes individual changes that leave gendered power inequities in place” (Zoller, 2005, p. 184).

Fourth, where specific issues relating to women’s health and wellbeing were highlighted, such as in the case of women’s safety concerns and physical activity, no reference was made to these issues in the Report’s recommendations. For example, a section on ‘The built environment and crime’ noted that “women’s perceived fear of violence can influence their behaviour more than actual rates of violence” (EPRC, 2012: 96) and that safety concerns limit women’s ability to participate in society the same way as men do. Safety concerns regarding active transport use were also cited, with “women from lower socioeconomic groups and CALD [culturally and linguistically diverse] backgrounds who tend to live in higher crime neighbourhoods, work during non-business hours and typically have fewer transport options” (EPRC, 2012: 96) being identified as among those least likely to walk. However, despite such evidence, no recommendations were produced to address these concerns.

Another example that highlights the important omission of gender and lack of gender-specific recommendations, is that of lone parents, of whom 85% nationally are women (Australian Bureau of Statistics, 2011). Despite lone parents being identified in the report as having the highest percentage of risk factors for chronic heart disease or type II diabetes in Victoria, no gender-specific recommendations were produced. Instead, recommendations were made about healthy eating and physical activity; however these focused narrowly on the environment, such as the density of fast food and alcohol outlets and the provision of walking and cycling infrastructure, public transport and public open space. Overall, the gender-neutrality of the report obscured the needs of women as the availability of unhealthy products and lack of public infrastructure were constructed as the primary determinants of individual health behaviour. This is perhaps unsurprising given the ‘professionalised construction’ of the policy problem.

Conclusions

Gender inequalities manifest in a number of ways including through policymaking processes. In this short paper we have used a critical feminist perspective to investigate a recent Victorian Inquiry into Environmental Design and Public Health. We find that the Inquiry’s emphasis on expert knowledge and moral individualism has silenced the input and concerns of women and instead entrenches extant gender relations. We make four key points to illustrate our argument. Firstly, professional or ‘expert’ knowledge was privileged over ‘non-expert’ voices which were confined to the periphery or unheard. Secondly, the report is gender-neutral and consequently obscures the lives and concerns of women which are folded into, and obscured, by those of ‘populations’ and ‘families’. Thirdly, the focus on assigning responsibility for health outcomes solely to individuals ignores social relations and processes, and overlooks the dynamic between structure and agency. And fourthly, where specific issues or concerns relating to women are highlighted, they are not translated into any of the Inquiry’s recommendations. Ultimately, policy processes of this ilk obscure the reality of women’s
lives, disempowering them while simultaneously legitimising their marginalisation and exclusion from public health discourses in general.

References


