THE JOINT SESSIONAL COMMITTEE ON GENDER AND EQUALITY, MET ON WEDNESDAY, 13 JUNE 2023, COMMITTEE ROOM 1, PARLIAMENT HOUSE

TASMANIAN EXPERIENCES OF GENDERED BIAS IN HEALTH CARE.

The committee met at 10 a.m.

CHAIR (Ms Forrest) - Welcome, Miranda, to the public hearing for the Gender and Equality Committee Inquiry into Tasmanian Experiences of Gendered Bias in Health Care. Before we start I will ask you to agree with the statutory declaration, if you're happy to do that, but before we do that I will note that this is a public hearing. It is being broadcast and the transcript will be provided and published at a later time. Everything you say to us stays public and protected by parliamentary privilege unless you make a request that anything you would like to say should be treated confidentially and then the committee will consider that. Parliamentary privilege attaches to this hearing. If you repeat anything outside of the hearing that may not apply. Do you have any questions before we start?

Dr HANN - No, I'm happy with that.

CHAIR - If there was anything of a confidential nature you wish to share with the committee, you can make that request and we will take that as a separate part of the proceedings. That will not be published or directly referred to in our report.

Dr MIRANDA HANN WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - So that you know who is in the room, opposite me are Josh Willie, Dean Harriss, Rosalie Woodruff, Dean Young and Nick Duigan, and Michelle O'Byrne is online. Michelle is probably still driving at the moment so she will be listening but not participating, to be a safe participant, and she'll be appearing in the room as soon as she gets here.

We have your submission, which we have read and appreciate. I'll invite you to make an opening comment and then the committee will have questions for you.

Dr HANN - I will probably just speak to the trans and gender-diverse aspect of my submission, largely because I don't expect there are going to be too many people commenting on that element of gender access to health care.

I'm a GP and I work at Ochre Medical Centre in Hobart. I largely work with the LGBTIQ community in Tasmania and probably anywhere from about 30 per cent to 50 per cent of my patients are trans or gender-diverse identifying. I don't have a good way to calculate that with the way best practice is set up but it's a large proportion of the patients that I see. That means I have a high exposure to the stories of poor access to health care that the community shares with me and have perhaps a bit of a different insight to other health providers in this space.

There are pretty horrific stats in terms of the access to health care for trans and gender-diverse people. One of the papers I'm happy to share with you records that one in five have been refused care by a medical professional and that's just outright refused, and

50 per cent of trans and gender-diverse people have to teach their doctor about transgender care. I would argue that that stat is probably under-representative of the number of people I experience who have had to teach their doctors and certainly I've had patients teach me things. A total of 28 per cent have faced harassment in a medical setting and 48 per cent have postponed medical care because they couldn't afford it. All of those stats are very much within the realm, if not under-representative, of the community that I see in Tasmania. Because of this, there's a huge healthcare disparity in this patient population and huge healthcare needs that aren't being well addressed at the moment in most of our health care settings that we have in Tasmania.

CHAIR - Thanks. With regard to the postponement of care, is that all care or is it care related to their gender-diverse personhood, if you like?

Dr HANN - All health care. Particularly right now in Australia when we're in a sort of primary healthcare crisis with reduced access to clinicians who can provide affordable care and the reduction in bulk billing because of lack of federal funding towards primary care, it means that most access to primary care requires payment and because of the large degree of discrimination against trans and gender-diverse communities in all areas of life, including employment, most people have a harder time maintaining longstanding employment and thus there's a big financial disparity in this community as well, so being able to pay for and access services becomes very challenging, and then if they have to pay for medications that becomes very challenging. It's accessing any type of health care.

CHAIR - So even if they get a headache or the flu or something?

Dr HANN - Yeah.

CHAIR - Is the fact that they're gender-diverse when they turn up or try to make an appointment, are they rejected - you were saying they're rejected or not able to get an appointment, but how does that work? I'm interested in how that happens.

Dr HANN - Typically the rejection doesn't happen at the time of booking. Healthcare providers are a diverse group of people in themselves and we don't have great education about trans and gender-diverse people within our healthcare education. I went to the University of Queensland and we had one lecture that was an hour long on LGBTIQ people, so that's all people, not just trans people, and that was it for my education I received through medical school. A lot of people don't have a good understanding of this community. They don't understand the health complexities and certainly don't understand how to provide a safe and affirming space for trans and gender-diverse people. In addition, we all come with our own stigmas and biases and there are certainly providers who have greater stigma and bias against the trans and gender-diverse community and will refuse care based on those personal grounds.

CHAIR - I would have thought it would be completely unethical for a doctor to refuse to treat someone purely because they're trans.

Dr HANN - The rule around the ethics of that in medicine is if you refuse to provide care to somebody, you have to refer them on to someone who can. For instance, like with abortion, if you don't provide abortions you have to be able to refer that patient to another space that will provide them. That doesn't mean these people are referred onwards and it doesn't mean that's an ethical pattern that's followed. In order for that to be enforced, the patient would have to report the clinician and I doubt most patients know that that's a requirement within our ethical framework in medicine.

Dr WOODRUFF - Thank you so much for the thought you put into the submission. I've got a lot of questions but I just wanted to talk about the training because you referred to it. It seems to me - and also in the comments you made about female gender bias - that going upstream, some of the changes obviously are cultural ones in the medical profession. I think you mentioned that there is training for teaching a different narrative in medical school. You said you don't think it's being done aggressively enough in relation to female gender bias, but it's obviously not being done at all when it comes to gender diversity. You're not responsible for the medical training, but do you have a view on who is and what work is being done at the upstream level at medical schools and what the role for government should be in that space? It seems to me in Tasmania that the majority of people who are trained are going to work in the public health system, so we have a responsibility, as funders of services, to make sure that they are gender-safe, gender-aware. Is there a role or a process that happens, or maybe this is something we need to look into with the university and the medical training school, with Working It Out or something to get better education?

Dr HANN - I have not done work specifically through UTAS. I've worked with their interest groups. They have a women's health interest group and a diversity group. I have worked with a couple of their special interest groups, with students and done lectures with them. I do know that they engage with Clinic 60 to do educational talks on gender and sexuality. But because those lectures are coming from Clinic 60, it means that the lean of the presentation is very much around sexual health. Sexual health is only a really small part of the medical needs of the trans and gender-diverse community. It is certainly not comprehensive of the healthcare complexity that we see in this community. They tend to be multimorbid, meaning they have multiple diagnoses, both mental health and physical health diagnoses, on top of their gender and gender health needs. Unfortunately, I can't comment specifically on this because I am not one of the lecturers at UTAS and so I don't know what they are doing to change the narrative there.

I do a lot of education in rural areas, so I work with all the rural interns and RMOs and do three-monthly educational sessions with them. That's specifically on inclusive trans and gender-diverse health care. I do education sessions with other GPs and we create video links and conferences that GPs will be able to go to.

But I don't know what is happening at UTAS because I am not tied in with their networks.

CHAIR - With the rural training, is that through the Rural Clinical School you do that?

Dr HANN - I do it in consultation with HR+, so it is with the GPs who are working rurally.

Dr WOODRUFF - Maybe it is a role for the committee to look at the training that happens about that.

You said if a doctor refuses to provide care, the ethics of the profession require them to refer a patient on. Assuming that that happens, you are obviously a person who has, for whatever reason, created a specialty in providing care for people, people refer to you as somebody who is open and inclusive and able to be helpful. Is the lack of care gendered? Are female doctors likely to be more open to gender-diverse people than male doctors? Or is that not the case?

Dr HANN - I'm involved with this community because I am part of the LGBTIQ+ community, so I see everybody in the community and it is a very small space and a very small community in Tasmania, which means I became quite popular quite quickly. Word of mouth within the community meant that that has become my patient cohort very quickly.

There is a stereotype of compassion about female providers but certainly the male GPs we have in Tasmania are incredible. Frank Meumann has just won an award for the services he has provided because of being an incredibly supportive and inclusive space, especially from a mental health perspective, as a GP. I don't think it is necessarily is a gendered space in terms who is a safe provider. I happen to work in the space because it is my community, not because of my gender. Nurman Noor is another GP in town who does a lot of work with the trans and gender-diverse community.

CHAIR - Can I go back to the training? We can talk to UTAS about how they manage it here. You didn't go to UTAS, you went to a Queensland uni?

Dr HANN - Yes.

CHAIR - From the evidence we've got, including in your submission, but also in others, it seems to be an additional barrier in the rural and regional areas, which access to health care is generally, it's not just this area. But obviously it's even more difficult for members of the LGBTIQ+ community in rural areas. The training that's provided through the GP training programs and Rural Doctors Association of Tasmania (RDAT) programs, are you aware whether they do any particular parts of that? This is those preparing people to be GPs, particularly for rural practice.

Dr HANN - I did not get any training in this specifically during my GP training. We had one lecture on mental health and there was a not well-done comment around gender-inclusive care.

CHAIR - As part of the mental health program?

Dr HANN - Yes. It was part of a mental health lecture. That was one provided element of education that I found quite problematic because it just reinforced stereotypes that are not necessarily accurate or true to everyone's experience. Certainly it was very performative in the way it was done. But I also recognise that I'm close to this space so when I feel like things aren't done well, I notice more than perhaps other people would. Otherwise, I haven't received any specific education.

There is one topic section that's part of our package of educational materials we were given that included a bit of education around trans and gender-diverse health care. But I think it was a three- or four-page document that you were expected to read on your own. That has subsequently changed because the GP training changed models in February. I have not seen the current resources that they've got for this community.

Most of my education has been things that I've found on my own. I'm part of AusPATH, which is the Australian Professional Association for Trans Health. They provide a lot of education. I've gone to a number of different lectures and training sessions put on by different states. There's been nothing offered in Tasmania. I had to outsource outside of the state. New South Wales and Victoria often hold training programs. They are a bit bigger, so that makes sense. I've attended those training sessions, but because I'm not from those states, I actually had to lie about my location in order to attend those training sessions - which I owned up to as soon as I went to the first one. They're not offered to interstate people. In Tasmania, we have nothing so there was no option for me to do any learning or upskilling without getting creative.

CHAIR - Who was the provider of those programs you had to lie about initially?

Dr HANN - One was a sexual health group in New South Wales, a sexual health clinic and a number of GPs and nurses. That one was excellent. It was provided through Illawarra-Shoalhaven Gender Centre. Then ACON does them every once in a while. The one in Victoria, the name is slipping my mind at the moment, but there's a couple of people in Victoria that provide training.

CHAIR - Not through universities. They're through other healthcare provider situations, by the sound of it.

Dr HANN - Yes. Sort of like how our primary health network here does regular lectures, so similar to that type of structure [inaudible 10.19.20].

Mr WILLIE - I read your opinion piece. I saw the delayed diagnosis issue, particularly for women, but also for the LGBTIQ+ community. Do you have any understanding of the cost to the system? There's obviously a very real human cost, but there's a disproportionate cost to people and the system too if people are not going to appointments and there's all these barriers that we're talking about.

Dr HANN - I can't give you numbers specifically, but I know it's about 10 times more expensive for a trip to the emergency department than it is for a trip to the GP to address the same issue. That is certainly something both female patients and trans and gender-diverse patients are going to have to experience more often, because if you are not heard within a GP clinic setting, your symptoms get worse and your next step is the emergency department.

Had those symptoms been investigated or the merit had been taken seriously a bit earlier, that may have been prevented. Certainly, from a cost perspective, avoidance of primary care means your next step is going through the emergency department. The cost of health care for each of those presentations is substantially higher than if we just did the preventative health for that person. Typically, people with complex medical needs presenting via emergency departments are not presenting just once, they are going to be presenting multiples times and thus, increasing their costs to the healthcare system significantly.

I cannot give you exact numbers, but from the general practitioner's conference, the difference between assessing and managing something in primary care venues the emergency department is about a 10-fold difference.

Mr WILLIE - You talked about it a little bit and it sounds like it has happened organically of people have got to know you as an inclusive practitioner. Is there broader information provided to LGBTIQ+ people on inclusive practices they can go to, a more formal way rather than just by word of mouth?

Dr HANN - Yes, I have been working with Working it Out to try to get a referral resource list going. Their capacity is quite limited because they do literally everything for the state in terms of LGBTIQ support. As a result, I have generated a provider and resource list of who to see for mental health, surgical support, things like paediatricians and psychiatrists, allied health like physios, OTs and speech pathologists, both providers who are safe and affirming within Tasmania but also virtual referral options.

I self-generated this list based on what I have been told by the community and also who I have worked with within the Tasmanian health area. I have shared that list among health providers in Tasmania and also on the different Facebook pages we have for the community. I am part of a LGBT Tasmania Facebook page. There is a restricted transgender Tasmania Facebook page only available for people who are in the community. I have just had people I know in the community share that resource for me to be available to community members and they can access that.

Informally I have done that, but unlike a lot of other states that have a website you can go to and can click through and try to find providers within your area for specific things, we do not have a resource like that in Tasmania.

Mr WILLIE - I think we have Working it Out here tomorrow, to ask them.

CHAIR - Or Equality Tasmania.

Mr WILLIE - These practices are having the same challenges and a lot of them have closed their books and are not taking on new clients, that sort of thing.

Dr HANN - I have also closed my books because the waitlist to see me is five or six weeks, which makes primary care not effective if you cannot follow up with people. The demand for services in Tasmania is very high and our access to primary care here is fairly restricted and very limited.

Part of that is the general climate of health care in Australia, part of it is people not addressing any health care for the years through the pandemic and we are playing catch-up. Part of it is we have a huge population change that happened though COVID-19 in Tasmania, we had a lot of migration down here and we have not maintained doctors. Part of the reason we do not maintain doctors is because primary health care is not adequately compensated for and so, there are high rates of burnout among GPs and practices that just cannot sustain the amount of pressure put on us for short time periods with inadequate compensation and so, we have lost a lot of GPs through the last few years.

CHAIR - The list you have generated is great, but it is a point in time too, isn't it? It's out there now, unless you actually -

Dr HANN - It's a Google doc so I update that.

CHAIR - Oh, you can update it. That's helpful. I was thinking otherwise someone new comes into the picture that may be able to offer the service if you can update it. It's up to you to know who is around and who is inclusive.

Dr WOODRUFF - Miranda, you talked about pronouns and them being out of sync, and the systems we have as being incapable of dealing with providing information to medical practitioners which they need to know about a person's gender pronoun being correct information, particularly if they change. There's an issue here about Medicare, so you could change it at the practice level and make all your forms be more inclusive with gender pronouns. But the problem is that when that person hits Medicare and bulk billing, they're forced into a binary box. That's a kind of Commonwealth issue, by the sound of it.

But then you specifically mentioned the Royal Hobart Hospital with old records not automatically getting linked and updated. Do you want to speak a bit more about that?

Dr HANN - There's lots of layers to your question. I will start with the Royal. I worked at the Royal for three-and-a-half years, something like that, in the emergency department and our electronic medical records in the Royal, at the moment, if someone's name and pronouns have changed because in Tasmania we've got fairly easy ways to change birth certificates and, thus, Medicare and the name on medical records. If your name has changed and your gender marker has changed, your old record is not automatically integrated into the new record. What they do is, they end up just creating a new medical record for you and that information isn't pulled through into the new record. That's specific to the Royal and how their electronic medical records work. Where I work, we use a system called Best Practice and it is more transferrable so you are able to bring those records through with the new name. But it's going to be different and specific within each hospital system and within each practice depending on what electronic medical system they use.

Beyond that is that in Tasmania it's very easy to get your name and gender marker changed on birth certificates and documents but it's not the same in other states. So there's quite big challenges. It is impossible to get a change within other states, meaning that then there's a group of people who are living here who are unable to change that and thus get misgendered regularly, or categorised into different stereotypes more regularly. That's actually state versus federal because there's state-level changes that affect your ability to change your Medicare.

The next level would be with the electronic medical records we often have to put on options for she/her or he/him. Some of them have they/them but I have quite a few patients who use multiple pronouns, like she and they, or he and they. Those types of nuances that are present within the community aren't necessarily present on our medical records.

The last part about that is the prefix in front of people's names. That's often not changed for people, which means, say, my referral still had a 'Mr' in front; it would be 'Mr Miranda Hann would like to come and see you to get a' - whatever health professional you are. Unless you go in and manually change that, those prefix markers are another element that provides areas of confusing misgendering for people on referrals.

Dr WOODRUFF - That's an electronic system issue that is different by private practices and even with public hospitals within Tasmania. They have different electronic record systems?

Dr HANN - Yes, those electronic records issues are going to be different for every health system you are in, whether it's primary care, hospital or private hospital. None use the same record system. Quite a few GP practices use Best Practice, but medical specialists do not and surgeons do not and the hospitals do not. They all have their own sections and the ones that the surgeons use are different than the ones that our endocrinologists use, which are different than the ones that the hospitals use. None of those electronic records talk, so if you are going to be sending information between different providers or services, you are essentially faxing a new document each time that you are sharing information between services.

Dr WOODRUFF - Well, that all sounds hard enough to make me feel like I need another coffee. The reality is, it can change at a glacial pace as things change in the community, and they are changing, but that is too slow for people. Is there anything, any role that you can see for government in helping to be a bit more assertive, in showing some leadership or having a best practice of where electronic systems change, where they should be changing to, leading a conversation with communities about that?

Dr HANN - Yes, I think there has been some talk about getting all of the hospitals onto shared electronic record systems.

CHAIR - They are, they are working on it at the moment. We talked about that in Estimates last week. It is slow, but there is an intention to get all the hospital records the same, but that does not deal with the specialists, it does not deal with the general practice, it does not deal with the private hospitals.

Ms O'BYRNE - Can I interrupt there? One of the things that we do have in Tasmania, and it is unusual, is an individual patient record for anyone who is born in Tasmania. This work has been done 10 years ago, it should not be that complex. Miranda, have you looked at the Northern Territory, which had a model where they were overlaying the system that would -

CHAIR - Oh, we have lost Michelle.

Ms O'BYRNE - allow you to call up individual record, fully recreate files or merge files; it actually just allowed you to drag information from files. Does that happen? Sorry, ……[inaudible] the way things are.

Dr HANN - In theory, that should be very easy to do, but because I am not in the public health system anymore, I do not know what the IT barriers are to doing that for the electronic medical records that are used at the Royal.

Ms O'BYRNE - Okay. The Northern Territory basically got doctors in ED to design a new system so they could get the information they needed at that time. That leads into my broader question, which is: in terms of the structural issues, is there any jurisdiction that does it well that you are aware of? I am assuming that we all do it not great. Who would be the most advanced in terms of a model of structurally reforming the training as one less element, but also the data and record-keeping?

Dr HANN - I do not know the answer to that. I have not seen one that does it well.

Ms O'BYRNE - That is an answer, too. That's a fine answer.

Dr HANN - I have worked in Queensland, Victoria, Tasmania and the US, and I have not been exposed to one that is comprehensive.

CHAIR - We might need to have a bit of a look at that ourselves so we can find out. Miranda, I am very conscious of the time and I am sure you have patients waiting to see you. In terms of a closing comment, what do you think would make the most difference? We can make recommendations to the state Government; obviously, Medicare issues are a separate thing, but this Government can lobby. If there was one or a couple things you could say that really would make the biggest difference, what would they be?

Dr HANN - Ruby Grant, who is a researcher here, just did a study on transgender and gender-diverse people's access to healthcare services in Tasmania, and the number one thing that was requested was a dedicated LGBTIQ+ health clinic and service, which we do not have in Tasmania.

CHAIR - And you agree that would - ?

Dr HANN - Absolutely, yes. It is the first thing I looked for when I moved here and could not find it and then had to figure out what GP to go to. It is the way that I know, as a service user, it is how I would pick my GPs, it was how I would pick my health service, it is how I would understand things that work within the state I was living in. Not having that here has been floundering for me - and I am a very privileged and educated individual in the community. It just means that the service that you are walking into is safe, you are not going to be misgendered, you are not going to be made to feel 'other', you are not going to be put in situations that are going to make you feel more vulnerable than you already do in a healthcare setting, which is vulnerable for any person. If you can make some of those access barriers feel less scary then people are going to use the service more. It means there will be adjustments made for neurodiverse patients, who are a much higher proportion than our gender community.

It means you are part of your community as you're getting your healthcare treatment. You're walking in and the people around you are people who you know and make you feel safe. It's sort of like our Aboriginal Health Service. Our Aboriginal community accesses the Tasmanian Aboriginal Centre (TAC) and the Aboriginal Health Service preferentially because you're walking into community and community's going to use a different language. Community's going to treat you differently and community's going to understand your needs more effectively than perhaps those who aren't part of the community or aren't exposed to the community as regularly.

CHAIR - Thank you very much for your time, Miranda. I'll let you go so you can get back to your heavy workload. Thank you for taking the time out of your busy day to speak to us.

Dr HANN - I'm happy to speak again if you need me to.

THE WITNESS WITHDREW.

The committee suspended from 10.37 a.m. to 11.28 a.m.

Mr JONATHAN BEDLOE, SECRETARY, MEN'S RESOURCES TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Mr Bedloe, to the public hearing of the Gender and Equality Committee's inquiry into the gendered nature of health care. We have received your submission and we appreciate it. We will invite you to make a brief opening statement and add further to that.

This is a public hearing. Everything you say is covered by parliamentary privilege while you appear before the committee. That may not extend beyond this room, so please be aware of that if you speak about it afterwards. Everything you say is in public, unless you make a specific request that we hear some evidence in camera. The transcript will be published on our website at a later time and in a formal report.

Do you have any questions before we start?

Mr BEDLOE - No.

CHAIR - The committee members are Dean Harriss, Rosalie Woodruff, Ruth Forrest, Michelle O'Byrne and Dean Young. Nick Duigan will be back later, and Josh Willie at the end. Thank you.

Mr BEDLOE - Thank you. By way of an opening statement, I wish you all a happy Men's Health Week.

I am here on behalf of Men's Resources Tasmania, and have done most of the work to prepare our submission. Unless we are citing reports and the like, any stories we might have are really anecdotal evidence. We don't have the resources and time to be able to do formal surveys and the like for this inquiry.

I am referencing a fair bit of material from the Australian Men's Health Forum. I am not speaking on their behalf, although I do a bit of work for them from time to time.

Men’s Resources Tasmania is very supportive of all efforts to support women's health. Certainly, we are not here in any way to question or challenge things that are being done for women. We are fully supportive of that, but we are here to speak to inequalities we feel are there towards men.

We are an unfunded organisation, so most of what we do happens through volunteer time and efforts. For me, being the main person putting this together, I'm trying to run my own business as well, so I have had limited preparation time.

CHAIR - Your submission was comprehensive, I thought it was good, so thank you.

Mr BEDLOE - It was a pleasure.

CHAIR - There are many things in here, but I want to look at one in particular - the promotional work that is done by governments at all levels on health-related matters.

You talked about the Slip, Slop, Slap sunscreen campaign, which is pretty old now, and make the point that men experience higher rates of melanoma. Back in the day, they weren't gendered characters, as I recall it - they were kangaroos and things, weren't they? Either way, it was a non-gendered approach. Where there are aspects that may have a gendered impact, in terms of higher rates of one particular form of cancer - related to, say, sun exposure - but the message should be the same for all, how do you see that needing to change, if it does?

Mr BEDLOE - Yes, I guess that example absolutely is a pretty old campaign, although I think it has had recent iterations and additions.

Ms O'BYRNE - Yes, they've added 'Slide'. Slip, Slop, Slap, Seek, Slide.

Mr BEDLOE - I guess, using that example, we would say that if the rates are disproportionately affecting one gender, then possibly some parts of the campaign would be better targeting the specific genders.

If I can give another example, in the parenting space, programs and services are pitched to parents, and often the default in many families is that the mothers will go along to those, and dads don't necessarily see themselves. Obviously, if they were stopped and asked and challenged to think about it, they would probably say, yes, it is for parents. We know that when programs specifically target dads, and name dads up, and make it clear that they are included in whatever the programs are, it has a much higher success rate of getting them involved.

There is a big discussion happening in the community around gender and around bias and that sort of thing, and we have a long way to go. Down the track, though, we would hope that when things are pitched at parents, men and women, dads and mothers, would both recognise their role. But we are not there yet. I think there is work to be done, and part of that work means actually targeting men or dads in that instance to help them identify themselves for those programs.

CHAIR - As a former childhood educator and midwife, I never seem to have any trouble getting the male partners along to our natal classes. They may have been dragged, some of them, in fairness, but we also used to include a special dads approach in most classes. There would be a component where the dads would meet with another dad and that sort of stuff, to try to talk about those matters.

You made the point here about the screening. We know that all new mothers have antenatal screening as well as postnatal screening now for depression and other matters. You said that it doesn't happen at all for men - is that your understanding that it doesn't happen at all or would men have to self-identify before they would be administered a screening assessment?

Mr BEDLOE - That's my understanding. It's becoming more of a routine thing for women in maternity spaces. I don't know how formal it has become but I'm not aware of it becoming routine in the same way with dads. I think dads are overwhelmingly probably getting involved in those antenatal classes, but post-birth things are quite different. We've certainly heard stories of child health nurses visiting, doing those early childhood health checks. Dad is at home with the child and the question has been, where's the mother or the main parent or things like that. Hopefully, those things are changing but certainly we've heard plenty of those sorts of stories where dad hasn't been acknowledged as an equal parent and potentially just as interested in the health of the child.

CHAIR - So, from what you're hearing from your members or the people who speak to you about this, do you think it should be something that's done as par for the course like a mental health screening for new dads or should it be done differently? I am interested in what your members are telling you.

Mr BEDLOE - It's an opportunity to engage men in their health. We know that with women and girls they're engaged in their health quite early because of their role as future mothers and through their adolescence and engaging in managing their periods and things like that. It doesn't really happen in the same way with men and boys and it probably doesn't need to happen in the same way; however, lots of people still argue that men don't see the doctor at the same rates that women do, or that they could do later in life and that's a bit questionable. I'm not sure that's still 100 per cent accurate, but nevertheless, engaging men in their health at those routine stages when there aren't necessarily any issues, is an opportunity to get proactive rather than waiting until when depression - or in the case of early fatherhood, if it is postnatal depression - might be harder to pick up when we also know that a lot of men don't feel they get the help they're looking for when they first make approaches. There's various evidence out there now to show that men do seek help but often they don't return for a second visit because they don't feel that they've been heard or received the support they're actually looking for.

CHAIR - I want to come to the barriers, as you said. One is that they don't feel heard. Is that what you're saying, if they do present?

Mr BEDLOE - Yes, possibly, they don't feel heard or they don't feel that they're getting the support they're looking for. Obviously, with any support service, it will be different people on different days and we can all have a bad experience with somebody who's just got out of bed on the wrong side, that's for sure, but it's fairly consistent that Tasmanian suicide reports show quite clearly that men have engaged in seeking support but often only attend various services once. That would suggest they're not getting what they're looking for.

CHAIR - I'm wanting to identify the key barriers as you see them.

Mr BEDLOE - It may be a lack of availability of male workers in some workforces - this isn't to say that women can't perform a great job in health services, of course they can, but for some men seeing another man may be important, though certainly not for all men. The male-friendliness of services and the approaches that are taken by some services, for instance, talking about feelings. If we're talking about depression or suicidality, there's a school of thought from Stop Male Suicide in the Australian Men's Health Forum that shows men are much more concerned about situations and the contexts around their lives than they are about their feelings.

We would look at supporting them in terms of the situations they're in rather than the feelings and emotions that they're experiencing. It's sort of taking an outside-in approach rather than an inside-out approach. There are not really any male-friendly services training happening, as such. It has in the past happened occasionally. There's been one or two providers who have done that. But I'm not aware of evidence of it happening on a consistent level out in the community.

CHAIR - Did anyone else have a question?

Ms O'BYRNE - I had one about the survey that only arrived the day that you did the submission. I'm assuming you've had more time to look at the survey since the submission, or maybe not.

Mr BEDLOE - I've not, no.

Ms O'BYRNE - It just mentioned you got it on the day you were doing the submission. Given it can identify where people identify their workplace or their engagement with men's health, do you have a Tasmanian part of that? Is it possible to glean from that data a Tasmanian picture? I'm wondering if there are any variations that are region-based.

Mr BEDLOE - I can certainly enquire about that and see if there's any specific Tasmanian data.

Ms O'BYRNE - It would be interesting to have that for the committee.

Dr WOODRUFF - I've got a few questions. I'm trying to understand what MRT is fundamentally trying to achieve. There are a few things that stand out, like if you're just looking at the data in terms of gender differences with different health outcomes or different diseases. There are obvious ones like men get prostate cancer at very high levels, men commit suicide across most age groups at much higher levels than women. There are things like that.

I suppose I do feel as though MRT is trying to present things both ways, and I struggle with some of the language in here such as 'a positive bias towards women's health which excludes men's health is baked into the Tasmanian policy landscape'. I struggle with that. We've just heard from a medical GP where she quoted some quite specific numbers and her experiences as a GP, about the landscape for women that still persists where women's pain or other symptoms are regularly dismissed, belittled, downplayed by male medical professionals. That is the kind of standard framework that has been in place under a sort of patriarchal society for millennia.

Mr BEDLOE - Sure.

Dr WOODRUFF - We haven't dismantled that in the slightest. Of course, everyone's affected by that. Men have privilege in our society by virtue of being men. Sometimes that plays out very badly because it suppresses the sorts of things you're talking about - vulnerability, feelings, emotions. But in terms of what you're seeking for change to happen, I don't agree with the statement that men have not advocated well for health and wellbeing in the past. I don't agree. I think the whole medical system has been set up by men for men first, as patients first. But there are very specific parts you're drawing attention to, which are obviously correct, that there is no space and there's no real effort to provide the opportunity for men to talk about feelings and vulnerability. We know that's the blockage to being about to -

CHAIR - Is there a question coming?

Dr WOODRUFF - Yes, sorry. I suppose I'm trying to tease out what MRT really wants. I see some things here which don't quite make sense to me about the funding for women and the funding for men. I would like you to articulate it quite clearly.

Mr BEDLOE - I think what we're getting at and what I'm getting at with that statement is that there's a lot of effort going into addressing the areas where this disparity affects women, and we agree with it and we think that should happen. I think that yes, for sure, we're in a patriarchal society; I don't disagree and I think, as you said, that's not good for men either. Men have set up the health system and have created a lot of these systems and processes. However, I think to be fair, it would be with the aim of health for all without a gendered lens and that led to a disproportionally poor impact on women. I don't think it was set out necessarily to be that way.

We have focused approaches on addressing inequalities for women, as we should, and we don't really have the same drive to address inequalities that affect men, and that's what I'm really getting at, in the sense that it's baked into the policy system, not necessarily right across the board in every aspect of health, but when you look at the policy drive, we had a bit of a win more recently getting men focused on the state's suicide prevention strategy, although even within the high-level strategy document, it didn't really put any emphasis on the system focusing on male suicide; it was at the implementation phase where there's a section, so I acknowledge that.

In other areas of policy, it seems like we're not really acknowledging that there are disparities that affect men. The other one would be around heart disease, with a lot more deaths due to heart disease in people under 65 affecting men. Of course the health system's doing its best to address those, but what we're advocating for is to say there needs to be, in our view, some advocacy and policy settings that address those things where possible, not everything but certainly in some areas where there are those disparities that affect men worse, we think it would be reasonable if there's some attention put on that.

Dr WOODRUFF - You talked earlier about male-friendliness of services. It sounds to me as though your MRT is wanting services to be person-responsive?

Mr BEDLOE - Yes. I mean, ultimately person-centred.

Dr WOODRUFF - Which is not taking the person as they present, which I suppose would be great for people who are gender-diverse.

Mr BEDLOE - Absolutely.

Dr WOODRUFF - Great for women and great for men. You're not talking about needing to create new services or new programs, but to have an understanding of training for professionals so that they are person-focused, not a generic approach to dealing with the person who comes in as a patient.

Mr BEDLOE - Yes, that's probably put much better than I have. I think everybody would agree the person-centred thing would be the ideal, and what we're saying is that 50 per cent of the population are male, lots of services that are there that tend to reach women better will work really well for lots of men, and probably some services that might be more targeted at men will actually reach some women better as well, because there's lots of crossover between people of all different genders. There's lots of things we have in common. What we're saying is that we'd like to see some effort going into what male-friendly practice looks like. It's things like health promotion, it's about the conversation and how we have those conversations, what works for men in terms of creating a space where they can feel comfortable to be vulnerable - those sorts of things, in addition to what everybody's doing already.

Dr WOODRUFF - Maybe MRT already does this work with Working It Out and the Women's Health Centre and other specific organisations and culturally and linguistically diverse health organisations and Aboriginal health organisations, to look at how all of our health services can be changed, improved and be person-friendly for all people.

Mr BEDLOE - Yes. We have Working It Out and organisations like that that are doing exactly that, trying to create services, trying to support training or deliver training that helps people to meet those communities better, like Women's Health Tasmania and probably a number of other organisations. We're not wanting to oppose anything they do, we just think there's more that could be done in addition that will specifically create better support for men and boys.

Ms O'BYRNE - I want to look at the workforce diversity issue and where you see the barriers are for men entering into female-dominated areas of employment. One of the arguments we have had recently is that women don't enter construction programs et cetera, so we need to create opportunities for that. However, the areas that are dominated by women in employment tend to pay less, so is that a barrier and disadvantage for men entering those workforces or do you think there are cultural barriers still? It's just that I notice that men going into women-dominated sectors tend to progress very quickly into leadership roles, so I'm trying to understand where you think that imbalance might occur.

Mr BEDLOE - I think pay is an issue and obviously that's a problem because, to my mind, those women in female-dominated professions should be paid better and that would probably help the issue because culturally there are still a lot of men that feel they're the provider, that that's their role, right or wrong, but that's the world we still live in. There are various strategies trying to attract women into male-dominated professions, such as Keystone Tasmania, which is currently running a program around engaging women in construction and building.

Ms O'BYRNE - I think that funding has ended.

Mr BEDLOE - Right, but we don't see a similar campaign happening to attract men into the female-dominated spaces and we know that for primary school educators and early childhood educators, there's a very low percentage of males in those professions now and lots of fear around getting into that space because of bad behaviour by men in the past. Obviously there are things that need to be done to manage those sorts of issues and can be done, but if we did create such a campaign to encourage men into traditionally female-dominated professions, I think that would free up spaces in the traditionally male-dominated spaces as well for more women to enter those. To me it's the other side of the same coin.

CHAIR - But the pay disparity is quite significant.

Mr BEDLOE - Absolutely, I don't disagree. I think it's terrible and we should be paying teachers and nurses better. I absolutely, fully agree.

CHAIR - And age carers and -

Mr BEDLOE - Yes, and early childhood educators.

Ms O'BYRNE - I think the other point is that when men go into women-dominated areas, they move quickly through to leadership roles, so there is a -

Dr WOODRUFF - They become school principals.

Ms O'BYRNE - They become principals - sorry, Josh, but they become senior and move into administrative and senior roles as well, so if the argument is you can't be what you can't see, you clearly are seeing them in those roles, so what other barriers do you think might be there, other than pay disparity?

Mr BEDLOE - I think there is the fear factor around being labelled as some sort of perpetrator. I suppose it is that idea you cannot be what you cannot see, but there is a reality there is not a lot of young men going into those professions. It would be fair or a good idea for our children to have more men in those areas. There are efforts going into addressing inequality in leadership roles and I fully support those to make sure women are getting into those positions. It does not seem right at all they are not in senior positions in education, for example, in the same numbers. That does not make any sense.

CHAIR - To bring it back to health care. Nursing particularly, is a very female dominated workforce and traditionally was almost entirely female. We are getting more males involved at that level, but certainly in the medical profession, particularly once you get to special areas like surgery, they have been very male dominated, with a very robust patriarchal structure, shall we say? In terms of making the lower paid providing care in those settings or nursing, as opposed to medical specialty, what do you think needs to happen there to try to even it up and seeing men stay at that level rather than being the nurse in charge of a ward or the director of nursing or whatever? How do you see that we can attract men into those positions?

Mr BEDLOE - It is not an area of expertise I have by any stretch, but yes, we need to continue the efforts to address the inequalities there in the leadership. There are efforts going on through various Tasmanian women's strategies and the like. If we could address the pay gap, which, from my understanding, is much more about the type of profession rather than people within a particular profession, that would help. If men still feel that need to be the provider, that is another thing we need to challenge. This is where we should make paternity leave much more accessible, with strong policies and maybe another campaign to encourage men to take up their paternity leave opportunities.

That is another cultural challenge that is all part of that gender approach and need to try to address inequality. It is the other side of the same coin. We hear about driving more efforts to open up male-dominated workplaces and contexts to women, but we do not hear the opposite. We do not have those campaigns, the policy drivers or the settings to do the same on the other side. Sorry to be using 'sides', that's not how I want to portray it, men and women; we are all, ideally, partners in our community.

CHAIR - How would you see an approach, program or campaign to attract more men into those traditional caring roles, as carers or nurses or others such as childcare workers?

Mr BEDLOE - Say we had a campaign encouraging men to be carers. We could have a set of TV commercials that talk about men as carers that actually show men in those caring roles in the garments of nurses, not in the white-collar areas.

CHAIR - Or the hard hats.

Mr BEDLOE - Or the hard hats, but in the everyday nursing get-up, same thing with early childhood, campaigns imagery showing men as great carers, as people who children aspire to be. We know with the separation rates a lot of children do not get good positive male role models. Early childhood and primary schools are a great opportunity for that. Unless there is going to be some campaign and efforts to help educate young men on how they can address the perceived risk of them going into those areas, what is in place to support them to be there, whilst keeping themselves and the children safe if there are worries about abuse and the like?

CHAIR - If you go to the healthcare settings, you talked earlier about and raised the point and said 'person-friendly'. In terms of making a place where men would feel comfortable to go, particularly if it is a matter related to their mental health, we know there are some gendered issues with that, not so much mental health itself, suicide completion perhaps. Do you believe that men prefer to see men, such as mental health nurses, in those sorts of circumstances, or does that not matter?

Mr BEDLOE - It does not matter as much as we might think. I do not know the exact numbers, but I can let you know from some AMHF exploration on that, it was something like 40 per cent or may have been more than 50 per cent, were not worried which sex they were served by. Something like 20 per cent wanted men, 20 or 30 per cent actually wanted women. I do not think that is the issue. It is more that the approach to the conversation could be quite different.

For a lot of guys being asked how they feel, when they are at a point of thinking about suicide, it is not what is on their mind, they are not thinking about how they feel. They are worried about the financial situation they are trying to deal with, the relationship breakdown and looking more for solutions and ways to actually address the issue. This is why for us a lot of the efforts to improve suicide prevention service is probably actually about getting financial counsellors trained in suicide prevention, for example, or relationship counsellors. I am sure a lot of them are but, again, with a bit of a focus change we could have in the conversation on how we can support men.

CHAIR - If you are saying a male is experiencing suicide ideation, from your experience and the people you work with, they do not want someone to ask how they are feeling, they want to hear how they can fix their financial situation or relationship problem or something else? It is more of a 'fix it' thing.

Mr BEDLOE - It is a very simplistic and generalised thing I am saying. Instead of 'How are you feeling?', 'What's going on for you?', it's 'What are the situations you are trying to deal with?'.

CHAIR - That comes to the training of the people providing these services, to be aware of the gendered nature which people present.

Mr BEDLOE - Yes, that is right.

Dr WOODRUFF - For the committee's record, AMHF, was that a survey? What does AMHF stand for?

Mr BEDLOE - That is the Australian Men's Health Forum and they are a nationally funded peak body who have done some of those reports and surveys I have referenced. I say they are a peak body, but they are funded to less than three full-time equivalents.

Dr WOODRUFF - Yep. Was that a survey done nationally by some organisation or survey company?

Mr BEDLOE - I am not sure off-hand. I think that one was their own online internal survey but would have been done across their networks.

Dr WOODRUFF - I have a question about your comments on the Tasmanian Gender Budget the Government focused on. You pointed to the $28 million of services for the whole program going towards family and domestic violence services, of which you said there's no male-specific services and perpetrator programs are underfunded and do not meet demand. Have you spoken with organisations like Engender Equality Hobart, Women's Shelter or Laurel House about their views about perpetrator programs and male-specific services?

Mr BEDLOE - No.

Dr WOODRUFF - I am wondering on what kind of basis you would want to present those as needing funding, unless there's evidence. Because I have domestic violence and family violence as one of my portfolios, what I've learnt is that every good intention can lead to an unintended consequence that can make things much worse in the area of family violence. Many good ideas need to go by the wayside when speaking to people who are working every day and are understanding the small difference that something like a perpetrator program could make. Without the evidence, I couldn't imagine there would be a basis for funding that, and also without the support of those communities. I am not arguing against that. I don't have any basis to do that. My question is, what is MRT's relationship with those organisations?

Mr BEDLOE - That comment probably comes from anecdotal conversations with people from Relationships Australia, who do run at least one of the perpetrator programs. I think it's called the men's program. They have said they can't meet the demand that they've got. Again, this is anecdotal.

Ms O'BYRNE - I think it would be fair to say that no violence structure meets the demand they've got. [inaudible] … they get the same thing except it's a heavy stick response issue.

Mr BEDLOE - For sure.

Dr WOODRUFF - Why haven't you engaged with those other women-specific family violence organisations?

Mr BEDLOE - We'd love to. When we've got some time and some money to exist, as I say, most of our efforts are done on a voluntary basis. Things like putting in to these sorts of inquiries are done because we feel we're not aware of other voices that are bringing a male perspective. That's why we put a bit of effort in that. But otherwise, we're just trying to - we're not really doing much of anything, to be honest. We've set up a new program recently, trying to provide some coaching and mentoring to some men coming out of prison and that sort of thing. That's a new thing that we're trying.

Dr WOODRUFF - In the area of family violence, I suppose I'm putting a question mark around presenting it as though those programs would be the best outcome to reduce family violence without having evidence or without having engaged with the sector. Probably a necessary step in any kind of enhancing the work that's done in this area would be to engage - not that I'm telling you to do that. I think it's really important to engage with those organisations that are at the coalface.

Mr BEDLOE - Absolutely, we'd love to. Let's just leave it at that.

Dr WOODRUFF - I've got another question about the services and programs for LGBTIQ+ and CALD populations. Men and people identifying as male within these populations anecdotally report they experience poorer outcomes and less support for similar reasons to elsewhere in the system. Could you expand on your statement about that? Was that anecdotal or where did that come from?

Mr BEDLOE - That's come through AMHF - Australian Men's Health Forum. It's just the experience that we have found that men in those spaces just experience the same sort of thing, that there's a focus on women, people with other gender experiences and bodies get the preference within those organisations and that the men are often left behind. I don't have specific examples and it's not something I've had a lot of personal experience with, but I've heard it talked about that that is often the case.

Dr WOODRUFF - In an LGBTIQ+ organisation it would be the gay men who are feeling that they are not getting their -

Mr BEDLOE - Potentially, yes. I haven't spoken to Working It Out. This is based on a conversation with Glen at the Australian Men's Health Forum.

Dr WOODRUFF - I would question whether that's a significant problem in Tasmania. Maybe it is. I think a conversation with Working It Out would probably be fruitful.

Ms O'BYRNE - Two other issues. Men's Resources nationally have identified that there is a gender bias in health sectors being directed towards women. You said that due to lack of time and resources, you have not been able to gain specific evidence and stories of lived experience. I am not sure how large your membership cohort is or what your outreach is like, which might be useful for the committee, but the fact that it's not coming through as an identified feature in the range of issues that you deal with, does that indicate that it is not an issue? If men are not identifying access to health services as a barrier, does that indicate that it is not one or that there are others that are greater barriers? I'm trying to understand the disconnect there because they're not self-identifying.

Mr BEDLOE - It's more that we haven't gone out with a particular process to capture those stories.

Ms O'BYRNE - Right, but do you hear those stories?

Mr BEDLOE - I certainly do in the relationship space. In frontline health care, no, I don't hear those stories.

Ms O'BYRNE - I appreciate you've not done research and this is anecdotal.

Mr BEDLOE - However, we do hear stories that support the idea that men will seek help for a mental health issue or a situational issue once, they just don't connect and they don't go back. I hear those stories all the time. That's a male-friendliness, it's the approach, it's the welcome, it's the posters on the walls. All small things, but they all add up to people, men, going into spaces sometimes feeling not welcome or that it is not safe, emotionally safe.

Ms O'BYRNE - Our Watch is doing a lot of work in terms of all of the research done on all the things you have talked about: our cultural issues, our identifiers about the way we are supposed to behave or we're perceived to have behaviour. Our Watch does a lot of work with fundamentally changing language. Does your organisation nationally deal with Our Watch? That's very much around the language we have used to describe men, describe women, which feeds into what you are saying that men feel they have to act in a certain way and therefore are not feeling comfortable in other spaces.

Mr BEDLOE - I am not aware of AMHF doing particular work with Our Watch, no.

Ms O'BYRNE - The language there is their key framework in terms of behaviour and attitudinal change. Is there anything that you feel you haven't talked about?

Mr BEDLOE - No, I am happy with that. I'm sure there's lots more I would like to say.

Ms O'BYRNE - How big is your organisation in Tasmania?

Mr BEDLOE - We have about 20-25 members and a social media following of around 350. We email out around 300 e-newsletters.

Ms O'BYRNE - Regionally, where are you?

Mr BEDLOE - We are more southern-based, but we have board members up in the north-west and we're involved up there as far as we can be. We're not doing a lot of front-facing work with people other than the program I mentioned and occasional presentations. For example, we have done some men's health presentations focused on healthy communication in some male-dominated workspaces around the state. Often those have been statewide bodies, so we've gone statewide.

Ms O'BYRNE - You use your national resources for those, given you don't have much of a state funding base?

Mr BEDLOE - No, we charge for them. We have no formal relationship with the national body. I was involved with them in the past, so I know who they are. We're very reliant on them. We've had some state-based reports that they have essentially written and we have contributed to. They are our go-to for data and information.

Ms O'BYRNE - You're comfortable asking if they can give us some Tasmania-specific data?

Mr BEDLOE - Yes.

CHAIR - When did you actually establish the Tasmanian group?

Mr BEDLOE - We were incorporated in 2015. We had been around before that, mostly just meeting informally as mostly frontline workers, people working with men and trying to work out how to do that better.

CHAIR - That was the driver?

Mr BEDLOE - Yes, that was the driver. Counsellors, nurses, child carers, all sorts of people. Since then, I don't think it is unfair to say it's been fairly key person dependent on me. We have little bits of funding from Tasmanian Community Fund to do *The Blokes' Book* and things like that, small project-based stuff. More recently, we've started to offer talks, where we charge.

CHAIR - Are they online when you do them, not just in person?

Mr BEDLOE - Sometimes, depending on who we are working with. We try to do it in person.

CHAIR - What is the focus of those sessions? Is it a health message or is it broader than that?

Mr BEDLOE - It is health and communication. One of the main ones we've been running is how to have healthy conversations and helping men to work out how to support each other. How to have those conversations if they're struggling.

It's fairly simple stuff, but at the same time a lot of guys get a lot out of it. It's bringing things to the conscious for them. If they thought about it, they could work it out, but it brings the healthy conversation approach to the fore for them.

Ms O'BYRNE - Are you aligned with EverHim or any of those other men's wellbeing and health groups?

Mr BEDLOE - I've heard of EverHim, but I'm not aware they are still running.

Ms O'BYRNE - I think they still work in the construction industry.

Mr BEDLOE - We've had a bit to do with OzHelp in the past. They're now run by Lifeline. I am connected with Lifeline as a trainer with them.

Dr WOODRUFF - Do you think that Lifeline is up to speed with the sorts of things you have been training other groups on?

Mr BEDLOE - Yes and no. One of the main suicide prevention trainings they run is very similar to the approaches we would be suggesting. For example, they wanted to do one of their assist courses, a two-day suicide prevention course last year targeting men, and they couldn't get any men to it. Why? The messaging of getting men engaged in it wasn't right. There was an effort made, which is fantastic. I'm not a marketing person, but it didn't work. Maybe it was also about when it was offered. Disappointing they couldn't get men.

Dr WOODRUFF - What's their profile of women to men counsellors?

Mr BEDLOE - I don't know the statistics, but it's pretty clear when you look at pictures of groups that have gone through those trainings; they are about 75 per cent women, if not more, in the suicide prevention training. It's the same in the mental health first aid training I run. I'm trying to target male-dominated industries and sectors.

Ms O'BYRNE - How does that go?

Mr BEDLOE - For me, not very well because I'm not a very good marketing person. There are other people running those courses who are getting into those spaces.

Ms O'BYRNE - A lot of male-dominated companies are doing mental health first aid training for a range of places.

CHAIR - Thank you for your time and your perspective, and for raising some of those issues that matter to you and your organisation.

Mr BEDLOE - Thank you for the opportunity.

THE WITNESS WITHDREW.

The committee suspended from 12.21 p.m. to 1.32 p.m.

Mr RODNEY CROOME, PRESIDENT, EQUALITY TASMANIA, AND **Dr RUBY GRANT**, EQUALITY TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED VIA WEBEX.

CHAIR - Welcome. I think you've both given evidence to committees before, but I remind you this is a public hearing that's being streamed and will form part of our public record unless you make a request to provide information in confidence which the committee will consider. Everything you say before the committee is covered by parliamentary privilege, but outside these proceedings, that provision may not apply. Please introduce yourselves and speak to your submission and then the committee will have questions for you. Thank you.

Mr CROOME - Thanks, Ruth. My name is Rodney Croome and I'm the president of Equality Tasmania.

Dr GRANT - My name's Dr Ruby Grant and I'm a research fellow at Latrobe University and a member of Equality Tasmania.

Mr CROOME - I'll start with some opening remarks about gender equity in accessing health care in Tasmania for LGBTIQ people and then Ruby will say a few words about a study that Equality Tasmania auspiced, particularly in regard to trans affirmation health care.

Thank you for allowing us to present some evidence today to this inquiry. We're particularly pleased the inquiry is taking evidence on LGBTIQA+ access to health care and inclusion in mainstream health services in Tasmania, not only because that is an important issue in itself but because there's an increasing amount of evidence available nationally and in Tasmania about what kind of access is available to LGBTIQA+ people and what kind of bias and discrimination we experience in accessing health care.

The evidence I'm referring to is national evidence. I note that in the Working it Out submission to this inquiry, which had similar recommendations to our submission, there was a national study referred to, Hills et al 2020, which Ruby might know a bit more about because I think it was from La Trobe University, which found quite conclusively that the experience of accessing health care is much better for LGBTIQA+ people, there's less discrimination, less stigma, when they access specific LGBTIQA+ health services, or services that have inclusive practices and have consistent employer training for staff.

But I really want to talk today about Tasmania-specific research. Much of the research that's been done in Tasmania has involved Ruby and also Dr Ange Dwyer, who has been at the University of Tasmania. One study of particular importance is the Telling Us the Story report that was released in May last year. It was commissioned by the Tasmanian Government and conducted by the University of Tasmania, by Ange and Ruby.

There were a number of worrying findings by that report in terms of healthcare workers lacking knowledge about LGBTIQA+ people and the health issues we face and lacking training in dealing with those health issues. There were very worrying findings about continued discrimination and harassment of LGBTIQA+ people accessing healthcare services by healthcare professionals. There were worrying findings, I think the figure was 14 per cent of those people surveyed said they actually had to educate their healthcare provider in LGBTIQA+ healthcare needs and of their own needs in particular. Almost 10 per cent said that they faced inappropriate questions from healthcare providers and 7 per cent said their needs were ignored. And those figures, as you can imagine, were higher for trans and gender-diverse people, and also intersex people.

That's why the Telling Us the Story report made a number of recommendations that we reiterated in our submission to the committee. It was because of those kinds of findings, and the findings in the national study about the importance of specific services and inclusive services, that we recommended a funded LGBTIQA+ mental health service in Tasmania.

At the moment, the Tasmanian Government has funded a scoping exercise, looking at what such a health service might look like in Tasmania. That is an important step towards that goal and we're very pleased that that step's been taken. But, ultimately, if the current scoping exercise finds that it's feasible and that there is a good model, then we need to be talking about actually funding that service.

We are going to be talking about other LGBTIQA+ health services in Tasmania. I understand there's a move underway in Hobart to establish a clinic specifically for LGBTIQA+ people, which is an important step forward and I applaud that. But, of course, the health needs of LGBTIQA+ people across the state won't necessarily be addressed by a clinic in Hobart. We have to take into account the fact that there are probably fewer inclusive mainstream health services in the north of the state so that that health service in Hobart will still not address the gap that we see in the north and the north-west. Our recommendation, which echoed, again, the Telling Us the Story report, was also that measures need to be taken to ensure that mainstream services are inclusive, particularly training.

Training of healthcare providers is such a big project and one that has so far to go in Tasmania that the Telling Us the Story report and also Equality Tasmania recommend a staged approach where we focus first on doctors and nurses, the frontline providers who are currently treating LGBTIQA+ people in Tasmania. Then we move on to the medical school and to specialist medical service providers in Tasmania.

Like I said, the recommendations in our submission come from the Telling Us the Story report and the research that has been conducted in the last couple of years. I'm happy to answer any questions about that. Now I'll hand over to Ruby to talk for a couple of minutes about a piece of research that Equality Tasmania itself commissioned. This isn't from the Government or the university but something we did specifically looking at access to trans and gender-diverse health care in Tasmania.

Dr GRANT - Thanks, Rodney, and thank you everyone. In 2022, in my role as a board member of Equality Tasmania, I worked with some other researchers and community members to capture the experiences of trans and gender-diverse Tasmanians in terms of their experiences of accessing Tasmanian health services to medically affirm their gender. That's sometimes called transitioning. We knew anecdotally, as a community organisation who hears from the members of our community, that trans and gender-diverse people are experiencing particular barriers in terms of medically transitioning in Tasmania. We really wanted to capture that through this community survey so that we could inform and work with services and government to improve access and quality of trans-affirming care in Tasmania.

We found some critical shortcomings around the availability and perceived quality of gender affirmation services in Tasmania, which concerningly led many to seek care interstate. We have heard many stories of people going to Melbourne, going to Sydney to access what they saw as higher quality or easier-to-access services. This was a real concern because we know that trans and gender-diverse people's health outcomes are significantly better when they have access to gender-affirming care, if that's something they want for themselves. We see all across the board better health outcomes with reduced stress via quality of life when trans people have access to gender-affirming care.

We found that Tasmanian trans and gender-diverse adults face particular challenges in terms of financial barriers to care and also geographic barriers. As Rodney alluded to before, many folks in the north-west and north of the state face particular barriers to accessing services for a number of reasons, but particularly there was a perception that many of the best-quality services were located in Hobart or interstate, which is a concern.

We found that trans and gender-diverse people are wanting to access particularly sexual health or other services to affirm their gender. Particularly just general practitioners can help with that. But they found that they often faced long waitlists and delays for care, with an average of three to six months. Now, three to six months doesn't sound especially bad in the scheme of how long you can wait for certain procedures or health care. But bear in mind that often when trans and gender-diverse people come to the decision to affirm their gender medically, they have often spent years coming to terms with their gender identity and deciding that's the path they want to go down. To wait another three to six months for something that they've spent years coming to that decision on can really be distressing. In many ways those waits exacerbated mental health issues which caused greater strain on the Tasmanian health system, particularly in mental health and emergency care.

We found, concerningly, in terms of gender, that many trans and gender-diverse people weren't accessing services for gender affirmation. They often told stories of feeling like they had to present their gender or express their gender differently to be taken seriously by healthcare providers. Or they felt that they had to tell a particular kind of story of trans experience that they thought their healthcare providers wanted to hear, in order to access care, which was really dehumanising for many people and made the experience very difficult.

But we did find some good things. For the most part, when trans and gender-diverse Tasmanians do get access to good health services, their health improves and they are, overall, quite satisfied with the care they do receive, which really highlights the importance of quality health care for this community.

We found that when trans people feel respected by healthcare practitioners, they tend to have greater satisfaction with the care they receive, and that leads to lower stress levels in their lives, which is really great.

Overall, our recommendations are in line with some of the recommendations of the Telling Us the Story report, and the recommendations we are making for this inquiry.

From this project, the trans survey, we recommended that funding be increased to the Sexual Health Service to meet the increasing demand of trans and gender-diverse adults seeking gender affirmation services, with sexual health services a key place where people often go - to increase that capacity and try to address the issue with waiting lists. Also, we recommend ongoing professional development in this space to help support that community.

I'm very happy to take further questions on the findings of this survey, and the other extensive work I've done on LGBTIQA+ access to health care in Tasmania.

Mr CROOME - Thanks, Ruby. Just before any questions, I forgot to mention that a really good resource on the personal experiences of LGBTIQA+ people accessing health care in Tasmania are the Department of Health's LGBTIQA+ resources, produced in 2021. It includes video interviews with LGBTIQA+ people about their healthcare experiences, and is part of a bigger training package the Department of Health has for its employees, which I think there's been a good take-up on, if I recall correctly from meetings. The personal anecdotes there are very revealing.

CHAIR - Thanks, Rodney. I am interested in whether you see there are specific and nuanced barriers, challenges and experiences for people who are, say, gay or lesbian, as opposed to, say, trans or intersex, just to try to give us some idea whether it's the same sort of challenges faced by all, or whether different members of this community experience issues differently. Does that make sense?

Dr GRANT - That's a good question. LGBTIQA+ people do share with anybody the kinds of barriers that many Tasmanians face in terms of accessing health care - but there are certainly specific experiences that we know of anecdotally, personally, and from the research I've done for a number of years in Tasmania, showing that on top of the barriers - geographic barriers, existing issues around wait lists, issues accessing health care in rural communities - we do tend to see that LGBTIQA+ people face particular barriers to accessing health care because of that ongoing concern about inclusion, about affirming services.

It's one thing for a service to put a rainbow sticker on the window and say, yes, we treat everybody equally and we affirm everyone, but there's always still a little bit of doubt for many people because of the ongoing discrimination or micro-aggressions that LGBTIQA+ people can face when accessing health care - particularly in sensitive areas like sexual health care and sexual health screening.

In the case I was mentioning before about gender affirmation, there's a real concern about mistreatment. That mistreatment may be real. It may be something people have had personal experiences of before. It can also be anecdotal. We have a relatively small LGBTIQA+ community in Tasmania, and even just hearing second-hand stories of even the smallest little things can really deter people from wanting to even access services. Things like misgendering. Things like assuming someone has a husband or wife, based on their gender presentation. Things like that can really lead to another layer of discomfort around health services.

Mr CROOME - The different groups within the acronym that we've been throwing around do obviously have similar and also divergent health needs, so, for instance, gay men who have been living for decades with HIV, although it is no longer a deadly disease, it still can take a toll on one's long-term health. I understand from reading the literature on this issue that there's still a low level of understanding about those long-term effects of living with HIV amongst medical professionals, including in Tasmania.

People with variations in sex characteristics who have had unnecessary and non-consenting surgeries in childhood can also live long term with the negative impacts of those surgeries and, again, there can be very little understanding amongst healthcare professions about what those long-term impacts are for people who have undergone those surgeries as children.

There are different forms of prejudices, as you can imagine, which get in the way of access to health care. Often the prejudice in regard to gay men involves sexual health, there'll be stereotyping and misunderstanding of gay men. The same with lesbians, a misunderstanding of lesbian sexual health, and the issues for trans people that Ruby has already outlined, because of an upsurge, let's be frank, in antagonism and misunderstanding about trans and gender diverse issues, that can translate into the healthcare sector. As Ruby said, trans people being deadnamed and misgendered, even, unfortunately, deliberately because of this misunderstanding and fear and antagonism that seems to be on the rise, at least in some parts of the community.

CHAIR - I think it might have been Ruby who made the comment that there were some positives in some of the work that you've been doing. I think at times some of us move slowly and we attend to one matter at a time. Do you think there's probably a better awareness generally of the health needs of, say, gay and lesbian people, where there's been much more legislative reform many years ago in that space? More recently we've had gender law reform more to do with supporting transgender people. Has there been progress in those other areas? And what was that brought about by, if it was, and does the same thing translate here for trans people, and certainly intersex? Intersex has been terribly misunderstood over the years.

Dr GRANT - It's a space that's rapidly evolving and there's much more information available out there. This is something that's much more widely talked about and addressed. I still think there's a way to go. We still see in standard medical degrees, there's not a lot of focus on the specific needs and experiences of LGBTIQ+ communities across an entire medical degree, which does contribute to gaps in practitioners' knowledge, or if there's expertise in the area it's because of a particular personal interest or investment. So we're not seeing the wider uptake as we would like to see. But I think overall things are improving.

I think that's a really good point there that while there might be increasing awareness of, say, gay and lesbian health, there are other groups within that community, such as people with intersex variations, trans people and bisexual people, often left out of the specific needs that we still may not be attending to as much. But overall, I think it's fair to say that things are improving.

CHAIR - Would it be because of the education of healthcare professionals, or what's been the lever for that?

Mr CROOME - I'd agree with Ruby that there have been improvements, but we don't want to overstate them. There is still a lot of prejudice experienced by gay and lesbian people in health care but perhaps not as much as in the past. Studies certainly show that difficulties in accessing health care, including prejudice and stereotyping, are experienced to a greater extent by trans and gender-diverse people and intersex people. Things have improved and I guess it's a combination of legislative reform, which sends a very positive message to the community, and on-the-ground training. There's no doubt that there's been longer-term training of gay and lesbian health issues than there has been in trans, gender-diverse or intersex health issues. That's simply because of the visibility of those communities but there is still a deficit when it comes to every letter in that acronym.

In medical training schools there isn't much attention at all paid to LGBTIQA+ health, from what I understand. Looking at the analysis of the curricula of all the medical schools in Australia, there's still very little that's done in terms of accrediting healthcare providers when it comes to their competence on LGBTIQA+ health issues - little or nothing. Overseas doctors who come to Australia and who are welcome, obviously, may not have had any acquaintance with LGBTIQA+ issues in their country of origin, so there are a number of different issues that in terms of training and accreditation Australia needs to move much further on when it comes to every letter in that acronym.

Going back to the point on legislation that I made, there are clearly anti-discrimination laws, recognition of same-sex relationships in the law, including marriage equality and our Relationships Act here in Tasmania, that have made a significant difference in the community and amongst healthcare providers. There's much more respect, for instance, from healthcare providers towards same-sex partners than there has been in the past because the law says that they deserve the same respect as heterosexual partners when it comes to medical decision-making, for instance, particularly in an emergency situation. But it's still the case that all too often same-sex partners are ignored or there is a dispute about whether decision-making in a medical emergency should be a same-sex partner or a blood family member of the person who's in the emergency ward. That still happens; it's not like it doesn't happen anymore, even though the law says it shouldn't happen, and I'm happy to provide the committee with examples of that happening in Tasmania in recent years.

My point is that it happens less than it used to because of legislative changes and in terms of future legislative changes, what we've mentioned with the gender recognition laws of 2019, they will, over the long-term, have a positive impact on healthcare provision for trans people. If our state follows the Australian Capital Territory down the path of prohibiting the unnecessary and non-consenting medical interventions on children with variations of sex characteristics, if we do that - if we prohibit those kinds of unnecessary surgeries in the way the ACT just has - then obviously that would have a positive impact on the healthcare access of intersex people and awareness of their health issues.

Dr WOODRUFF - Thanks, Ruby and Rodney. On the practice training recommendation in your excellent report - Telling Us the Story, you talked a bit about that, Rodney, and the need to get at all levels but we've also heard from other people who presented to the committee in a similar vein that this was a GP who'd only received one hour of training in their whole degree around - I'm not sure if it was around LGBTIQ or trans and gender-diverse issues, the lot - so all of that complexity in one hour and that's not so long ago.

Moving upstream, it sounds as though you haven't directly engaged with the medical school. This is partly a Royal Australian College [of General Practitioners?] issue but it's also a local university issue, potentially, in terms of what's on the curricula and what's being taught here. Would you have any suggestions for the committee about the role of government at the Commonwealth or state levels? We can only really make recommendations to the state Government but we can consider how the state Government advocates at the federal level as well in terms of getting upstream with these training issues and engaging and bringing people up to speed.

Mr CROOME - First, if they received an hour that's probably more than most, even though it's patently inadequate. Second, I'm a long-term member of the Department of Health LGBTQI+ reference group, and I know this issue has been raised with the medical school a number of times and I'm not sure how much progress has been made, which is a nice way of saying I don't think much. In terms of what can be done at a state and federal level in this regard, I'd like to give an undertaking to the committee to provide a supplementary submission on that. Just in the last few days I've received some background information about what training is available and what accreditation is required and what governments can do about this. I'd like to have a chance to digest that and then put that in a supplementary submission to answer your question directly.

Dr WOODRUFF - I think that would be very helpful for us, otherwise you're spending a lot of time with the downstream issue when you need to start off with cultural awareness earlier on.

CHAIR - On that, if I might, do you know if that's an accreditation that's recognised by AHPRA, or what sort of accreditation process are we talking about here?

Mr CROOME - The accreditation process of medical schools in terms of teaching LGBTQI+ issues?

CHAIR - Yes.

Mr CROOME - I can provide more information about what that looks like in the supplementary submission.

CHAIR - Okay, thanks.

Dr WOODRUFF - I had a second question about pronouns and electronic data systems. It has been mentioned to us that there is so much variation within Tasmania in different electronic systems held within the public and private specialties and the mismatch with Medicare. Do you have any comment on the best way forward to fast-track some appropriate move towards consistency in the use of options for people to identify their own pronoun by which they'd like to be referred? It's a small thing but it can be a big thing and it can stand in the way of people feeling like they are heard and included. Has this come up as an issue? I assume it probably has, and other than everyone should try to do better, do you have anything more specific? Are there any conversations in government that maybe Rodney can talk about from the reference group? Is there engagement with the IT, because we are having a digital update? There's a lot of work going on and we want to make sure that it's as inclusive as possible.

Mr CROOME - The LGBTIQ+ reference group in the Department of Health that I mentioned before has been looking at this issue since the passage of the gender reforms in 2019. I'm not in a position now to give an update on where that's up to but I'm sure if you were to ask the department to provide a submission on that they would, to give you an idea of how far they've got. It is, as you've said, a very complicated issue. There's a number of different data-gathering systems that the department uses and sometimes the department doesn't gather data at all, when it should do. For instance, the department advised the Premier and Health minister that the cosmetic surgeries we were talking about before, the unnecessary non-consenting surgeries on intersex kids, didn't happen in Tasmania, and a quick search of Medicare rebates for surgeries in Tasmania showed that in fact that they do happen, because rebates are in that publicly listed information for those particular surgeries. The issue is the state department just wasn't gathering data on those surgeries, even though the federal data is there.

There's a lot that needs to change with data-gathering in the Department of Health and maybe you could ask the department to provide the information about what reforms it's undertaking. I could also go back through the notes from the reference group and provide whatever information was provided to that group about the progress that's being made.

CHAIR - Just on the coding of these surgeries and thus the rebate, you might not have this so maybe it's a question for the department, but I'm just interested in whether you've got the information. What surgeries are we talking about? Obviously, repair of hypospadias would be one of them, but is there a range that you can point to that are going on in Tasmania that are coded in such a way that this data can be collected?

Mr CROOME - Yes. I understand it's more than just hypospadias. There's a number of different procedures which fall within that category of cosmetic procedures on kids with variations of sex characteristics. I don't have the numbers in front of me as in the Medicare rebate codes, but that data is available, it's been collected and I can ask that to be provided to the committee so you can see what surgeries are actually happening.

CHAIR - That would be helpful. It might be easier to ask the question directly of the department as to how many hypospadias repairs occurred or this code occurred in Tasmania in this period of time, because then you're on more solid ground, if you like, of holding them to account.

Mr CROOME - I can make sure the committee receives that. In terms of data-gathering more generally, including data regarding people's pronouns, which goes back to Dr Woodruff's original question, is it the best thing for you to ask the department where it's up to with that, or do you want me to provide more information about that?

Dr WOODRUFF - I think we can ask the department that. If there's anything you want to pass to us for our advice and information, that would be helpful, but -

CHAIR - It would make our questioning more effective.

Dr WOODRUFF - It's not just data collection. I suppose what I was referring to is how people self-refer and how it's reported in data collection by the Government.

Mr CROOME - I'd assume that in the healthcare system and the hospital system there's collection of data about people's sex and gender and their pronouns. I can see what information is available to me as a member of that group and about where the department's up to with that and let you know.

Dr WOODRUFF - Thanks.

Mr WILLIE - It's clear from your presentation today that non-inclusive practice is creating a barrier to accessing health care. There's a lack of training available to healthcare professionals. I'm interested in whether you have any research on the cumulative impact of those barriers specifically for the LGBTIQ+ community, things like delayed diagnosis and the impact on the system in terms of the human cost but also the system cost, people repeatedly having to present to emergency departments and things like that. Do you have any specific things you could point to that you know of?

Dr GRANT - That's a good question. In terms of cumulative, not off the top of my head; it's hard because, like we were saying before about how this has certainly improved awareness of LGBTIQ+ health has improved over time, this is an area of research that is newer; particularly in Tasmania we do not have a lot of data and research that can very accurately answer that question about what the cumulative effect is. Certainly, we would know anecdotally through the work we have done for many years that there is one and it is the work we hope to continue doing now to be able to actually capture what that is. Sorry, that is not very helpful.

Mr WILLIE - That is all right. It is like the broader community - if you can invest in preventive health and get people accessing health care earlier, then it is less expensive in the long run. Is there any specific research on the LGBTIQA+ community?

Mr CROOME - Like Ruby said, that would require longitudinal studies. There would be such studies from overseas - probably, from the United States and Britain. In Australia there are some national studies conducted by La Trobe University repeatedly over a number of years that might be able to provide some indication of the long-term impact. In Tasmania, because the research is relatively new, it is a bit hard to tell. All that we can really say - we have just heard it from anecdotal evidence - is that barriers to health care, prejudice, discrimination, lack of understanding, lack of training and lack of available services in your area have an impact on physical health because people are not seeking health care when they should. Physical health problems deteriorate and, obviously, it also has an impact on mental health, because when you are in a medical environment you are often talking about quite intimate issues - issues to do with your personhood and your body - and to face discrimination in vulnerable medical situations like that can be particularly difficult and has a particularly heavy adverse impact on mental health.

I do not want to make it about me, but I know having been in medical situations where I have faced stigma or stereotyping because I am gay has been very difficult, because I want answers to medical issues. I do not want someone assuming I do this or am that just because I am in a relationship with another man. It does deter you from continuing with that particular medical professional and seeking other help, because you just do not want to be in that vulnerable situation again.

Mr WILLIE - The other thing that came up this morning was awareness within the community on where inclusive practices are and that information being available, not just through word of mouth but in more formal channels. Do you have any suggestions on improving that for the committee? We heard from a doctor this morning who was very proactive in terms of creating a list herself. She has been working with community for a number of years.

Dr GRANT - Yes, lists such as that are a really great example. This is a community who in their mind, even though we have faced many barriers to health care, many LGBTIQA+ people are incredibly health literate because they have to be. They are very well connected, so this kind of word of mouth for unofficial lists happens everywhere. There are lots of different Facebook groups where people have collated this kind of information and share. The point in your question is it is not good enough for these things to be informally collated by individuals in the community and what does that mean for a young queer person coming out who does not have those connections to community. There have certainly been more formalised versions of these kinds of lists of inclusive services and businesses and Working it Out's Signpost app is something that was trying to do that more broadly on health services, other community services, businesses and places. I do not believe that is currently being resourced anymore and something that has fallen by the wayside. It probably was not able to reach as many people and would have been great if it could. We would certainly encourage such lists being more formally provided and maintained. Lots of other state governments have official sites on their health department page that have lists like this, or there are other such resources available. Having the resources maintained and updated and also promoted within communities so it can actually reach people who need it most would be really beneficial.

Mr WILLIE - That might be a recommendation of the committee, perhaps.

Ms O'BYRNE - I had some questions on data but I think they're mainly picked up. I think what we find is that the department collects a lot of data but they don't actually have the extrapolation capacity or they collect it in such a global way that you can't get anything decent from it.

CHAIR - The new system is supposed to address a lot of that.

Ms O'BYRNE - Yeah, bullshit. Sorry, strike that.

CHAIR - As we were told at budget Estimates.

Ms O'BYRNE - Monash has a health economics unit. They did some work in this space. Have you seen any of that? Or is that something that would be worth us looking at?

Dr GRANT - Mm-mm.

Ms O'BYRNE -No? One of the things that goes into Josh's question around sometimes to explain to people why they have to change the argument about just being better isn't enough. You actually need to put some dollars on the page. I just wondered whether or not you'd see any of that.

In that case, my other two questions: In your report which came out of the knowledge, autonomy and respect report, it said that when people access a service, they've actually found it to be satisfactory, that it's worked okay. What are the defining characteristics of those services that work well that you don't see in others? Is there something structural within them, or is it simply that eventually you can, if you lobby hard enough and work hard enough, find someone who knows what they're doing? Or is there a structural thing that you can identify that fails in the others?

Dr GRANT - I will clarify that this survey doesn't have the capacity to answer that question from the data itself. Through the [loads of?] work I've done, I've done research that looks at LGBTQ people's experiences but also looks at practitioners' experiences, and the barriers and challenges they face, from some of my earlier work. I definitely think the services that do well are ones where practitioners are willing to go that extra mile and do their own research. Or they say, 'Look, I might not know everything there is to know about trans-inclusive health care, but I'm willing to do the work and upskill', whether that be through professional development or even just the individual practitioner reading up, and trying to connect with services and things like that. Having those connections to community is something we see in services that people find the most beneficial.

Ms O'BYRNE - How underfunded do you think the Sexual Health Service is? I note that one of the last lines was about increased funding for the service. You could increase funding very minimally and make no difference. What would make a tangible difference in outcomes?

Dr GRANT - I would say increasing service capacity. I don't know how many FTE there are for the practitioners, but also them increasing that capacity for the training of all the staff members, encouraging ongoing upskilling and professional development, especially around trans and gender-affirming care. The main thing is the number of services available, particularly throughout the state.

Ms O'BYRNE - Yes, I was going to ask if there's a regionality issue as well in terms of access.

Dr GRANT - A lot of our participants who are in Hobart would have accessed Clinic 60 and there's the equivalent clinics, I think it's Clinic 34. There's a clinic in Devonport and one in Launceston. I don't know what the case is for Burnie. There might be one in Burnie as well. Anyway, many of our participants, especially in the north and north-west, find it incredibly difficult to access those services if it's a fly-in, fly-out kind of basis, if the one person who provides this kind of care is only there on one day a week or something like that. There are those big waitlists.

Also, in more regional and rural parts of our state, maybe the best course of action for accessing gender-affirming care is just to see a general practitioner. But if there is only a handful of general practitioners who are known to be inclusive and affirming for trans and gender-diverse people, those people are going to book out really quickly. So it is increasing that capacity in terms of having more practitioners but also ability for those services to be operating in those places more regularly.

Ms O'BYRNE - We might get the waitlist data.

CHAIR - Yes. We had better wrap it up because we have another witness waiting for us. Thank you, Rodney, we will write to you to see if we can get some of that data around the medical coding for those procedures. Was there anything else?

Mr CROOME - Supplementary information about medical schools, about the data-gathering, about intersex surgeries, ………..[inaudible] data-gathering, sex and gender and pronouns, and about Medicare codes for intersex surgeries.

While I am talking, I just want to back what Josh said about a recommendation in regards to making information about inclusive services more accessible. It would not cost much to properly fund Signposts so that the information could be gathered about inclusive health services in Tasmania and presented there. And it would not cost much for that information to also, like Ruby said, be on the Department of Health website. It would not cost much at all and it would make a big difference.

CHAIR - Okay. Thanks very much for your time today, both of you, we appreciate it.

THE WITNESSES WITHDREW.

The committee suspended from 2.22 p.m. to 2.26 p.m.

CHAIR - Welcome to the three of you representing Health Consumers Tasmania. We appreciate your appearing before the committee. We did't receive a written submission, but we acknowledge that you are here to speak to us on your thoughts on the inquiry into Tasmanian experiences of gendered health care. It is a public hearing. Everything you say will be covered by parliamentary privilege while you are appearing before the committee, but that may not extend beyond the hearing. It is broadcast and the transcript will be prepared and published on our website at a later time, and inform our committee report. Do you have any questions before we start?

Mr LEVETT - Before we start, we'll probably be providing more of a lived experience context.

CHAIR - That's fine.

Mr LEVETT - There may be a couple of times where it's appropriate that the conversation is here or not.

CHAIR - To explain that, if there are matters that are more sensitive or you wish to keep confidential, if you could keep those parts of the evidence until the end, if you let us know when you get to that point, and you want us to take the rest of the things you want to talk about in confidence, we'll stop the broadcast and the *Hansard* will be taken in a different way so that it won't be published. If after that, you decide that perhaps there are things in that you'll happy for us to use, we can provide you with a copy of the transcript and you can make that assessment. Otherwise it won't appear as a public-facing document.

I invite each of you to take the statutory declaration, and then introduce yourselves and speak about what you want to talk to us about.

Mr BRUCE LEVETT, CEO, AND **Ms ELLEN MacDONALD**, COMMUNITY ENGAGEMENT MANAGER, HEALTH CONSUMERS TASMANIA, AND **Ms DIMITRA PAPAVASSILIOU**, LIVED EXPERIENCE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

Mr LEVETT - I am the CEO of Health Consumers Tasmania. We are a private, not-for-profit, community-base organisation. I report to an independent board. We are funded by the state Government and the federal government through Primary Health Tasmania. Even though we receive their funding, we are totally independent and we have our own voice.

A lot of our work is involved at a number of levels. We formally research the community when appropriate, through surveys or what we call 'kitchen tables'. We have a lot of deep conversations with community around health issues that they may not want to put in a survey, or there may be personal issues they are happy to talk about in a private context. They rely on our goodwill and judgment in terms of how we feed that through to committees like yours. We will act as a voice for the community when it's appropriate, but we prefer the community to use their voice when they're able to.

We train staff in how to engage with community, and we train community in how to engage with health staff. That's a bit strange, but we try to get that connection happening, which doesn't happen very well at the moment. That's all I want to say about Health Consumers Tasmania, unless anyone has any comments on who we are. It's important that you understand our context.

Dr WOODRUFF - You're a paid staff member, are you, Bruce? Or is everyone a volunteer, and how many people are involved?

Mr LEVETT - We have a staff of 12 people. We have offices in Ulverstone, Scottsdale and the Huon; we have a presence on the Tasman; we have two staff members down there. We then have a number of what we call organised groups. They're semi-structured. There's a Tasman Voice for Health, 12 self-selected community people who advocate for their community on health-related issues. We have similar groups established in Scottsdale, Ulverstone and the Huon, we're doing work in the Central Highlands, Dover, Geeveston and the west coast, so we do a lot of regional work and often work in what we call at-risk communities where if a GP leaves, they have no service.

Ms O'BYRNE - It's a very regional framework you have. Is that an element of your funding and have you done the identity of need in those communities?

Mr LEVETT - We were initially established with core funding of $300 000, which was Hobart-based, 1.5 FTE. With the current Government here, our core funding, it's not sufficient. We have some election funding that enables us to be what our charter says is a statewide organisation, so until December at least we have a reach across the state.

CHAIR - Not down the west coast, though.

Mr LEVETT - We've done some kitchen tables on the west coast but it's less advanced there in terms of getting - the council there have a fairly strong health and wellbeing group and we don't have the resources to be down there to what we call mobilise a community, to get the community to form whatever they want and then start advocating for whatever they need.

Ms O'BYRNE - In identifying those communities, is there a link between them having regular GP and health services or locums? If I look at a lot of those there, some of them are serviced by historically quite settled GP practices, but many of those are locum ones.

Mr LEVETT - It happens on two dimensions. We get called into locations where they align to our risks. The Ulverstone, Scottsdale and Huon ones were part of broader recommendations we had from government and they chose those three out of a number we provided to them.

Ms O'BYRNE - How many did you provide?

Mr LEVETT - Four.

Ms O'BYRNE - And they chose three?

Mr LEVETT - Yes. We recommended four places where we felt the community wanted us in the first instance.

Ms O'BYRNE - And you got that from your kitchen table work, or how have you identified those?

Mr LEVETT - Through the work we do in the regions, just talking to the communities.

Ms O'BYRNE - Okay. Which one missed out?

Mr LEVETT - Sorell, maybe because we're on the Tasman Council group. I don't know.

Ms O'BYRNE - I'm more familiar with Scottsdale than the others at the moment and they've got quite a number of GPs but they're historically locums, so it's that constant changeover of staff, which I think can be one of the challenges in people accessing services.

Mr LEVETT - Yes. We were particularly interested in communities that don't have a hospital.

Ms O'BYRNE - Scottsdale has a hospital.

Mr LEVETT - But not a major hospital, not one of the four.

Ms O'BYRNE - I'm just trying to get some patterns, that's all.

Mr LEVETT - Yes. Tassie's so diverse, and we're looking at the east coast as well so that's another area where we're not involved yet but if we can get some funding we'd love to be up there.

Ms O'BYRNE - You'd go everywhere if you had the money, basically.

Mr LEVETT - Yes. Our experience is that once you get outside the three or four towns, in terms of health access issues it's dire and we need it everywhere and there's only so many of us. The current Government understands there is opportunity to do health differently and they're looking to us for advice on how they can do that in those regions, but we know governments move slowly.

Dr WOODRUFF - Is your role then working with people in those communities that aren't serviced to provide some advice about how they can access services, what little is available and how they'll get there? I don't quite understand what your role is.

Mr LEVETT - Our role is to understand what their health service needs are and then we work with them to see how they can fix those needs, easier said than done. So, on the Tasman, we spent time there working in the community about what their service requirements were. They identified: mental healthcare support for young people, so they were able to get some more services down there; GP services, they got some additional hours; psychiatry, they got hours; so we understand exactly what the community wants and then we help mobilise them or empower them to advocate for those services in the region.

Ms O'BYRNE - Which comes back to your point about creating the demand that makes somebody move to a community.

Mr LEVETT - Yes, that's right.

CHAIR - So, Ellen, do you want to say anything?

Ms ELLEN MacDONALD, COMMUNITY ENGAGEMENT MANAGER, HEALTH CONSUMERS TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Ms MacDONALD - I am also employed at Health Consumers Tasmania. I am paid to work there and my role is as the community engagement manager, which is a statewide role. I got involved in consumer representation after my lived experience of bowel cancer in 2020, so I will be talking a little bit of lived experience and a little bit of what I know from working with communities across the state today.

I am based in Launceston, we are all over the place, and I facilitate the training for health staff and consumers in how to work together, particularly around consumer representation on different health service committees and groups, and also in delivering training around healthcare rights to certain groups and, I guess, supporting different peer groups where consumers have an interest or where they do not have an opportunity to connect with each other, providing opportunities for that to happen.

Ms DIMTRA PAPAVASSILIOU WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Ms PAPAVASSILIOU - I'm here today thanks to Health Consumers Tasmania for the invitation as a person with lived experience of birth trauma in Tasmania. I have been connected with Health Consumers Tasmania through a peer support group that has been established to support women and birthing people, so I will be here today to share some of my experiences in terms of my view around gendered bias and my experiences of birthing here in Tasmania.

CHAIR - Who wants to lead off now?

Ms MacDONALD - Thank you very much for having us here and allowing us to present today. We are talking about gender bias in health care and we are focusing on the experience of transgender and gender-diverse consumers in Tasmania and also consumers who are cisgendered women. I guess, from our work with consumers, the attitudinal barriers and experiences of these groups in accessing safe health care are different and can present differently, but they are sort of underpinned by the same thing, which is a preference for the male-centered, binary-gendered lens of health care and how it is delivered.

I will address barriers to diagnosis for cisgendered women because of a male lens that is seen in the symptoms or the dismissal of symptoms due to having female anatomy, gendered expectations and bias experienced by women and birthing people and around birth trauma, and the lack of understanding, the disbelief and discrimination experienced by transgender and gender-diverse communities, so, as Bruce said, we will be talking to that lived experience side of things. Feel free to ask me questions, I am not exactly sure how it works.

Ms O'BYRNE - You start, we will interrupt.

Ms MacDONALD - Awesome, great. That will be great, I will appreciate that very much.

CHAIR - Only go as far in public as you feel comfortable doing.

Ms MacDONALD - In terms of barriers, particularly for cisgendered women and accessing diagnosis, I guess I wanted to use the example of the diagnosis of ADHD in girls and women and I am not sure if it is something that has come up already here, but the diagnostic criteria have traditionally preferenced the male-stereotyped version of symptoms. It's often missed in girls and women because they don't often present as a hyperactive boy. Women have had the experience of being missed in terms of diagnosis as a child. When they have sought diagnosis as an adult, often it's still not understood.

Ms O'BYRNE - Is this when women often present with anxiety issues and they start saying they should do an ADHD test?

CHAIR - I think the same applies to autism.

Ms MacDONALD - I don't have the data in front of me but I do know that boys are more often diagnosed. There is a lot of data to show it's not as gendered as it appears due to the access barriers. There is a lot of unconscious bias in how women with ADHD are perceived. That internalised hyperactivity that often is how women and girls present with ADHD isn't very well understood. There is a gamut of access barriers around psychiatrists and prescribing, but also the interaction with health practitioners in being understood and being able to access treatment if people choose.

Were there any questions on that?

Ms O'BYRNE - Young boys are often identified so there are support structures around them. When you're a middle-aged woman who is identified through other than medical pathways, what support is provided to allow them to deal with a new reality?

Ms MacDONALD - It's sometimes difficult to access supports. If you're in the position of being able to afford a psychologist then that's easier. It can be difficult.

There are peer online groups and different spaces where people can connect with each other. From what I know, from women I've spoken to, understanding how your brain works is empowering. If you understand how you work it's much easier. There's a lot of misdiagnosis of anxiety.

Ms O'BYRNE - Is there any data on that that you're aware of or is it anecdotal information?

Ms MacDONALD - I think there's quite a bit of data. I'd be happy to have a look and send anything through.

CHAIR - The incidence of undiagnosed ADHD and autism in women and girls?

Ms MacDONALD - Yes. There is the federal government inquiry on support around ADHD and access to diagnosis.

Ms O'BYRNE - That's a broader health inquiry.

Ms MacDONALD - The other area I wanted to talk about in barriers to accessing diagnosis was from my own lived experience of bowel cancer. What I know from other women who have experienced bowel cancer is that sometimes quite obvious and very debilitating symptoms are perceived as women's issues and are dismissed.

I was diagnosed early in 2020 and was experiencing abdominal pain, iron deficiency, fatigue, changes in my bowel function. I saw three GPs before it was investigated as cancer. So, it took a lot.

CHAIR - Were you misdiagnosed during that time with other things?

Ms McDONALD - Ah, 2020, it's not very long ago.

CHAIR - It's not very long ago, with all the bowel screenings from the federal government, that's really distressing.

Ms McDONALD - I think there's multiple things at play. There's obviously my age as well because young onset bowel cancer isn't very common, and also the fact that I have a higher weight. It is very intersectional. One GP I saw just thought I had a poor diet and recommended oregano oil capsules. She told me I could get these tests done but it wasn't urgent. She was looking at my liver and not anything to do with my bowels. She did a blood test and that sort of thing, and recommended that I have a scan of my liver. She thought I had pain from my liver. Perhaps that was an assumption because of my weight, that maybe I had some fatty liver condition or something like that.

Ms O'BYRNE - Something that has been raised a bit is the assumptions about people depending on how they physically present, like 'you're very thin, therefore you must be healthy' or 'you're overweight, therefore you must be unhealthy', and neither of those two statements are true.

Ms McDONALD - No, and you can't tell just by looking at someone.

Ms O'BYRNE - But you think it impacts on the way they do investigative work?

Ms McDONALD - Yes, absolutely And for me it was compounding in some ways because of the dismissal that I had for concerns about my health in the past, and the 'lose weight' line. You start to doubt yourself and gaslight yourself in a lot of ways as well.

They found low iron and there was all of these things. The second GP that I saw because I was still concerned said it's pretty normal to have low iron when you've got young kids and you've had babies, and all of this sort of stuff. And I said it's not -

Ms O'BYRNE - Ugh - women!

Ms McDONALD - Yeah! - and you should be tired because you've got three kids.

CHAIR - Just to go back to the misdiagnosis; you identify as female. Was there then a presumption that it would be some gynaecological thing and so you've just got to suck it up because you're a girl?

Ms McDONALD - It wasn't so much that. I think the second doctor I saw made assumptions that it was normal to have the low iron and to be tired, and sometimes you do just have abdominal pain.

CHAIR - Do you think it would have been the same if you had been a male and gone along with abdominal pain?

Ms McDONALD - Absolutely not. And the low iron and fatigue. I made it really clear that it was not normal for me to have low iron. I had never had low iron, apart from when I haemorrhaged when I had my daughter but I bounced right back and was fine. I absolutely don't think it would have been dismissed in the same way.

The third GP I saw, who I saw for severe anxiety - in the back of my mind I was quite concerned about my health at this point, I had not even brought up any of the other things - but she saw the notes from before. The way I perceive it is she saw me for the person who was sitting in front of her and she said, 'What about these things?', then immediately did the standard bowel cancer screening test, an inflammation test, more blood tests. Within a week I was going for a colonoscopy and they found bowel cancer. I didn't expect to find that at all. But that is definitely the way I saw that situation, that she didn't just make assumptions. She has never dismissed me in concerns that I've brought to her.

CHAIR - Is this in the same GP practice?

Ms McDONALD - It was two different GP practices. The first one, the oregano oil capsules, was a bit outside my comfort zone so I went to a different practice after that. It's fine, some people might appreciate natural health care. I went to a different practice and the two GPs at that time, one was a locum, the other was a regular there.

Dr WOODRUFF - Ellen, is the experience you have just described something you hear in different regional communities around the state?

Ms MacDONALD - Absolutely. I think particularly in the bowel cancer space, where people would think there wouldn't be very many women in their thirties diagnosed with bowel cancer in Tasmania, but there absolutely is, it's quite a similar experience. We've heard from other consumers about dismissal of pain symptoms. You've probably heard from people around the endometriosis space and things like that. It's not uncommon and it is compounded. I think we'll talk a bit further on about the workforce issues and the lack of ability for people to have consistent GP care. That second GP I saw, I think he was going back to Melbourne and was probably wanting to wrap things up in a nice bow and say, 'You'll be all right', and pat me on the head. I think it's not uncommon at all. On paper, when you look at something as a doctor, I'm sure, when there are other reasons why this could be this way, it would make sense to relax that a little bit or to say, 'It probably is this, it's really unlikely to be that', but I just want people to see me and what I'm experiencing. I met all the clinical guidelines for immediate referral for a colonoscopy but it took a while to get there.

Ms O'BYRNE - I was interested in your experience and those of the consumers you've been engaging with. Because they've got that sort of disjointed health pathway with different doctors and not a continuity of care, do you find that people might get a suggested pathway for a diagnosis and then don't follow through with finding out about it simply because everything else is so disjointed and 'That was a stupid idea before that I didn't have that, so I don't believe I could have bowel cancer, so I'm not going to do the bowel cancer screening test'? What's our response to not getting that holistic continued level of care in terms of the advice consumers receive? How do consumers interpret that?

Ms MacDONALD - I think there is a lot of doubt that we have about our own experiences. I wrote here in my very extensive notes I have been referring to that I wondered if I was being dramatic in terms of being a little concerned about these things, or if I was overstating -

Ms O'BYRNE - Catastrophising.

Ms MacDONALD - Yes, 'Oh, I'm just a bit anxious about this sort of thing', but I had a 7-centimetre tumour in my bowel. I think that it's also difficult when you have had people in your ear about all this sort of stuff and then you experience further barriers. After I was told I needed an urgent colonoscopy I didn't have private health insurance and at that time the wait time for an urgent colonoscopy was eight months. I had the finances to pay for one privately, but if I hadn't had that, I would have waited eight months or had an obstructed bowel and emergency surgery. I think that some people who might be doubting themselves might say, 'Well, they say it's okay to wait eight months'.

Ms O'BYRNE - It's all too complex.

Ms MacDONALD - Yes.

CHAIR - Until it's not.

Ms MacDONALD - Absolutely.

Ms O'BYRNE - It's too complex, too hard to get your head around.

Mr LEVETT - To your point, the navigation is really the issue. People have enough trouble getting into the health system and once you're in the health system, navigating it is still, for most people, really impossible. The example you always get is that someone will get some advice from their GP to call someone or get a referral, but it's just too hard, or they're told to follow up and they don't know where to go, so they just walk out the door.

Ms O'BYRNE - Or they need encouragement or someone to hold their hand while they do find out.

Mr LEVETT - The navigation is just too complex.

CHAIR - You would have seen in the rural health committee inquiry, one of our recommendations was to have appointed health advocates who can accompany a patient on their journey.

Mr LEVETT - We strongly support peer workers.

CHAIR - Yes, same sort of thing. Whatever you call them, but that's that person.

Ms O'BYRNE - When you hear crisis information, your brain shuts down a little bit.

CHAIR - Yes, you only hear the first bit.

Ms O'BYRNE - It's too much to process.

Mr YOUNG - Eleanor, I think you've kind of answered this already, and it's a broad question, but how do we end up with doctor three, not doctor two?

Ms MacDONALD - I have a long list of suggestions. From my experience as a consumer representative, I think greater involvement of people with lived experience in every level will change that. There is data to suggest that consumer involvement can reduce attitudinal barriers that people experience. I would advocate for that.

The training of health practitioners, what can happen in that space, their accreditation, so training programs, accreditation, the statewide system level, the service level. Training around unconscious bias will help a lot of people because it is quite intersectional. I haven't even touched on the experience of people who have intersections - women who are Aboriginal - understanding how we engage with people changes the way we're engaged.

Ms O'BYRNE - I dealt with a neurologist who ended up having a brain tumour. She presented as a consumer to her professional body and they were genuinely shocked about her experience as a consumer even though she was a practitioner. There's a massive shift.

CHAIR - Patients are different from professionals.

Mr LEVETT - People forget what it's like to be a patient, even GPs. I've had a GP almost break down in my office because the specialist wouldn't believe her interpretation on what course of action she should have. The specialist, bloke, just said, 'No, this is what I'm doing, I'm not going to follow what you're suggesting'. That meant that she had to start again and get care in Victoria.

CHAIR - Completely disempowered.

Mr LEVETT - This is a GP, who's completely disempowered. If that happens to GPs, people like me who have no health background have no chance. Then you talk about women, less chance.

Mr YOUNG - Maybe the days are gone, but when I was a kid, I had a doctor from this high to this high.

Mr LEVETT - I'll cut in there, I totally agree and that's a myth now. The industry still says this is how the system works. For most people it's a myth.

Dr WOODRUFF - Even if you want to stay with the same person, they move.

Mr LEVETT - That's right. My GP moved, so I moved with my GP, but the notes she had on me stayed with the building.

CHAIR - There is a mechanism where you can ask for them to be transferred.

Ms O'BYRNE - Once again, you have to know.

CHAIR - But you don't even know that.

Ms O'BYRNE - Does the data show something like only 20 per cent of people have a regular GP? It's a really low number.

Mr LEVETT - There are lots of numbers. It's less than 50 per cent, which is what I'd quote.

Mr YOUNG - That cuts out one of the things where I guess you're not being believed as much. If they've been seeing you since you were -

Ms O'BYRNE - They know you're different.

Mr YOUNG - Because they know this is different.

Ms MacDONALD - Yes, but doctor three I'd never seen before either.

CHAIR - We will go back to your experiences again, if that's all right, just so we can keep on track.

Ms MacDONALD - Just reflecting on what Mr Levett was saying about the disempowerment in the system, that was why I wanted to get involved in consumer representation, because of my experience. I had a background in disability advocacy and felt quite capable of speaking up for myself. I felt thrust into a system that was just not made for me where I had trouble speaking up. I was taken aback by my lack of power and control over my own situation and ability to speak up for myself. Often you do and you're pushed back down a little bit. I did have other recommendations, but we can probably -

CHAIR - If you want to go to Dimi and then we'll come back to the recommendations?

Ms PAPAVASSILIOU - I don't know where to start. Where do we start with gender bias and birthing?

Dr WOODRUFF - In 1431, when guilds started and women were getting hanged for witchcraft. The first woman hanged for witchcraft was a midwife.

Ms PAPAVASSILIOU - My whole experience is hard to explain and to put into words, really. Where do you start? It's so convoluted. I think that does actually reflect what having a baby does to you in the sense that it's really complex, and there's lots of different things that impact it.

I guess when we talk about these areas, we can start off with antenatal care and how that kind of experience was for me as a person. Look, mine was really cut up and I think also that may be a bit of the experience here of people who have come from the mainland. I experienced most of my antenatal care in NSW - a typical public hospital experience in terms of those standard blood tests and ultrasounds. I had one GP I'd seen for quite a while, so I had a really trusted relationship with her. She had lived experience of mental health with an anxiety disorder, so she had gone through that with me, and kind of knew how to work with me.

As soon as I moved to regional Tasmania, to Judbury in the Huon, which is about 50 minutes from the hospital in Hobart, I was like, what am I going to do? We decided to go private - so I had intended to have a home birth but was transferred here to the Royal and gave birth at the Royal.

Just from the get-go, I think antenatal care is very gendered. Nothing happened to my partner; everything was happening to me. I was the one getting the ultrasounds, going to appointments. All the GPs and specialists were directing questions to me, nothing to my partner, and I felt like that was a really - from there, it just sets up what's the expectation of birthing. I was the vessel, and my partner, a man, was just in that journey somehow and I was to relay all the information to him about my pregnancy.

Ms O'BYRNE - All the responsibility, and therefore, blame.

Ms PAPAVASSILIOU - Yes, from the get-go, exactly. Even genetically, with blood testing, they're testing us, they're not doing blood tests on your partner for anything. It's all about yourself, and obviously I guess they're testing for the baby, for that interaction, but from the get-go, I think it's a very gendered approach that we present with birthing in general, and in terms of pregnancy and that whole experience.

I really feel that with my mental health, it could have been so much better cared for and recognised. My old GP told me to get off my Lexapro, because he thought that it would cause issues with the baby. I originally went to him to check my blood to see if I was pregnant because it was a Saturday and my female GP wasn't open, and he was like, get off the Lexapro, and I was wondering if that was okay, and then I went to my female GP and she said, just stay on it if you want to. You know the risks, the risks are not high, lots of people take antidepressants - SSRIs - during their pregnancy, that's up to you in terms of your mental health and where you want to go with that.

She also recommended that I stay in touch with my psychologist, which was really lovely in that whole process. But I found it interesting that the male doctor was like, get off the Lexapro - the baby, the baby. And I felt really bad, like that was a terrible thing and I was taking something that was going to hurt my child.

I'm not going to go into my whole birthing story because it's very complex, but it did cascade into a lot of interventions that turned into what I would say were very traumatic experiences for me and my baby. Sorry, I'm going to cry -

Ms O'BYRNE - We have tissues.

Ms PAPAVASSILIOU - Thank you. I think I suffered quite a large postpartum haemorrhage, as well as perineal and vaginal tears, which led to more excessive bleeding - so I thought I was going to die. The whole process itself was not good. It was very - it's so hard to explain.

CHAIR - Take your time, that's all right. And stop any time you need to.

Ms PAPAVASSILIOU - Thank you. I definitely was very much coerced and bullied into different interventions at the time, and I really felt disempowered through the whole process, which I think really amplified my traumatic experiences, both physical and psychological.

Ms O'BYRNE - Was it everyone? Did you find or was it such a whole lot of information and demand at once?

Ms PAPAVASSILIOU - It was just messy and I think that whole process of doing a home transfer was extra messy. Because it was happening over days and my blood pressure was going up, but at the time I wasn't screening for any pre-eclampsia. But because of that and I was already 40 weeks and over, they were just like, we've got a room, let's just induce you. I didn't want to be induced, that wasn't the intent. I said I don't actually have pre-eclampsia, and they said, 'No, you could just have hypertension because you are a bit higher. You are already 40 weeks, why don't you just give birth, why don't we just induce?'

Ms O'BYRNE - Because we don't actually know how pregnant people are, still.

Ms PAPAVASSILIOU - It's a gap, 37-42, I could give birth anytime between then, it's not like it's a day and it's going to come out. That is another argument that we could have with the health professionals. They gaslight you into believing that you're crazy. I had things thrown at me like, 'Your baby could die', all sorts of nonsense to be coerced into doing things I didn't want to do. I felt very disempowered during the whole birth. On top of that, the postpartum care, it's been two years now, and I am still being diagnosed for my pelvic floor injury because it was, from my experience, just this disconnect again, that I was told I should see a pelvic floor physio. Your debrief is up on the table with blood under me, and they said, 'You need to see a pelvic floor physio - bye', and that was their debrief. We explain how trauma reacts with people. I shut out all of that. I had no idea what was going on.

Even in the hospital, I told them that I'd had a traumatic experience, so what do I do? There was no information or referral to anything. I had to go privately. I couldn't afford it at the time. Then someone on a Facebook group happened to tell me about the pelvic floor physio community continence centre. I thought great, now I can go and see someone for free and there was no referral.

CHAIR - There was no direct referral from their obstetric unit?

Ms PAPAVASSILIOU - They just told me to go see a pelvic floor physio.

CHAIR - They didn't give you a direct referral though?

Dr WOODRUFF - They didn't actually organise it for you?

Ms O'BYRNE - Dimi, did they just send you home?

Ms PAPAVASSILIOU - I spent three days in and then they just said, 'It's up to you'. I was like, 'Do I need to be here?' They said, 'We don't have enough blood, we can't give you a blood transfusion, so you have to make it up - eat greens, eat mushrooms, eat red meat, okay?'

CHAIR - They actually told you that?

Ms PAPAVASSILIOU - Apparently, they had a low supply and they have to prioritise and they were just like, 'Well, we're just going to say what we see in your blood test now, we can say it's okay, but you need check within a week because it takes a while for your red blood cells to show what's happened to your blood'.

CHAIR - There is a lag.

Ms PAPAVASSILIOU - They were like, 'You look okay'. So, I went back to the GP and I had insufficient - I was very tired. They ended up dismissing, no connection to any outpatient services. I was lucky, my protective factor was my mental health. I understood my mental health and I went to the doctors to get a psychologist appointment now, because I knew I wasn't well.

Dr WOODRUFF - That would have affected your relationship with yourself and your child -

CHAIR - And your partner also, I imagine.

Dr WOODRUFF - Which is the potential cascade for longer-term recovery.

Ms PAPAVASSILIOU - I still can't talk about it very well without crying. I still see a psychologist and I think something that has been really helpful here and I feel a big missing factor is that there is lots of good clinical care turning up around traumas, such as EMDR, sort of the rapid eye movement, but it's actually very hard to find someone who does that here in Tasmania. I was lucky to find one and privately pay for it but I couldn't do many sessions and it's not as simple as going in and doing it, you might have to have something that someone does, just do different therapy beforehand.

CHAIR - Stop just for a moment. Did you want some of this to be in camera?

Dr WOODRUFF - Because it's all being telecasted.

Ms PAPAVASSILIOU - I'm okay.

CHAIR - Yes?

Ms PAPAVASSILIOU - Yes, thank you.

CHAIR - Just let us know. You talk about this being a gendered thing, and obviously childbirth is quite gendered, but how do you see the system needs to change in order to recognise and appropriately treat some of these things? If another person - whether they're male or female but particularly if it was a male - had a massive bleed and required lots of suturing for whatever the injury was, do you think they would have been sent home with potentially a falling iron level, as well as going home to look after a child or children? Do you think that would happen, and if you don't think it would happen, what do we need to do? We want to make recommendations about making things better for people like you and Ellen as well, and there are many others out there. What would that look like?

Ms O'BYRNE - Before you go to that, within your frame of people that you support, are there other non-cisgendered women who are having that kind of ignoring of their treatment? It's really hard for you as a consumer to say it would never happen to anyone else, but you would have spoken to vast numbers of people.

Mr LEVETT - We did a kitchen table and I won't mention the location because that will identify their work, but there were five women under 35 and their lack of trust of the system meant they would not go to see their local GP, full stop.

Dr WOODRUFF - Because of an experience like this?

Mr LEVETT - I'm not sure, there were just trust-triggering issues which would not enable them to go to see their GP.

Ms O'BYRNE - So this is a small community with a GP, rather than a large community with a range of GPs?

Mr LEVETT - Yes, that's why I won't mention the location. I understand that for at least one, maybe two, the only interaction they had with the health system was with a home birth that went wrong, so they ended up in hospital. They would push and push and push to not engage with the system because they didn't trust it.

CHAIR - Some of them were free birth and that's even more risky, sadly.

Ms MacDONALD - In terms of non-cisgendered women, in terms of the birth space, I think non-binary and transgender men are not represented in almost all, in my experience, documentation that comes from health services, even in accredited training programs for health practitioners in oversight and accreditation spaces. I think that you're not even acknowledged as existing is problematic, but I know that we provided a PowerPoint presentation with some information from transgender and gender-diverse consumers on the access barriers they experience as well, just the treatment that people receive and the curiosity is a barrier.

Ms O'BYRNE - I was just thinking, because Ruth's question was around a man who had a haemorrhaging bleed and what the response would be, have you had haemorrhaging men as consumers say they were completely ignored?

Ms MacDONALD - I haven't, not that I -

Ms O'BYRNE - Is it a failure of the system overall or is it -

CHAIR - We are going to run out of time so could we go back to how the system could be better at trying to avoid these things in the first place? In an ideal world you would get a magic wand, so where would you wave it?

Ms PAPAVASSILIOU - It's a hard one, because speaking to what Ellen said before around access, you are made to think you're mad, or things are normal, like holding your baby and because you're holding your baby, you pee your pants. That's normal? It was like I was being gaslit. I'm being told I'm crazy, basically. I think it's a bit of that attitude of staff, as Ellen spoke before about around unconscious bias and understanding how that can form your opinion, or how you react to someone when you see them is a huge factor that could be really helpful from a birth trauma perspective, even understanding trauma and how that presents. I think it was acknowledged, I can see it in people's faces that people know birthing can be traumatic but they don't know what to do with it.

Ms O'BYRNE - It's normally traumatic.

Ms PAPAVASSILIOU - Yes. It's like, 'Oh, you bled a lot'. One midwife told my partner, 'People always bleed during birth', and then the other midwife we saw later was like 'No, what you went through is actually quite extraordinary, that's not a normal thing, that's why your body is reacting like this', because it also impacted my breastfeeding. All these consequences are part of that. I just found that these things are kind of normalised when they shouldn't really be. It's hard because could training solve that? I don't know. Some of it is so societal and so culturally ingrained in the way that we work.

CHAIR - Do you think trauma-informed practice could -

Ms MacDONALD[?] **-** God, yes.

Ms PAPAVASSILIOU - What does it look like in someone?

CHAIR - That's why I'm asking, yes. Did you successfully breastfeed your baby?

Ms PAPAVASSILIOU - I got there.

CHAIR - You got there, but it was really hard?

Ms PAPAVASSILIOU - I persevered. It impacted me so greatly. I felt like I had to, because for me that was me persevering. I was just lucky I had the support; I have a great partner who supported me. A family member came down; we're quite isolated, we don't have family here in Tassie, so we relied on people to come down. I think that would work in any setting. If everyone was able to see that people carry trauma, even childhood traumas, they're things that we really need, and I think that early-on discussions when people get pregnant, just screen it around previous pregnancies.

CHAIR - I might go to that point. I'm a midwife by profession but I worked with a caseload model, which provides continuity, so you start from the beginning. From your perspective as a consumer, what does trauma-informed care look like during the antenatal period and during the labour and birth and postnatal period? They're three different points, obviously. What does it look like?

Ellen, from your experience too, because obviously you were traumatised by your whole experience too in a different way, but what does it look like?

Ms PAPAVASSILIOU - I feel for me it's relational, so having a really good relationship with all your health professionals. It's not just your GP, it's not just your midwife, it's a collection of people and they all need to have a good relationship. That was something I felt I lacked in some spaces and I wish I had the feeling of safety that, because it's relational, they know me. They make me feel safe in the way that they interact with me, the way that they might talk or the space that they give me through my whole experience, but also [inaudible] the principles of trauma-informed care, empowering me to make decisions, giving me information that's evidence-based. There's so much bullshit within the birthing space around what's evidence and what isn't. I think that's something that's really lacking, so that we can make informed decisions, not for the health professional to make a decision for me. That would have been amazing in terms of having that.

Dr WOODRUFF - Giving you agency.

Ms PAPAVASSILIOU - Yes, being informed enough to make decisions that I'm confident with. I feel like sometimes health professionals think that we're going to make stupid decisions. We don't know everything.

CHAIR - Even today?

Ms PAPAVASSILIOU - We all want the same thing. We all want the safety of everyone, not just the baby, but I want the safety for myself. Is that a selfish thing to ask for? I don't think so.

Mr LEVETT - Going back to your peer worker concept and the fact that the content was found on Facebook, we are seeing more and more people being forced online for health advice, which can -

CHAIR - And all the risks associated with that.

Mr LEVETT - So for us it is, how do you have that information that could be presented safely for people to be able to look at in a way they can understand and read, and then be able to make decisions? That is where, for us, a really good -

CHAIR - And Facebook groups aren't necessarily therapeutic.

Ms MacDONALD - Can be very triggering, I think. Don't want to go into that rabbit hole.

Mr LEVETT - In terms of solutions, it is how do you have that referral process that is safe, that is targeted -

Ms MacDONALD - Co-designing it with people like me who understand what the experience is like will always be better. We can hear about people's experiences and then go away and think that we can come up with solutions on our own. But it doesn't work because it is not really going to reflect what will work for people, even how the information should be shared. We have found across the state, people want to hear information and receive information in different ways.

We were talking before about consumer experiences around birth trauma. We have heard experiences reflected across all different models of care - it isn't just one particular model of care or another. I think it's all come from a place of people not feeling like they have agency and not really being listened to about what their preferences are.

Dr WOODRUFF - I just wanted to go back because it is very concerning what you said about those clusters of young women under 35. That's really horrifying. I fear that you probably may agree that that's not just necessarily an isolated community where that is happening. I could imagine, from what I have heard about the pressures on young people and particularly on young women and men, but especially women who have survived childhood trauma and abuse, that there are many reasons, particularly sexual abuse, why young women wouldn't want to go anywhere near a health professional.

Is there any suggestion or proposal to go out and reach into those communities? You obviously did a good job of connecting with people like that in the first place. What do we do about people like this? They are so isolated and in so much danger.

Mr LEVETT - There are a number of layers to that. One is trust. The community is losing trust in a lot of institutions and, unfortunately, health is an institution in which the community is slowly losing trust. Is the ambulance going to arrive on time? Can I see my GP when I need to? There's a whole lot of factors around that. That is a really hard question to answer. The other side is -

Dr WOODRUFF - Sorry to interrupt but they were saying they weren't going to access. That is another issue as well.

Mr LEVETT - We think the health system needs to be reframed. How do you move a primary care system into the community that is developed, designed, sometimes driven by the community? They will tell you whether they need an extra youth mental health worker or they need something else, not having three different service providers providing the same service to that community. How do you delegate that decision-making to communities? We think it is easy but the system won't allow it.

Dr WOODRUFF - This is a model that has been developed in Victoria, that has been piloted in Victoria.

Mr LEVETT - We are talking to cohealth in Victoria. We think it is possible. We think we need to move into what we call a preventive space rather than a 'fix it' space. We can't stop fixing it because that is the health system. But how do you build a preventive system so that people - doesn't matter who they are, doesn't matter their background, what they believe - can walk through the system and stay as long as they need to? Everyone will want to feel a different level of wellness. That is really strong research for us.

We would advocate that everyone has a free health and wellbeing check as least twice a year. We don't understand why people, when they're young, 0 to age 2, get checked all the time and then something stops until they get to about 40. At 50 you start getting letters about being tested again.

CHAIR - Unless you are pregnant.

Mr LEVETT - Unless you are pregnant, yes, there are times where that changes. But for the general populace, we don't care about their health and wellbeing from the age of two.

Ms O'BYRNE - Other than crisis.

Mr LEVETT - Yes, other than crisis. We argue that it needs to be completely reshaped. I don't think it's an easy thing to do but we believe it needs to happen.

Ms O'BYRNE - And it's not a place-based thing, it is a person-based thing.

Mr LEVETT - Person-based in their place.

Ms O'BYRNE - It's very much about the person's needs.

I want to ask about that agency and the lack of agency that certain parts of our community often identify in health care and many of our engagements. Is agency an issue across the board, or is it an issue for sections of your consumer base that you work with? Depending on whether you're a woman, if you are transgender, does it get worse as you go along?

Ms MacDONALD - Absolutely. Depending on the biases that are there, whether or not you're believed. I guess some of these reflections that I had from transgender and gender-diverse consumers and their experience of, 'Oh, you have mental health problems because of your gender identity', rather than understanding what the situation is and the support that people need and the discrimination that people face, and how that can impact people's mental health. Or even being disbelieved about their gender identity. Particularly for people with a disability, it is not uncommon. It depends on the intersections in people's lives.

I also think that our health system has come from and continues to be this 'doctor knows best' kind of space for all people. Often, it is hard for people to speak up and understand that they have rights. Then, even when you do know these things, when you go into the spaces and you are treated in a way, it is really hard to speak up. It is something that probably everyone could experience but different groups of the population are more adversely affected, for sure.

CHAIR - We only have a few minutes left but are there things you want to tell us in camera that you think would be helpful for the committee to understand?

Ms MacDONALD - I am happy to share because I have a long list of recommendations for lots of different areas but I think we've covered most of it.

CHAIR - You're very courageous sharing some of your experiences. It is not easy. Thank you for being so open. If you're happy to send through the recommendations, that would be great, and we may come back to you with further questions.

I will also say to all three of you that if there are other individuals who want to speak to the committee, even if they want to do it in an entirely confidential manner around the gendered nature of bias they have experienced in our healthcare system, we would be happy to hear from them. They can be assured of their privacy and respect for that, if they are concerned about that. If you want to pass that through to your networks because we will be a while doing our work here. As you've both identified, the personal experiences, which is what this is about, come from personal interactions and we need to try to understand those if we are going to actually do anything about it.

Mr LEVETT - We can reach out to a couple of groups but I guarantee they won't come to a room like this.

CHAIR - We can meet them in an off-site location. We will record it so we have a record but that will never form part of the public record. The way we treat private and confidential submissions is that we do record them, they are transcribed but not placed anywhere public, and they are locked in the Clerk's office so they are quite secure.

Ms O'BYRNE - People might be comfortable jotting down some things if they don't want to be identified. However, it is easiest for them to tell their story.

Ms MacDONALD - Can they do it over the phone?

CHAIR - Yes, they can.

Ms MacDONALD - What is the time frame?

CHAIR - Well, we have a way to go. There's a winter break coming up and we don't do a lot of committee work because people try to have a break and there's school holidays. We also have to hear from other witnesses. We still have the Government to hear from. Do I mention the war, but if there was to be an early election the committee work would have to stop at that period anyway. It might take a while to finish our work.

Dr WOODRUFF - Don't mention the war.

CHAIR - There's plenty of time. Thank you. Is there a closing comment you'd wish to make before we wrap up? I know I cut you off a little bit. I'm conscious of that.

Mr LEVETT - As a last comment, a lot of our research shows that people's health and wellbeing is based on their ability to do what they want to do.

CHAIR - Self-determination.

Mr LEVETT - Yes. The case I use is a 60-year-old bloke who gets up every morning and buys his packet of cigarettes and a paper. He can walk to the store to do it. He goes home, has his cigarettes, reads his paper. He's healthy from his perspective.

It's about how we look at where people are at; how do they gauge what's important for their health and wellbeing and then how do we factor that into what course they choose to take? The system does not talk to the individuals, because they talk through their perspective of what health and wellbeing is and they don't look at it from an individual perspective up. That's a comment to leave on the table.

CHAIR - Thank you very much, I appreciate your time.

THE WITNESSES WITHDREW.

The committee suspended from 3.32 p.m. to 3.35 p.m.

CHAIR - Well, thank you both for appearing before the Joint Committee on Gender and Equality's inquiry into Tasmanian experiences of gendered bias in health care. I thank you for your submission. I think both of you have appeared before committees? I'll just go through the procedure then. It is a public hearing. It is broadcast and the transcript will be prepared and published on our website at a later time, and inform our committee report. Everything you say here is covered by parliamentary privilege; that privilege may not extend beyond the committee hearing, so keep that in mind. It will be public unless you make a request that you provide evidence in camera, and the committee can consider that. I think you might have heard my explanation of how that is treated. Do you have any questions before we start? I will ask you both to take the statutory declaration and invite you to introduce yourselves and make an opening statement. We appreciated getting your submission earlier.

Ms ADRIENNE PICONE, CEO, TasCOSS, AND **Ms MEGAN TAIT**, TasCOSS, WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED

Ms PICONE - Our work at TasCoss as the peak body for the community services industry focuses on how we can support all Tasmanians, particularly those at risk of being left behind or currently experiencing disadvantage. We know many Tasmanians experience poorer health outcomes than people in other places in Australia, and that many people in our community struggle to access the health services they need. We also believe changes are needed to better support our community organisations, including our members, who support Tasmanians with their healthcare needs.

Gender bias, which refers to the practices or beliefs which may favour or preference the experience of one gender over another, can significantly impact our ability to receive timely, effective and appropriate health care. All of us can experience gender bias, but the effects can be significantly more detrimental for those who are already experiencing poorer health outcomes, or may have already been struggling to receive the supports and services that they need.

In our response, we've chosen to highlight the experiences of three communities who we believe are particularly vulnerable to the impacts of gender bias in health care: Tasmanians with disabilities, LGBTQIA+ Tasmanians and those from culturally and linguistically diverse communities. To address the needs of these communities, we strongly support the development and delivery of specialist health services, as well as targeted initiatives to promote access to healthcare services.

However, as gender bias stems from beliefs or attitudes about gender, we also strongly believe there is need for community-wide education and support. This includes more comprehensive training for healthcare providers to increase their awareness of gender bias and how it may impact their work, as well as greater opportunities for diversity and inclusion training across the community sector, including but not limited to health and allied services.

We also strongly support the development and implementation of initiatives to promote the rights of all Tasmanians to adequate health services and universal good health, including preventive health measures.

Finally, we believe the eradication of gender bias will be greatly assisted by the development of a rights-based framework to affirm the rights of all Tasmanians, which should include the introduction of a Tasmanian charter of rights to ensure all Tasmanians can live a good life.

CHAIR - There has been a recommendation by other groups that there be specialist services. Predominantly the evidence we've received to date is around specialist services for members of the LGBTIQ+ community because the current range of services aren't seen as inclusive for many of them. Rodney Croome and Ruby Grant were speaking to us earlier. They were talking about a centre in Hobart, which is great for people who live in Hobart, but how do we ensure that the varied and many members of different communities who live around our state can have their health needs met?

Ms PICONE - I would say yes, and. Yes, we would support specialist services. But I think it's broader than that. What we really need to be focusing on is more about inclusion and diversity training. So, really it's about how we ensure all services are accessible, that there's a lack of bias, both conscious and unconscious, from service providers, but how we can better educate medical professionals and the wider community and we would say, yes, specialist services but really, our focus more broadly, I think, needs to be around health literacy.

CHAIR - So whose job is this?

Ms TAIT - Just adding to that, I think it's interesting to think about those two things, the diversity and inclusion training and then thinking about educating people. I think it's really interesting, that evidence that we just heard. It's not just about a system that's responsive, it's about that really important preventive health. I think so often, so many of our services rely on people having knowledge and the ability to articulate that they're experiencing a particular type of issue and then knowing where they can access. That's actually quite a degree of information and capacity that you're relying on people in our community who are really struggling. So if we have systems that are not requiring people to be always responding to crisis situations, but rather we're having a system that's embedding those health checks, embedding that practice of being able to recognise when you or someone close to you isn't doing so well, I think that would be a much more effective way of designing a service.

Dr WOODRUFF - Adrienne, you said health literacy, what did you mean then? Did you mean that's different from sort of inclusion and training - that's another thing?

Ms PICONE - It is different but it's actually not dissimilar from what I was hearing Bruce talk about, the previous speaker, which is around agency and self-determination. I think part of health literacy for me is one, it's about individuals understanding the system and they're understanding their own health needs and being able to access that, and make those well-informed decisions, but it's also about organisations understanding their own responsibility within the system to define that.

Ms O'BYRNE - When you were saying about the system that we need to have, how deep do we need to design this system, how do you go about that? Where is our first point of call? Is it the higher-end medical services or is it about empowering people in those sort of day-to-day interactions that you might have? Where do we go in terms of redesigning a system?

Ms TAIT - I think that there's several places that you can go. I think first of all, the recommendation that you engage with communities directly to talk about their needs is really important. So for those three cohorts that we've explored in our submission, I think there's a real need for people to be engaging with people from those priority cohorts to talk about what their needs actually look like.

There's been a lot written about this already. We've had an entire royal commission into disabilities, so there's a lot of material there. We can already access information about some of the unmet health care and social needs that are already being experienced by that population. There's also a need for community-wide training as Adrienne was saying in diversity inclusion, which is a different issue.

CHAIR - Whose job it to deliver this? I'm just interested in who you think is best placed to deliver it and at what point.

Ms TAIT - I think it's probably best delivered in community and in collaboration with community organisations that already have well established links to their own communities, the people in their community and also trust within the community. That will be particularly important for populations that might not have a great deal of trust in institutions.

Ms O'BYRNE - In a world where people are becoming increasingly disengaged and isolated, how do we then systemically deal with that? If you're a member of an organisation, you've already identified that you have a need and that you want to work with people and you understand the need for that collaboration. If you are completely disconnected, and we have so many people now who are feeling that way, where do we start with that? How do we create that connection?

Ms PICONE - With people who are just isolated, disenfranchised, not able to access the services?

Ms O'BYRNE - Who are often the ones, when they get to the health system, things fall apart very quickly because they've not had any framework before they've got there, and then they've met a very autocratic response from the health system or a non-listening response from the health system.

Ms PICONE - Surely that comes back to some level of reasonability within the health system and with the service providers themselves in terms of the training that they undertake, the attitudes.

Ms O'BYRNE - So, systemwide training?

Ms PICONE - We all have various degrees of bias, both conscious and unconscious. I think part of that is recognising that and working on ways to overcome that. I know there's some great training already happening here in Tasmania and I think that's something we could do a lot more of. TasCOSS also has a program around health literacy. We work with organisations about their health literacy and the way they engage people within the organisation and engage clients. There's many layers; it's not just government's responsibility.

Ms O'BYRNE - If we're rolling something out, how deep do we need to be to have the best effect?

Ms PICONE - Yes, and have that commitment to preventive health as well, rather than just waiting until we end up in emergency, but really thinking about how we view health. We know from talking to Tasmanians when we're doing our Good Life [Initiative?] work that it is front and centre on everyone's minds. If we don't have good health then we really can't do anything and I think that is really in front of people's minds a lot at the moment.

Ms O'BYRNE - For schools and sporting clubs and things that people are often engaged in when they're younger and then they turn 16 and disengage, the role there is obviously a lot greater.

Ms PICONE - Yes. We do health studies for a little while but it's seen as a subject, not a life. You were talking before about people who are quite isolated and I think at the moment we can't talk about health without talking about the cost-of-living crisis. This is an unprecedented crisis we're experiencing right now and people are not just struggling to get a roof over their heads but actually get food on the table, so health often comes right down the list of priorities. If you're in survival mode because you haven't got somewhere to lay your head tonight, health then becomes something outside of that.

Ms O'BYRNE - If you're a parent you're usually prioritising others than yourself.

Ms PICONE - We hear that a lot from particularly mothers who say it's so expensive to go to the doctor that they will send their child to the doctor or dentist because they would just not prioritise themselves. Transport is another part of the equation in that people just can't get to the doctor for those follow-up visits or get the sort of help they need when they might need it in that preventive space. I think it's part of a bigger conversation; I don't want to isolate that one part of it.

Ms O'BYRNE - We deal with health episodically and that inability of us to have a lifetime pathway - I hate the word 'journey', but we all have a health trajectory - and yet the only times that we systemically and structurally respond is in episodic needs ….. [indistinct] rather than that sort of long-life wellbeing - how do I keep well, how do I know what wellness means for me, how is my wellness different from someone else's? That's how we build a proper preventive framework, but where do we start?

Ms PICONE - Not just seeing the doctor or dentist when there's a crisis but actually investing in our own and our family's health, yes.

Mr WILLIE - You touched on cultural and linguistically diverse communities and my electorate has quite a few. There are obviously the gendered barriers to health care but there's also culture and language, so it's almost a double whammy. Have you thought about how to activate more of that community-based health care you're talking about? I think a couple of years ago the Bhutanese community organised for a dental practitioner to be part of a cultural festival to help check people's dental care at that event, because there are a lot of elderly community members and dental care is a particular issue for them. Have you thought about the sorts of ways you could activate more of that? They tend to rely a lot on community leaders to try to break those barriers down for the broader community.

Ms PICONE - I think I referred to a couple of examples in the submission, which was a sporting program in the western suburbs of Melbourne that was ostensibly an AFL program that had targeted the health-based needs of communities there, particularly mental health and social exclusion. I think the success of that program really relied on the links that organisation was able to make with the community. With the initiative you described, it sounds like that community was able to identify an existing health need and a way in which they could maybe tap into a part of the population that wasn't accessing health care in that moment. That's a really great example of what can be done. I think the difficulty, in your position, is that it is so difficult to think about how to implement that on a broader scale because they -

Mr WILLIE - Or activate it on a broader scale, which is more the question.

Ms TAIT - Exactly, I think the success of those initiatives really relies on the fact that they are targeted to that community. I know Adrienne was speaking to the Migrant Resource Centre about examples.

Ms PICONE - Yes, which kind of comes down more to language. But it is interesting, we are kind of talking about what comes first, place or people? And where do you prioritise? I think this really ties into that question and that response.

But, yes, some of the examples we have from one of our members was more around cultural awareness training for service providers and health professionals. Even just a simple thing about one of their clients going into emergency not knowing what her illness was and leaving the hospital still not knowing, and not knowing about the follow-up care. That was partly because the health professionals were not aware of the free interpreter service.

There are really simple things and it does go back similar to the inclusion training or cultural awareness. How we can be aware of different cultural needs, particularly for women who have come from diverse backgrounds where there may have been violence or there may have been a different kind of awareness?

Dr WOODRUFF - You are talking about structural changes and we could all redesign the health system, and I am sure we would all love to. We would have our own versions.

In terms of organisations, what happens is that people can get overwhelmed in the moment, like professionals, by focusing on the job they are doing. And all of the conversations they have had at training that happened once six months ago about culturally and linguistically diverse communities is not there. The conversation they have had about talking to somebody who is gender-diverse is also not there. The only way to keep it present is, well, you can keep doing training, but there is a limited amount of time. In a perfect world we would all do more of that. But the other thing is for leadership in the organisation to normalise language and inclusive behaviours at the leadership level so it is there imprinted into everything all the time. Would you like to comment on strategies for working at that level, as well as at all the other levels, because I don't feel that we have got there yet? I don't know what your views are.

Ms PICONE - Maybe it is structural change, Rosalie, but I do think it is also attitudinal change and that needs to happen in the whole of the community. It is about - exactly what Michelle was saying earlier - the way that we view health in our society. Do we just wait until we have a crisis? Or do we see ourselves as whole humans who go through this life trajectory and have different points where we might need to connect with service providers or health professionals? It is an attitudinal shift, I think, in the way that we view health as individuals and as a community.

Dr WOODRUFF - Okay, I think it is a leadership issue to remind people that we can have permission to reframe the way we think about health.

Ms PICONE - Yes, you don't know what you don't know.

CHAIR - I will just go to a different area. One of your recommendations is that the Government prioritise the development and implementation of a Tasmanian human rights act. You have some commentary around the benefits of doing that. I just want to put the skeptic's hat on and say: say that the government of the day agree to do that, we bring in a piece of legislation that gives effect to that. Unless you put in place other mechanisms, it could just be words on paper that people are always butting heads up against in terms of, 'Well, you should be providing this, but you're not; you should be providing this, but you're not'.

It's not a standalone recommendation, I am not suggesting that. I am just asking how you see that interacting with all of the other bits, because on its own, it puts a stake in the ground but how do you make it have life?

Ms O'BYRNE - We had excellent abortion law reform but -

CHAIR - But then we didn't have access to abortions. You can have the legislation, but you might not have the policy. I'm interested in how you see that.

Ms TAIT - It's an interesting question and I will maybe speak to some of the research that has come out of other jurisdictions. The Human Rights Centre has an excellent report providing case studies from other jurisdictions in Australia where there are human rights charters or legislation in place.

There's quite a few ways that human rights charters or acts work. Like you say, it could be another example of this responsive work where it requires someone to be able to identify that their human right has been violated, articulate that violation and seek redress.

However, there's also evidence from other jurisdictions, and the example I'm thinking of, I think it's a women's health centre in Victoria talking about an attitudinal and cultural shift in their workplace since the Victorian Charter of Human Rights was brought in. They have said that since that charter has been in place they've now got another string to their bow, if I can put it that way, in the way that they can advocate and negotiate with agencies, including the department of Housing, and with health professionals. It has given them a little bit more power and agency. They find that even in situations where perhaps an agency or department explicitly acknowledges that a human right has been breached, they are more aware of and alive to this issue when, potentially, litigation could flow from this. That's made a big difference about how they frame human rights, even empowering the clients that they work with.

In relation to health, it would depend because the Queensland charter, as far as I'm aware, is the only charter in Australia that has the explicit right to access healthcare services included in the charter. In that jurisdiction that right has enlivened, it has allowed people to access not just healthcare services but also assistance that they require for healthcare reasons. There's an example, also from that report, about a woman who was not able to bring an assistance dog to a venue during a period of COVID-19 lockdown. That didn't end up in litigation; it was resolved through conciliation. That's an example of how that charter was able to work to make sure that a healthcare need was met.

Ms O'BYRNE - Canada introduced an equality act but it changed where the burden of proof sits. So instead of me having to prove that you discriminated against me in access to health care, the healthcare service has to prove that it provided the full access. That fundamentally shifts where the obligation sits, which changes the way organisations behave. It's still early days, maybe only four or five years, but from what I understand, they are seeing behavioural change across the community as they shift where the burden of proof sits.

The other thing I was going to mention, around an earlier comment, is interpreters. One of the things we have found with women is that if they have an interpreter with them from their own community, or their partner or their friend, they don't always tell everything that they want to tell because there are a whole lot of cultural implications. So there's a real obligation to use almost a completely independent interpreter service, which is harder in Tasmania because we have a smaller access already. I wonder if you've got much feedback on that for our CALD community.

Ms PICONE - Just that I think that the telephone interpreting service is Australia-wide -

Ms O'BYRNE - I know but you've got somebody sitting next to the person and they don't ring. That's exactly what the problem is.

CHAIR - It's not so easy when a woman is in labour, let me tell you. I've looked after non-English-speaking women who have no English, without an interpreter.

Ms O'BYRNE - My example is someone who had experienced a sexual assault, and police didn't take it anywhere because she hadn't presented enough information. But the interpreter she had was from her community and of course had a different view about the fact that she had been drinking, whether or not she'd therefore - where blame lay. So we had to go back to the police and start the whole process again with an independent interpreter. Those kinds of things happen across the spectrum for culturally and linguistically diverse communities.

Mr YOUNG - I guess this is following on from Josh and a bit of the community stuff, almost going back the other way, is there a way to empower the communities to act for themselves, to help themselves and how do we allow that or advocate for them even more?

Ms PICONE - Health literacy is really important. It's probably lacking. It comes back to what I was saying before that a lot of people in our community are in survival mode or very reliant on services. To move into that next step of being able to have that sense of agency is quite a leap. We're all obliged to start building that into the culture and the way in which as a culture and as a society we work.

Mr YOUNG - Knowing that it is okay to be loud and speak up and annoy us.

Ms PICONE - The question that Michelle was talking about before. It's one thing to have an act or a new set of piece of legislation but then how do we promote, communicate and implement that and ensure it's there and that everyone knows it's there within the community? There's no quick fix to this. It's a paradigm shift in the way we approach this.

Dr WOODRUFF - Adrienne, what does health literacy look like? Everything needs to change. How would you start it next year? Are you talking about what's being done in the health literacy space, what's missing? Do you have tangible ideas about how to get started? Accepting that it's a big thing, how would you get started?

Ms PICONE - I'd say it's piecemeal at the moment. What we need is a more comprehensive and broader approach to the way we're doing it. I have talked about the way TasCOSS is working. With a few organisations across the Tasmanian community, we need to really think about ways in which we do that more broadly.

Dr WOODRUFF - Would that be driven by the community sector or with the Government or with the Health department? Who should be taking leadership and bringing people together and working out this process? How should that happen?

Ms PICONE - I don't think this problem can be solved by any one group. We talked before about lived experience. It's important that we include people, particularly those who are disadvantaged or excluded from many services in our community about what they need. I think the answers are often in the community if we take the time to ask.

Dr WOODRUFF - So when you say 'we', who do you mean by 'we'? Are you saying that each organisation that's working in the health space or housing or community space should take more responsibility to reach into the communities and be more engaged with them, be more open and listening to people?

Ms PICONE - It's not just what we do but how we do it. When I say 'we', I mean 'we' as a community. I don't just mean TasCOSS or the community services industry. It's about state government, local government, it's about community services. It's the way in which we see ourselves as community and what we prioritise.

Dr WOODRUFF - One of the things we have as a community is an opportunity to make recommendations that involve specific actions. It's not one body's responsibility, but what would a mechanism be to enhance what's happening at the moment. Would it be getting community and government organisations together with that explicit purpose? Do you have any thoughts?

Ms TAIT - Something that comes to me as an example is some of the work that was done during COVID-19, where a lot of people were really isolated and a lot of organisations were finding ways to find people. They were having difficulty.

It's something I reflected on when TasCOSS was doing the work with our latest community consultations around the cost-of-living crisis, the incredible work being done in organisations like Neighbourhood Houses on a shoestring. The reason that was effective was that those people had genuine connection with the community. It's so tricky for them to do that work because the funding they receive is minimal. I am not suggesting we dismantle the entire health system and have only Neighbourhood Houses providing that health care, but it's interesting that in times of crisis people turn to those local community organisations.

Dr WOODRUFF - That's right. A really good point.

CHAIR - I think health literacy cannot exist without literacy generally. It takes us back a bit to your points earlier about when people are in survival mode, education goes out the window and if you've not got somewhere safe to live, then you can't engage. What I think I'm hearing is that we need a whole-of-community and whole-of-government approach to this. You have to address the underlying factors. No-one can be health literate if they can't read. You can't read the instructions on a packet of tablets that you've been given, that sort of stuff. Or you might be able to read but you can't understand it. Where do we start, in terms of addressing this?

Ms O'BYRNE - If you could just answer that for us and fix it, that would be great. In 10 words or less.

CHAIR - Tell us how you see that.

Ms TAIT - I am not sure I am able to respond to that straightaway because I think what Adrienne was saying about a multifaceted approach. I think communities need to be empowered but with genuine support from those who have the power and authority to make things happen.

CHAIR - I just need you to tell me that.

Ms O'BYRNE - If you wanted to talk about the participatory research for opportunities.

CHAIR - Tell us how it might look.

Ms PICONE - I think there is a significant group of people in Tasmania - we know 120 000 Tasmanians are experiencing disadvantage, living below the poverty line. For those people, if they're just thinking about whether they turn the lights on or whether they feed their family for that night, they are not thinking about health care or not able to think about health care. There is a whole group of people who are just excluded from the things that we all may take for granted and what we might see as the basics.

People are making life-or-death decisions and not going to the doctor or dentist when they need to. We heard from people when we were doing our cost-of-living forums saying they'd had some surgery and the doctor said they needed to drive from Deloraine to Launceston once a week for follow-up care, but they couldn't put petrol in the car, so there was no way they could do that, so they had to live with whatever the circumstances were. We really need to put this into that kind of context and recognise that this is, for many people, quite a dire situation and we need to understand that.

CHAIR - How does the gendered lens come over the top of that?

Ms PICONE - I would say the gender lens is that we know that generally speaking, women earn less than men, that they are experiencing higher levels not just of unemployment but of underemployment. They are often employed in industries that are very low paid, like the community services industry. And so, already that puts a gender lens over being able to access health care. When you double that with knowing that women are more likely to be the carers within the family, there's more single-parent families that are just women, and when the woman in the family is trying to provide health care for the whole family, the people she will prioritise will be the children. It is often that the woman misses out. It's compounded for women.

CHAIR - Then when you put other levels of intersectionality over the top - women who are lesbians, multicultural, with a disability -

Ms O'BYRNE - For some women, all of those things.

Ms PICONE - Exactly. Even just getting diagnosed. I'm sure you have heard this already in your inquiry but how are you going to access the health care you need if you're not even aware that you have a condition? Autoimmune conditions, conditions such autism. Women are socialised to behave in ways that could be masking the conditions that they have, effectively preventing them getting treatment. That's really concerning, particularly for the kind of women Adrienne is talking about, who are already socially isolated, or who are already living pay cheque to pay cheque, not thinking about what's going on with my health, but thinking how is my family going to survive this next month.

Ms PICONE - Also advocacy. We haven't really touched on self-advocacy. One of the things we know, because of the way we're all socialised, is that women are probably less likely to self-advocate - particularly women that are experiencing other forms of disadvantage. Often they won't speak up or ask for support or ask questions when they're in that sort of health situation.

Ms O'BYRNE - I want to move on to another point now. I've been working in government at some kind of level for 27 years, and what governments will do when faced with these kinds of things is to say we'll do an audit or some kind of mapping exercise. I cannot remember how many we've done over the years. How would you comment on the value of that kind of work, as opposed to your participatory research models and the different ways you'd engage with people? I've lived through I don't know how many service mappings and auditing of services and servicing provision. There are hundreds and hundreds of maps, but no noticeable change in behaviour, or provision of service or access to service, so I'd love some comments on that.

Ms TAIT - What comes to my mind is that huge gap that I just discussed. Any service mapping, for instance, is effectively not going to capture those people who are excluded from services and not accessing services. You're really only going to get that from talking to people and understanding their own situation. With people, the communities they trust, and healthcare providers they trust, if they're lucky enough to have them, that's where that information is going to come out.

Ms O'BYRNE - Can I touch on the importance of trust, and who you tell the story to. We heard previous submissions here around when we get medical professionals in, people don't have a relationship with them, but it's also whether you trust your pharmacist, or the person at the community centre, or a person at the shop. How does that factor into people's ability to self-identify or seek support?

Ms TAIT - I think that's huge. It is something that's been identified, particularly in relation to the LGBTIQA+ community here in Tasmania. The recent research report identified that even if people aren't experiencing gender discrimination or stigma relating to their sexuality or gender presentation, people in certain cohorts are likely to avoid accessing health care because they are frightened they are going to experience it. That goes way beyond mental health care. It flows into every kind of health care and allied health.

Ms PICONE - Do you have what you need? I feel like you were asking -

CHAIR - Our job is to get you to say stuff that some of us might understand, and support you to say it.

Ms O'BYRNE[?] - Bearing in mind that we can have our own biases too, so they should be challenged as well.

CHAIR - We do all have our own biases, yes. I really appreciate the fact that your submission outlined a number of recommendations. That's really helpful. If you had to prioritise where you thought the most impact could be made in the short term, and then perhaps the most impact in the medium to long term, what would you focus on? What would you prioritise to address the experiences of gender bias in our healthcare systems? Let's take it as a given that it exists. What do we start with in the short term, leading to the long term?

Ms TAIT - I think there's some real low-hanging fruit. Something that could be done immediately would be embedding gender diversity and inclusion training more broadly within the university training of all medical and allied health professionals, maybe alongside ongoing professional development training -

Ms O'BYRNE - When you say 'embedding' it into, you mean not doing a one-off session at some time during their training, but embedding it?

Ms TAIT - Exactly. That would be part of the university curriculum, definitely for general practitioners, but I would say possibly for a range of other allied health professionals, perhaps with the development in consultation with the AMA or other associations, or gender diversity and inclusion training more broadly being part of our ongoing professional development requirements, which I'm assuming many medical practitioners -

CHAIR - They all have it.

Ms TAIT - Exactly.

CHAIR - There is no health profession that doesn't have mandatory CPD.

Ms TAIT - I said that's low-hanging fruit. I appreciate that it's not necessarily easy, but possibly -

Ms O'BYRNE - It would make a significant impact.

Ms TAIT - It could have a significant impact. Perhaps it could start as pilot programs with identified priority cohorts of communities that we know are experiencing really significant impacts of gender bias. As we've said, everyone is probably experiencing gender bias. It could be the communities that we've outlined in our submission. I would also say that the Aboriginal community should be a priority. That's identified in Closing The Gap as a priority, so that would be well within the Government's remit to include that to allow those organisations that are already working with those communities to talk to the people who are accessing their services so that they can get the information that they need: 'We need a dentist here once a month, we need someone who is able to do outreach at this particular location with this community, or there's been a refugee cohort who's arrived in *x* town, and they have this health need that we suspect is unmet. Let's go out there and arrange a community activity to see if they can speak to us about their healthcare needs.'

The third thing is looking for ways to implement the diversity and inclusion training more broadly within the curriculum of schools. That might be a good way to start. We know there are organisations in Tasmania who are doing a fantastic job. Why not tap into those organisations and allow them to expand?

CHAIR - It is helpful that the committee has some pretty clear guidance on what our experts in the field think is going to have the most effect from the experience that you've had.

Dr WOODRUFF - The cheapest and easiest one is to implement a charter of rights through legislation, in terms of money, direction and leadership. That would set a standard for what you were talking about in Victoria.

Ms O'BYRNE - What do we currently do that you would undo as quickly as possible? Sometimes it's not about doing something new, sometimes it's what you're doing that's the problem - often with the best of intentions. The road to hell is paved with good intention.

Ms TAIT - What's coming to mind is the difficulties we spoke about in the submission in relation to accessing the NDIS. As Adrienne just mentioned, it's a system that was designed with the best of intentions to promote self-advocacy. It has been a fantastic development for so many communities, particularly when we're thinking about the ways women are socialised; women of a certain age, for instance, might simply not be comfortable advocating for themselves or in certain environments, and then thinking about a system where instead of the idea of universal health care, it's this model where people can choose their provider, but that provider can also choose whether or not to work with you.

We would say, and the research seems to demonstrate, that women, particularly women who have certain conditions, who might not behave in ways that are consistent with what we would see as socially acceptable behaviour for their gender, are impacted by healthcare providers who simply don't want to work with them because they're a 'difficult woman'. Women are likely to experience that in a different way to men. How do you undo that?

Ms O'BYRNE - We've had a couple of examples of GPs who don't want to take on older patients, because older patients are a lot more work and a lot less return. By the time they take off their clothes for the first exam, you're 30 minutes in. They're rude to them and so they never come back. We hear about those stories. The other thing with our core community is that people didn't want to take on new clients who were a brand-new person from overseas, because their initial health assessment was going to take two or three hours, maybe longer. They didn't have the time in their very busy practice to do that. One of the things that the Migrant Resource Centre in Launceston did was to partner with the LGH to get everybody their initial thing so you could hand over to your new doctor your file. That's a real problem for many people coming from unsettled backgrounds.

There are mechanisms that we've done before, but they're ad hoc. Sometimes they're responsive, like Josh's example of the dentist, but how do you make that more a reality for people? Sorry, that was more of a comment that a question. I apologise.

CHAIR - Going back to the specialist health services, you talked about having a service in Hobart and - you didn't get to the 'and'.

Ms PICONE - I guess the 'and' is yes to specialist services but also what we need is for existing services to be more informed around this. Yes, it needs to happen, but we also need to ensure that services are universally accessible.

CHAIR - And inclusive.

Ms PICONE - And inclusive, yes.

CHAIR - Let's take a little journey up the road to Circular Head, which is quite a conservative community; that's the way it is and I represent and love it. It can be more difficult for some women perhaps escaping family violence because all the money's tied up in the farm and that sort of thing, or it could be that if you belong to a church there it's much harder to talk about sexual and reproductive health issues. We understand that's the lived reality. When you're talking about a specialist services hub perhaps in Hobart, how do you see where you may have challenges creating a fully inclusive medical service in a geographic location like Circular Head? Because of those very real and genuine matters, how do you see that service being delivered into those communities in a way that's respectful but also accessible and inclusive?

Ms TAIT - I'm going to sound like I'm just repeating myself, I'm sorry, I just think the only way of doing that is by speaking to that community. I don't know the answer to that question because I know that community but I am pretty sure that the people in that community know the answer. It would be trying to look for ways of engaging that community so that they can speak to people about what they're experiencing and those gaps can be identified. Perhaps it's not with a help service in that instance, maybe it's through some other kind of community engagement activity, I don't know. That's a really good example where I just don't think that most of us in this room are going to be able to give you an answer to that question because we haven't lived that experience. That's why it's so important to have the voice of lived experience and the voice of that community in shaping that response.

CHAIR - We heard from Health Consumers Tasmania that they don't have people on the ground in Circular Head, and there are other parts of the state they've also identified they don't have people. Is that the sort of organisation we should be promoting as being funded to go into those areas, or is it better to work with the existing organisations in whichever place it is to try to upskill them? How do you think it's best approached?

Ms PICONE - I think there's probably a multi-pronged approach but I would say in the first instance it is about building on what's already there, because those organisations would have existing relationships, there's a high level of trust within the community and we don't want to reinvent the wheel or having people coming from Hobart telling them what to do. How can we build on what's already there and really enhance that?

Dr WOODRUFF - So it's about some group like Health Consumers Tasmania or another body reaching out to existing organisations, talking about the issue and trying to put some resourcing and support into and then getting guidance from them about what the next best steps would be about how to identify -

Ms PICONE - How can they resource them to do it?

Dr WOODRUFF - And skill them to do it.

Ms O'BYRNE - I remember when I had Health, Circular Head in particular and that whole sort of community was saying we identified about 25 different service deliverers who would drive in for one day a week and then drive back again, and the amount of money that was wasted in that transport time, rather than investing in building the services.

CHAIR - On the west coast and the islands it's exactly the same.

Ms O'BYRNE - But we spend so much time sending individual specialist services in that we don't get the bang for our buck, when you could actually do a lot more working directly with the community.

Dr WOODRUFF - Recognising that with health, some of the issues might be ones that people would prefer to talk to someone who's not from their area about anyway. There might be specific reasons why - family violence or terminations or all sorts of reasons.

Ms O'BYRNE - Island communities are a bit of a thing, because you have to fly in to the island if you're a service deliverer, so everybody knows when the mental health person's there or when the sexual health person's there, and they're all in the one hire car so everybody knows. It can be really hard, too.

CHAIR - There's a way of making those services incluisive and accessible by the way you structure the plan.

Ms TAIT - I think having empowering organisations and professionals working in all sorts of organisations to develop really strong partnerships and referral pathways as well; perhaps you're not getting the disclosure of family violence, perhaps you're not getting someone accessing a legal service, but maybe someone would go to a financial counsellor and a couple of questions might identify something as happening, and that again comes back to that question of education and training and making sure that across a wide range of professions people feel empowered to respond to the needs people are presenting with.

CHAIR - Do you see digital services as an important part of this, perhaps seeking input digitally? Telehealth specifically relates to health and tends to have a structure around it. I'm not entirely talking about a consultation online necessarily, but the use of digital technology to work with communities from an expert hub based elsewhere.

Ms PICONE - I think it can certainly be an adjunct to face-to-face services but not the only way the service is provided. I think we need to think about not just literacy but digital literacy and that a lot of people don't have -

Ms O'BYRNE - Or even internet.

Ms PICONE - Internet, don't have a device - exactly.

CHAIR - How to turn it on if they've got one.

Ms PICONE - Or privacy to take that sort of consultation, so I think it's part of the whole thing, but -

Ms O'BYRNE - Which is something we found with COVID as well, that a lot of the protections that were provided to women ceased to be there because they were no longer able to seek supports outside. Their phones were monitored, their conversations were monitored, there was nowhere they could go.

CHAIR - Is there anything you haven't said that you wish you had?

Ms O'BYRNE - If so, feel free to write to us.

CHAIR - You can say some more now, but if you think there's another thing you should have said, feel free to write to the committee and add anything.

Dr WOODRUFF - It is such an important peak body.

CHAIR - Thank you very much for your input and feel free to send anything else through.

THE WITNESSES WITHDREW.

The committee adjourned at 4.27 p.m.