Ms **AMANDA DUNCAN** WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED.

CHAIR - Welcome, Amanda Duncan and thank you for your submission and appearing before the committee. We appreciate your submission and look forward to your evidence. This is a public hearing. Everything you say will be covered by parliamentary privilege while you are before the committee, but that may not extend to outside of the committee. It's being streamed and will form part of our public record. The transcript will be published on our website later. If there's any information you want to give of a confidential nature you can make that request the committee and the committee will consider that. Do you have any questions about that?

Ms DUNCAN - What I've witnessed as a nurse and a midwife, I won't be giving patients' details but in terms of confidentiality, is that something I'll leave until the end?

CHAIR - If there's a risk of identifying individuals then keep it until the end and we can make it confidential.

Ms DUNCAN - Most of it is general context.

CHAIR - Let us know if you feel like it's going over that line and we can discuss in the confidential hearing. We invite you to introduce yourself and then speak to your submission and add any further comments, then the committee will have questions for you.

Ms DUNCAN - I'm Amanda Duncan, I'm a registered nurse and midwife with the Tasmanian Health Service. I have witnessed quite a lot of gender inequalities over my eight or nine years in the profession. I also suffer from endometriosis, adenomyosis, interstitial cystitis and some other chronic health conditions which have affected me, especially when accessing health care in Tassie. Are there specific questions or would you just like me to speak to the submission I made?

CHAIR - You can speak to it initially if you would like, if there are things you would like to add. How would you like to approach this? It is really your time here before the committee.

Ms DUNCAN - Do I need to read out what I have already submitted?

CHAIR - No.

Ms DUNCAN - I have questions, really. Firstly, what is the aim of this committee and the outcomes before I speak to any of you?

CHAIR - Essentially, we are trying to identify what the real issues are in gender bias in health care. Personal experiences as examples are really helpful to explain that. The committee will prepare a report identifying the key areas or issues that need to be considered. That is the process of making findings. When the committee finds that this is an issue and something should be done about it, or whatever, then we will make recommendations.

If you are happy to identify some of the key problems that exist and the examples of gendered bias in health care, particularly if you have any suggested solutions or anything the committee could recommend for the future, that is particularly what we are focused on.

We acknowledge that it is a real thing, the examples are helpful to explain what it looks like and then recommendations that might actually help, not overnight but eventually, reduce and hopefully minimise and eventually stop gender bias in health care.

Ms DUNCAN - I will start with a recent example which you may have heard of in the media, when I recently accessed the LGH emergency department. Unfortunately, I was in quite a lot of pain, had waited five hours, from around 11 p.m. to 4 a.m., waiting to see a doctor in excruciating pain. I had taken a lot of Endone in that time and was still in quite a lot of pain. It is important to recognise that to leave home, which is comfortable and safe, you are in bed, you have got a heat bottle, it is like when you are in labour and you want to be in your safe environment. To have to get up and leave is quite challenging to physically do and also organise transport getting there. And so, to sit in a plastic chair, sitting still for five hours, is incredibly hard. You are also aware of everyone else that is in the triage room waiting to be seen for clinical reasons as well, to then be seen after five hours and be told that there was not a bed available for me to receive IV fentanyl, which I needed at that point. They did offer for me to have the IV fentanyl on the floor in the ED waiting room after they gave me a blanket and a pillow. But, unfortunately, it was also understandably against hospital policy. They cannot give IV opioids on the floor in the ED department, so I was sent home in acute pain.

Something which occurred to me after that was during a media interview; someone rang up afterwards and commented why I didn't access another emergency service. But there are no other options in the north. There is only one emergency department, and Urgent Care closes at 8 p.m. or something like that.

Ms O'BYRNE - And also comes with a cost if you're -

Ms DUNCAN - It does come at a cost, absolutely. It made me think, how can we mitigate certain people for whom it is not necessarily an emergency as such but it is an acute condition, in treating that? And how can we use the specialised services in Launceston and in the wider region of Tasmania to help women have access to pain relief for acute exacerbations of their medical condition without needing them to go to the emergency department?

Ms O'BYRNE - How do you think that might work? One of the things in the story that you told publicly, which was really important to tell, was that women whose pain isn't being managed often go into urinary retention. You need a medical step to do that, you are trained and horridly had to go home and do your own catheter. That is not something that is possible for the vast majority of people whose pain management ends up with urinary retention.

Ms DUNCAN - No, and unfortunately a young lady I met in January in hospital, she and I both shared the same condition of a gynaecological and a urological nature. The week before, she had attended the emergency department in acute pain and she was just given Panadol after hours of being in pain. She ended up fainting in ED as a result. She was also in urinary retention and she had begged for a catheter and no-one would do one.

In January, when I was in hospital, the staff and nurses were amazing but whenever the catheter was removed, I would go back into urinary retention as a result of the pain. I do not

know how much you may or may not know about endometriosis, but the pelvic floor is heavily affected and all those functions can be affected. When I went into what my version of retention is, which is a much lower capacity of urine volumes than most average people's, I was told by some junior medical doctors that if the nurses made me wait long enough, I eventually would go on my own. I was in extreme pain and when I did go, I was peeing blood. I was told, when I requested an indwelling catheter to stay in, that I didn't need one and I was given the only option to do in-out catheters. I don't know if anyone has seen what they look like but they are very sharp and it was excruciating.

CHAIR - They are not flexible.

Ms DUNCAN - Not flexible at all. Also very challenging to do on your own.

CHAIR - They also carry risk of infection.

Ms O'BYRNE - That is the other thing, isn't it? All catheters carry risk of infection, too, so it goes back to are we managing pain in women in the first place?

Ms DUNCAN - For me, this is where I get frustrated because I have clinical knowledge and I was dealing with in-out catheters four or five times an hour, screaming in the bathroom in pain and I was told I didn't need a catheter because the catheter that I had had a greater risk of infection than doing one to four or five catheters an hour every hour. I kept saying, 'I think I have an infection', and I wasn't believed about that either. It got to the point where two female junior doctors and some female nurses went against medical advice and inserted one for me at my request, after six hours of being acopic because I was left in pain. It was really traumatic, I had no autonomy over my body. I kept saying that I wanted something and I wasn't receiving it. There's that.

I also do not think there is much education in specialties other than gynaecology around endometriosis and how it affects other systems, including gastroenterological and urological. Whenever I tried to explain something, I always had to provide evidence or proof of why I felt the way that I did. I had a photo from a cystoscopy a few years ago from my gynaecologist and it is quite obvious that there is haematuria, which is frank bleeding in the bladder. It is not until I provide that proof or imagery that it is like, 'Oh, okay, this is actually really bad for you', and then I am sort of believed but I have to validify what I am reporting for me to get believed.

CHAIR - Amanda, what I am hearing from you is that you are not believed and that your symptoms, which include the pain and perhaps the haematuria and other symptoms that you are very well aware of, having lived in your body for this time. Why do you think that is? Why are you not believed and why are your symptoms minimised, which is what it sounds like is occurring? Have you tried to work that out?

Ms DUNCAN - I think it goes back to - health care is institutionalised, it is quite a colonial, patriarchal and hierarchical culture and, historically, women have not been believed.

Ms O'BYRNE - Just being hysterical.

Ms DUNCAN - We are hysterical and I think that's just what being a woman is. You go through childbirth and you must be able to tolerate pain and it is a very different kind of pain. I feel like you are stuck between a rock and a hard place because if you have education and

understanding around your condition, you are almost gaslit for being too controlling, and too this and that about your own healthcare choices. But then, if you are not informed, you get brushed off.

I was in the ED once and was diagnosed with adenomyosis, and the male senior doctor was telling me that it is not a painful condition. Thankfully a junior RMO (registered medical officer) advocated for me, saying it is an incredibly painful condition. As a junior, it took a lot for her to say that to a consultant. I admired her for that and it was really validating.

As someone who has worked in the emergency department, I have been in handovers where someone just said, 'Oh, she is just here for her period, she just needs some pain relief'. There is no care in that in a lot of situations, because it is not a priority in terms of emergency medicine, it is just pain management.

CHAIR - Rather than acknowledging that in your case, a period means a whole heap more stuff than just bleeding. You're saying it's been minimised to a normal life event for a woman, rather than a series of medical symptoms and conditions that warrant different care than just some pain relief.

Ms DUNCAN - I think there is a lack of education in gynaecological conditions for women, not only endometriosis, polycystic ovary syndrome and uterine and cervical cancers. From what I observed when I worked in the emergency department, when females came in even with miscarriages or anything of a gynaecological nature, the common resolution was to call the gynaecology team for simple things like speculum exams, which is something the emergency medicine doctor should be able to do. The senior ones could, but a lot people felt like, well, I'm a junior, we may as well get someone who is in this profession to do it.

Ms O'BYRNE - That often results in a delay as well, by the time your gynecology team makes it down to ED - if they are available.

Ms DUNCAN - What I've observed is that no other specialty requires someone to come down for a basic emergency management worker, so that is something that's being added to the gynaecological team.

CHAIR - Having worked in ED yourself, you're saying that for almost any other procedure or investigation - except for perhaps sending a patient to the radiology department, or something like that - all other basic procedures in undertaking an assessment of a patient's condition are done by the ED team.

Ms DUNCAN - Yes.

CHAIR - And it's only anything that presents as potentially a gynaecological problem that you would call a gynaecological team?

Ms DUNCAN - Until a patient is admitted, whether it is under the urology team, general medicine or whatever - this is a generalisation, and I am sure it doesn't happen in every circumstance, but I have witnessed in a few circumstances where ED doctors, often junior doctors, will contact other registrars or RMOs in the gynaecology team to come down and assess a patient, which is not common practice. You would wait until that person is being admitted. I feel like there is not much training and education in this space.

Ms O'BYRNE - Could you touch on that? A number of things that you might present to ED with don't require hospital admission, but they do require an emergency response that can be managed within the ED. That understanding seems to be where the challenge is. People say, all these people present to hospital and they don't need to go into hospital, so they must have been okay. Broadly, of the emergency treatments that don't require admission, pain management is a significant one.

From your experience, how well is that resolved? I think we've had this conversation before that if a man presented with significant abdominal pain, most likely we would admit him and test immediately. That is not the experience women have.

I am interested in your perspective as a user of this health service, but also somebody who works in the health service. I notice that in all of your comments you have talked about how good and kind the staff have been. You have been very sympathetic to the stresses they are under. I am particularly interested in pain management, because that seems to be where we first dismiss a number of concerns.

Ms DUNCAN - That is quite a lot to cover there. That is a good question. I think there was a research paper the other week with evidence that supported what you just said - that men who have pain will receive greater pain relief and faster pain relief than a woman who presents with even worse pain, who will get much less, and often the waiting time is much longer. That has been provided in research.

Pain management I think is not well managed in the community. A lot of GPs are quite hesitant to prescribe schedule 8 and schedule 4 opioids like Endone and Targin because of the potential risk of addiction. I am fortunate to have a really great GP, but I haven't always had great GPs. There is that hesitation - just have some Panadol or Nurofen.

For that cohort of people who do not receive adequate pain relief prescriptions from their GP, there are no other options but to go to the emergency department. I think if there was better management in the community, it would hopefully prevent, in some circumstances, people needing to go to the ED.

There are also circumstances, like I had the other week, where I had taken everything I possibly could at home and then still needed to go into the ED. There is a hesitation of providing pain relief - but pain is an internal experience. You cannot see it. You don't go in with a gaping wound or a broken arm or anything like that, and you almost feel like you have to plead your case.

Mr WILLIE - In your paper, gender bias is obviously an issue, but you mention your grandmother had a similar profession. Do you think age is a bias as well?

Ms DUNCAN - In what sense?

Mr WILLIE - In what you said about your grandmother talking about autonomy and the improvements in women's health - and I quite agree with that.

Ms DUNCAN - Yes, I think it is challenging. Her generation, living through the 1940s, 1950s and 1960s, would have observed a lot of changes. In the article you are referring to, I also talked about financial inequalities.

I think there is always room for improvement. I personally do not feel like it is adequate enough at this point. My grandmother didn't have the same medical conditions as I did, and she was in the profession as a nurse and midwife, but I think in some ways we have regressed and in some ways we have progressed.

CHAIR - Can I go back to the issue of the gynaecological team doing assessments in the ED? There could be an argument put there that you are getting favoured treatment, because you are getting the specialist in the field to come and see you, rather than the ED staff, acknowledging that they are trained to do that sort of investigation. How do you respond to that, if that was put to you?

Ms DUNCAN - It has happened to me a few times where the gynae team has come down and it has been a relief, it's like someone understands what you are going through. There have been situations where I am just hoping that they contact the gynae team to come down and review me, and I think other people do as well.

How people conduct assessments may not be intentionally trying to upset or offend someone, but the questioning can be - I will give an example. I had an ED male doctor - a registrar I believe - assess me one time and I was trying to explain what I think could be happening, and I was told that these things don't happen. For example, I have a Mirena IUD inserted and I was concerned that it had migrated up my fallopian tube, causing significant pain. He said that doesn't happen. Well, it does happen, , and I have assisted surgeons as a theatre nurse removing two Mirena IUDs abdominally. I was then misinformed by someone who is supposed to have clinical knowledge that that doesn't happen. He also didn't assess whether it could have been an ectopic pregnancy. There were multiple red flags for me.

When the gynae team came down I thought these people are trained professionals in this area and I trusted the questions that they were asking me. I trusted that they were listening to what I was saying and believing it. That male doctor, when I had put to him very respectfully what I had seen and witnessed as a nurse, he said he was going to document in my notes that I had been aggressive towards him. The light at the end of the tunnel was when I saw the gynae team come down.

CHAIR - In your submission you talk about leave that's provided to women who miscarry or have a termination. Do you want to talk more about that? You mentioned this in your opinion piece on the financial impact on women. The overlay of all that is the gender pay gap. Could you expand on that further?

Ms DUNCAN - I can only speak about what's in our award as nurses and midwives. A lot of women don't have access to bereavement leave in early miscarriages. Different awards would say different things. Some recognise that from 12 weeks, others 20 weeks. In a lot of circumstances women are given three days of leave after a miscarriage for special circumstances, then it's up to people to use their sick leave or annual leave.

People with endometriosis don't often have sick leave or annual leave because it's exhausted all the time. I haven't had paid annual leave since 2016 because my annual leave is

always used for sick leave. In circumstances where women do have a pregnancy loss, they have to suck it up and keep working.

I spoke to a nurse in Launceston who was miscarrying while she was at work. She said, 'I can't afford to go home, I need my leave'. That's why I think there is a gender pay gap. It's not acknowledging that these very traumatic things can happen to women. If we foster their mental and physical wellbeing in that moment then I would suspect you get longevity out of the person.

CHAIR - A woman miscarrying at work, whether it be in hospital or anywhere, generally it's a painful process and nearly always quite painful. Usually there'd be blood loss as well. That someone would even contemplate staying at work during what seems to be completely unacceptable. I'm not saying that person made a bad choice, they felt compelled to make that choice.

Ms O'BYRNE - Imagine how much more difficult it is for the vast majority of women who are in part-time or insecure work. If you don't turn up, you don't get called in again. It can be the end of your employment. Particularly women with endo, who have so many illnesses, so many occurrences of unmanageable pain leading to time off work.

CHAIR - How do we address that? Women shouldn't be put in that position where they're having a significant medical event. One in four women miscarry. When they miscarry, it's not usually at a time you expect. Terminations can be planned, but miscarrying is not a timed event. Do you think there needs to be a different provision made? This is not something men need to face. How would you see that being resolved for women, whether they're in full-time work or insecure employment?

Ms DUNCAN - First is to honour the human being going through the experience. When I asked this person why she stayed and didn't let her employer know that she needed to go home, she said she was too embarrassed. She was mortified, so she just kept working on. She was in a lot of pain and she felt her patients were more of a priority than herself, which is rather selfless.

Regarding the employment facet of this, how do we negotiate to ensure that, regardless of what profession you're in, your employer has these - not really protections, I'm not sure what you'd call them -

CHAIR - Leave entitlements, perhaps.

Ms DUNCAN - Correct, for women. For women who have had multiple miscarriages in the past, there's the anxiety that they won't have the leave, the worry about losing other pregnancies and the worry of financially supporting her family. That does happen.

CHAIR - Do you think there should be recognition that this is a very gendered issue, and that there should be specific leave entitlements? Nobody's going to take it if they're not miscarrying. It's a pretty defined event.

Ms O'BYRNE - Going back to your experience of endometriosis, there are many times you are in too much pain to work. There is no structural framework around that. In the childcare award years ago, when I started there we negotiated an extra week of sick leave

during people's first year of childcare work because they caught every bug. Yet we still can't negotiate additional leave for women around menstrual leave or chronic pain management conditions. Do you have a view on that?

Ms DUNCAN - It's really hard. I've had great employers who are very supportive. I've also had employers who are not. Unfortunately, I had to go down the track of bullying and harassment at one point because I had people in middle management contacting me via social media, contacting friends to validate why I was taking sick leave. In health care you'd expect there'd be some empathy and insight into what that can look like. That causes additional trauma. As a result of that, I get very anxious whenever I have to call in sick because I think I need to justify it. I feel guilty for it. I often spend the whole day at home anxious that I've had to call in sick rather than focusing on my own health and wellbeing.

Ms O'BYRNE - I have spoken to a number of young women who only take casual work because they can't guarantee that they'll be available, and that permanent work is too hard. Do you think it leads to people having to make a choice of insecure work so that they can genuinely say, 'I'm not coming in today'?

Ms DUNCAN - Yes. I've done that in the past. I've worked in a casual capacity because I started to feel so guilty. I needed some control over when I thought I may or may not need to take leave. I've picked up casual shifts and a couple of hours beforehand I'd been unable to walk and needed to take pain relief and therefore unable to provide patient care. There are other professions where women may be able to work from home, but there are many professions women work in where that wouldn't be an option.

Ms O'BYRNE - I want to ask about the difference between how we respond to pain management in acute circumstances versus a chronic condition. Your conditions don't get better, even when you have surgery; if you choose to have surgery or are able to afford to have surgery for all of the difficulties within that, it doesn't make it go away. Do you have a view on how we respond to chronic condition pain management in the community? That seems to be in most cases, you don't go to -

CHAIR - A chronic condition with acute exacerbation.

Ms O'BYRNE - Yes. It's not that going to hospital is going to make you better. If you could manage pain, going to hospital is not actually the best outcome for you. You talked before about being safe and at home and in a place where you'd want to be able to manage your pain. Do you have thoughts on how we might better manage that other than we need to work on training and GPs?

Ms DUNCAN - There are some inequalities in that. I've spent so much money on naturopaths and other therapies, which unfortunately, haven't worked but you give it a go because you are desperate to do anything. But there is a cost, pain management clinics, physiotherapy. Even though private health does cover some of the cost, it does not cover all of the cost. There are times where you will just push through the pain, and especially at the moment for those who have mortgages, who are renting, it is very challenging. So that kind of gets put on the back burner and you are focusing on what you need to live in the now, and other -

Ms O'BYRNE - Would public pain management support be something that would make a difference? We have the clinic in Hobart and I think that is about it, so if you are regionally based, it is even harder.

Ms DUNCAN - So, there is not one in Launceston that is coming?

Ms O'BYRNE - There has been discussion about it but I'm not sure where it is up to, so I can't go on the record on that one. But even then, even Launceston is difficult if you live in Smithton or on the islands. It's that regional access.

CHAIR - Or even in Burnie, just getting to Launceston in that sort of state and then having to turn around and come back home again.

Ms DUNCAN - You can't drive. I always have to get someone to drive for me.

CHAIR - Just on that point, you can't drive but how can you possibly work in a way that is safe if you are in such excrutiating pain that you can't really think?

Ms DUNCAN - I don't work if I'm in that. I can't.

CHAIR - This is the thing - it is not like you are choosing not to, you can't.

Ms DUNCAN - You can't do it, no.

CHAIR - Is there anything you wish to say to us that you haven't? Or any other recommendation you would have, to try to address the very real issues you have identified, personally and professionally?

Ms DUNCAN - Just to summarise, what we have discussed is the cost involved with accessing certain things. I think education for medical staff as to what this is like. And I think access, safety and just the basic healthcare consumer rights in being respected, because so often you don't feel respected. I have gone home feeling absolutely crazy, I have cried. Trying to access health care has been more traumatic than the condition itself.

CHAIR - Sorry to hear that. Thank you for being willing to come and talk about that. I'm sure it's not easy for you to have to go back through all of that again and again, so thank you for doing that. We certainly believe your story and appreciate the time you have taken to write a submission and come and speak with us today.

Ms DUNCAN - Thank you. I appreciate your time.

THE WITNESS WITHDREW.
The committee suspended from 10.38 a.m. to 10.45 a.m.

Dr COLIN SMITH, AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE, WAS CALLED, AND WAS EXAMINED VIA WEBEX

CHAIR - Welcome, Colin, to this public hearing of the Joint Sessional Committee on Gender and Equality looking into gender bias in health care. We appreciate your submission on behalf of the Australian College of Rural and Remote Medicine. This is a public hearing that it is being broadcast and the transcript will be published on our website once it is available and form part of the public record. Everything you say before the committee is covered by parliamentary privilege, but that does not extend beyond the meeting, necessarily, so just keep that in mind. If there is information of a confidential nature you wish to provide, you can make that request to the committee, otherwise it is all in public session. Do you have any questions before we start?

Dr SMITH - I don't.

CHAIR - If you would like to introduce yourself and say a bit about the college, and then speak to your submission, our members will have questions as we go along.

Dr SMITH - My name is Dr Colin Smith. I am a general practitioner working predominantly in Tasmania and around rural communities. I am the Tasmanian representative on the Australian College of Rural and Remote Medicine (ACRRM) council. The council is the mechanism by which the different states feed back to the college board. I don't know how many of you know a lot about ACRRM, but it is a college based on the premise that the healthcare needs and how health care is delivered to rural and remote Australians differs from how health care is provided in metropolitan areas.

CHAIR - And you train GPs for that purpose of working in rural and remote locations, is that right?

Dr SMITH - That's right. ACRRM GPs, as RACGP registrars, can work in both locations, but we believe there are certain factors that are different in rural and remote areas.

CHAIR - Thank you. Do you want to speak further to your submission?

Dr SMITH - We were invited to do an opening statement. Is that okay?

CHAIR - Yes, that would be great.

Dr SMITH - ACRRM believes that gender bias has negative impacts for patients, providers and the wider health system, and believes that strengthening our awareness of issues around gender and bias will assist Australia's healthcare system in working towards a safer and more supportive environment for patients and providers. ACRRM believes that the best outcomes for all can be achieved when we learn to listen generously, have the courage to challenge previously held assumptions and commit to active listening and dialogue. The college considers the need for dialogue around difference essential to broader and more meaningful conversations and engagements across the healthcare system.

There are a couple of points if I could just speak more of what is in the ACRRM submission. Number one is the rural and remote context. We believe that rural healthcare

workers, doctors and other healthcare workers, have an important role to play in providing access to safe spaces for all patients in their community regardless of gender, sex or any other characteristics. We also believe that rural doctors and rural healthcare workers should have access to mental health and wellbeing supports, where they themselves can be vulnerable to discrimination.

Second, ACRRM is aware that there's a difference between sex and gender. Due to the tendency in the wider public debate to use the term 'sex' and 'gender' interchangeably, there could be unconscious biases about both sex and gender, which overlap. We feel it's important for our health practitioners, not just ACRRM but in the wider health system, to recognise there are many ways in which a person may define their own gender.

Third, our approach is to best practice care. We believe that gender bias can have a negative impact on medical diagnosis and the quality of health care people receive. It can lead to delays in diagnosis, missed diagnosis and worse outcomes. Gender-sensitive care leads to better patient outcomes and recovery from mental and physical conditions.

Fourth, the healthcare workforce. The national gender pay gap for healthcare workers is nearly 21 per cent, compared to non-healthcare workers, where the gender pay gap is 14 per cent. We believe there are structural barriers for women within medicine in general. In areas such as surgery, cardiology, women are underrepresented in the leave training in higher proportions than men.

Fifth, education and training. The ACRRM fellowship curriculum registrars develop an understanding of how internal biases can impact on health care. The college provides and promotes resources to improve doctors' understanding of key gender issues in practice. For example, ACRRM has a specific course in transgender primary care.

Finally, the college is committed to educating and supporting registrars and fellows of the college to provide the highest quality care to people living in rural and remote communities in which they live and work. College intends to remain practically engaged in all strategies to pursue this commitment.

CHAIR - Thank you, Colin. I am really interested to hear about the transgender primary care training that you can deliver through ACRRM. We have been hearing evidence from other health professionals, talking about the undergraduate degree, that there are little, if any, components of that degree that cover gender bias or inequality. Certainly not transgender. Could you explain to the committee what the program encompasses?

Dr SMITH - That's the hardest question that I was not expecting. I'm sorry. Can I come back on that?

CHAIR - You can. I am interested in how it fits into the overall program. The ACRRM training is delivered after the Bachelor of Medicine and Surgery. It's a postgrad program, if you like. I am interested in what that covers. Could you give us an outline of the course and when and how it's delivered?

Ms O'BYRNE - Could I ask what's the percentage of fellows who have taken it up? When we talked about training, we talked about how often the ones who do not opt in are the

ones who may need to access the training most. I am interested in the percentage of people who would have done the course.

CHAIR - Or whether it was part of the program regardless?

Ms O'BYRNE - Yes. Is it one of those opt-in ones where you choose a specialty or something that might be appropriate to your community to upskill in.

Dr SMITH - Embarrassingly, I cannot answer those questions. It's pretty new and was never anything that was offered to me as an undergraduate or a postgraduate. I did my training with RACGP and ACRRM. It is something in which I think most doctors, until very recently, would have had zero training.

Ms O'BYRNE - Would there be movements to ensure that people who have been practising for a while would access that now or is it something that you would do as a new entrant to the field?

Dr SMITH - I think you will find that most general practitioners, once they are fellowed, choose what they do.

Ms O'BYRNE - Yes, I think that's the concern.

CHAIR - It's part of their GP training through ACRRM, but not RACGP, as far as you know. Do they offer this same program?

Ms O'BYRNE - That is now.

Dr SMITH - I cannot speak for RACGP. I am sorry, I do not know.

Ms O'BYRNE - That is the issue now. There's a vast number of people who are practising, who have been qualified for some time, who would choose this one if it was an area that they have an interest in but may not. One of the concerns is that he or she is the only doctor in your regional community. If they haven't had access to that, then their ability to respond appropriately and in a trauma-informed way, perhaps, is not always there.

Dr SMITH - I can speak personally to having patients in my consulting room who have got - 'Holy moley, I have no idea how to start with this'. I think that would be the majority of GPs past a certain age.

CHAIR - I don't disagree with that. It's a new program. The key issue for me is is it part of the curriculum that all those post graduates doing their GP training through ACRRM will do? You can come back with that information, if you don't know.

Dr SMITH - I'm pretty sure it's an opt in, but I couldn't swear to that.

CHAIR - Okay, that goes to Michelle's point a bit then.

We talked earlier about the negative impact on patient outcomes because of the gender bias, particularly with delays to care and misdiagnosis. Can you talk about some examples of that or areas where you've seen that play out?

Dr SMITH - The figures would say that women suffer from mental health issues at a rate of twice that of men. Accessing those services are very difficult. You can't always guarantee that you are going to come across a GP who's able to cover that adequately.

There's new evidence to suggest that things like ischaemic heart disease or heart attacks are underdiagnosed in women because they present quite differently to men. There's a whole bunch of stuff that we are just starting to realise can be different.

If you have someone who has transitioned from male to female, part of the job of a GP is risk stratification; that becomes quite difficult because then you are putting hormonal treatments and a whole bunch of overlays of psychological stuff on top of things. That's an area we're just starting to think about.

CHAIR - It certainly makes a job more complex.

Ms O'BYRNE - We've had evidence previously in the committee around diagnosis of things like ADHD and autism that women often present in different ways and can get quite delayed diagnosis. Is that something you've identified as an issue?

Dr SMITH - That goes for a lot of mental health issues, a delay in diagnosis, made more difficult by lack of training and things like menopause.

Ms O'BYRNE - Can I put a plug for perimenopause training?

Dr SMITH - Exactly. There are a lot of mental health issues associated with menopause. Some of them are menopause and some of them are not menopause. I don't know that there's a whole bunch of GPs, particularly male GPs, without trying to stereotype, who are particularly good at that. It's a very difficult area to get treatment and management in.

CHAIR - In your submission, the rural and remote context talks about the nature of close-knit communities and the stigma and concerns around confidentiality, employment and social standing. Can you explain a bit more about the gender impact of that? Is it related to particular conditions or is it mental health, reproductive health or whatever? Can you provide more context around that section?

Dr SMITH - Things are changing. I think it was in 1997 that homosexuality was still illegal in Tasmania.

Ms O'BYRNE - The law changed in 1999.

Dr SMITH - Tasmania has come a long way since then. In my personal experiences, there are more and more people who are openly in different types of relationships and will openly express their sexuality/gender differently than they would have done many years ago. There's still a lot of stigma in remote communities. This is slightly not about gender, but I do remember a farmer I saw for many months who came in and would talk about his partner and how they were struggling. He kept coming back because he felt he wasn't being judged, but it took six months for me to realise that his partner was a man, and so -

Ms O'BYRNE - Josh is correcting you, it was 1997.

CHAIR - Sorry, keep going. With this man, it took six months?

Dr SMITH - Yes, so that was my fault. I wonder how often that happens. People come in and don't express what their social relations are, and things can be missed in diagnosis. Small communities are small communities. I work in a few small communities in Tasmania where everybody knows everybody. Someone will come through emergency and they'll go, that's Debra's daughter. It can be hard to be honest and open with those things if you can't trust the healthcare workers.

CHAIR - And you have to see them in the supermarket later, after you've done their pap smear or something.

Dr SMITH - And they have to see you.

Ms O'BYRNE - You have to go to the pharmacy as well, which is another level again. People who work in pharmacies have to see the person who -

Dr SMITH - A patient comes into a general practice and they see people in the waiting room, they see the receptionist, they see the nurse, then they see the GP, and then they go back to the waiting room and there's a whole bunch of other people there. That's an awful lot of places for stuff to go wrong.

CHAIR - How do you mitigate the risk in that process as much as you can, in terms of not allowing some of those biases, or perhaps shining a light on some of the biases that may play out in a patient's experience through there?

Dr SMITH - My personal opinion is that the number one rule is confidentiality. If you have a bias, that's going to happen. It may or may not be acceptable - but if you then allow that to leave the safe space of the consultation, then you've lost it for a very, very long time for a large number of people. Does that sort of answer what you're saying?

CHAIR - Yes, confidentiality in these smaller communities is obviously key. You've just described the patient's arrival and seeing the people in the waiting room, giving your name, and sometimes some detail to the receptionist, depending on how discreet they are, and then sitting in the waiting room, and then going into the doctor's surgery, the clinic room. Hopefully all of the confidentiality there is maintained, but then coming back out and there's some comment made about your next appointment, or a script you need to get or whatever.

I'm just talking about all the touchpoints you've mentioned. Is there a better way to prevent some of this risk to the confidentiality that sits behind a lot of this?

Dr SMITH - It is in the training, all the way through. A small community is a small community. You can't change the nature of these small communities. Well, that's not true is it, because the nature of small communities is changing, but in regard to this, that's not something you can effect on a day-to-day basis. I think it's in the training.

CHAIR - Training of your reception staff, as well as your medical nursing staff in a clinic?

Dr SMITH - Totally. I think receptionist staff get minimal training in patient confidentiality. They get training in how to book people in, book them out and take their money, but not in confidentiality. That's an area we miss.

Ms O'BYRNE - From the perspective of staff members, and regional doctors, regional nurses, people who work in the practice themselves, do you find many of them go externally to seek their own health care? Privacy is already a compromised issue for them. If you're a health professional, will you necessarily go to a doctor who works at the same practice, or are you going to go somewhere else, and is that the same for people who work in practices who aren't GPs?

Dr SMITH - That's hard to answer, because they wouldn't come and see you, would they?

Ms O'BYRNE - Do you note that you never see the people who work for you?

Dr SMITH - I'm not sure, it depends on the context. It depends on what they're coming in for. You'll see people bring in their kids, so you know it's less of an issue. I think if people won't, it's because they feel it's a risk. They might come in for something smallish, like a cough or cold, but for something a bit more serious and a bit more impactful on them, and something they might be embarrassed about, I think they've got to have quite a lot of trust in you and their colleagues to come to the same place that they're working in.

For example, in Scottsdale, which is one of the places I've lived in, that's an hour-and-a-half to the next practice, or an hour-and-a-quarter. That also does have an impact.

Ms O'BYRNE - Scottsdale was in my mind because it is a very small community, the waiting area is quite small, the hospital's just right next door, and in the pharmacy everyone knows you as well, so that ability to have any kind of privacy is actually quite compromised.

Dr SMITH - It is, but -

Ms O'BYRNE - I think people work hard to make it work.

Dr SMITH - Absolutely. I can only speak from working in a practice in a hospital, but I think across the spectrum you'll find that pharmacists are very good at keeping things confidential, and all the way through.

CHAIR - Going back to the training of reception staff, who you said are probably the ones who may miss out on some of these important opportunities. You talked about confidentiality, helping them understand the importance of that and how to maintain it. They're a lynchpin in any general practice, but particularly so in a rural practice where everyone knows everyone.

Is there other training those staff should have as well? Training is a big theme that's coming through here, so I'm just interested that reception staff haven't been identified as a group yet, except by you. What training do you think would be beneficial for them, in addition to confidentiality training?

Dr SMITH - I'm trying to think here - there's formal and informal training, isn't there, in terms of doing, say, a three-day certificate in training for this.

I think practices and practice owners and the businesses that run practices need to be aware that reception staff are undoubtedly the first people patients meet. I think they're not trained in confidentiality. They're also not trained in de-escalation. Should someone who's a bit angry for whatever reason come in, they're not trained in - how do I put it? The empathic feeling you get from reception staff will depend, as it does all the time, on that reception staff member. But I think there's a call for people having an idea of what it looks like from the outside. I'm not sure how to put that into words.

CHAIR - Empathy training, probably, is what you're saying?

Dr SMITH -Maybe, yes.

CHAIR - What about unconscious bias training? Would that be helpful for them?

Dr SMITH - The problem with reception staff is that in lots of practices, it has the highest turnover, and reception staff don't actually make money. We're talking about private businesses. They help everybody else make money, but there's no intrinsic value in reception, so I think it's not a priority for most business practice owners, so there tends to be quite a turnover.

CHAIR - I wonder, out of interest, why that is - not that it was part of this inquiry. I hear what you're saying, but because this is the first face they see, if there's a lot of unconscious bias going on about 'Oh, this trans person's back again', or whatever it is. We would hope that doesn't occur. It's a bit like our electorate officers. They are our face when we are not there. If they do a bad job, it reflects badly on us. I would think it would reflect badly on your profession if you have a receptionist who is displaying behaviours that may be seen as gendered in nature and, certainly, a level of bias.

Dr SMITH - I guess the alternative is if general practices weren't super, super busy and it was about keeping your client base because you had to, then you might find that we train better.

CHAIR - True, which is a bit sad in some respects that they're in the situation that you're in.

If I can go to the intersectionality matter, you have touched on it a little bit with First Nations women and other cohorts of women like women with a disability or other forms of disadvantage that may put them more at risk. How does the gendered nature overlay with all of that other intersectionality in terms of delivering health care?

Dr SMITH - I don't understand what you are saying, sorry.

CHAIR - Okay, when you are trying to deal with a person where English is not their first language, they may have dark skin, they may appear with a physical and obvious disability, does that make the gender lens over their healthcare decisions even more pronounced? Or do you think they are all separate matters?

Dr SMITH - Oh no, without a doubt, from all the way through the process, these things can present cumulatively. So, your experience as a non-English speaking Indigenous woman is way worse than your experience as an English-speaking white woman, which is worse, potentially, than your experience as a white English-speaking male. Is that what you're asking? These things can be cumulative or they can just present as, your problem is your indigeneity is what makes everything worse, but if you have a woman's health problem and you're Indigenous, then that makes your outcomes worse.

CHAIR - Yes, so where focusing on outcomes, it is layered in those circumstances. You may end up with - you talked earlier about delays to diagnosis or misdiagnosis. When I say intersectionality, I am talking about these things adding up so you will see further delays as a result of that.

If we could deal with gender bias, in the ideal world that potentially gives you more opportunity to look at the other areas of bias and deal with them, but we still have a way to go.

Dr SMITH - Yes, without a doubt. Obviously, we all know that you can't separate them out. You can't say, 'Right, we'll deal with gender stuff and then we'll deal with race and then we'll deal with financial and economic differences'. They all impact each other and they all impact how you can be dealt with. Does that make sense?

CHAIR - Yes. Some of us know the answer, but we need you to tell us.

Ms O'BYRNE - Otherwise it is not evidence in our committee.

CHAIR - Otherwise, it is not always evidence. It is our thoughts, so we need it from you.

Dr SMITH - Right, so the answer is yes.

CHAIR - Can I just go to your whole-of-system commitment? This goes partway to the training issue, but you also talk about strategies. Your submission says, under 'The important role for healthcare workers in working proactively to ensure that workforce reflects and supports diversity':

> This should include strategies such as promoting awareness of bias, barriers and discrimination, reducing bias, discrimination and disadvantage, and ensuring employees who may experience intersectional gender inequality are well supported.

And it goes on. So, can you talk about, at a practical level, what strategies should be in place, whether it be in general practice or in a hospital setting, if you are happy to talk about that as well, to deal with these very real challenges?

Dr SMITH - Do you mean from a training perspective? It all comes down to training. People like myself are fairly ignorant in terms of having training around race and gender. I have not had anything formal. I was trained in a British medical school and people would have been falling over fainting if that had been suggested in the 1990s. The colleges, the universities are getting better. I think it starts at the very beginning, it starts in your university, it starts in the diversity of your intake.

I was involved with Flinders University in the Northern Territory for some time. They had a very diverse and more representative intake, particularly Indigenous but also of women. That threw up its own problems. But it starts at the very beginning. Unless you have medical students and student doctors aware of these issues and thinking about them actively, then it is a bit late once you get out and you are sitting in an office and trying to see someone in 10 minutes and sort out their issues. So, it starts early.

CHAIR - Are you aware of any university that does this well?

Dr SMITH - I don't know, I can't answer that, sorry.

CHAIR - We heard from other GPs who have trained more recently than you and not in the UK, that there is still an absolute lack of this sort of training to help them even be aware of gender and equality, of racial issues or multicultural issues, and all of those things. One assumes that it is not happening. That is why I was particularly interested in the transgender program or course that was offered by ACRRM. We will get that information from you at a later time.

Dr SMITH - To stress that again, it is training. It is training earlier and training continuously about attitudes to gender and female health. I had been working for 20 years before I saw someone with gender dysphoria. Some things are getting better, things are coming out and they are talking to people who look like me about their gender dysphoria, so it is getting better from both sides. But we are still a long way from being very good at it.

CHAIR - What has led to that change, acknowledging there is a way to go? What do you think have been the primary drivers to making that first step?

Dr SMITH - I don't know if there is one answer to that. I mean, society is changing in general, is it not? The whole marriage equality debate, people are much more likely to express their sexuality now and, as things become more visible, they become more acceptable. I don't think I can put my finger on any set of circumstances. It is general change in society.

CHAIR - If you were to suggest to the committee, if you were sitting in our position, a couple of key changes that we should focus on to make progress in this area, what would they be? What would two or three key recommendations from your perspective be?

Dr SMITH - I can think of two. The first one is improved awareness and training, so early training. I hesitate to say compulsory but addition of awareness courses in medical training. It goes to nursing training, physio, OT training, it's not just doctors and nurses. And easier access for people who are no longer in training for these sort of courses and for exposure to these issues. They're the two I can think of off the top of my head.

CHAIR - You just talked about how busy and stretched GPs are and their practices. We all know that. It is impossible to create more hours in the day to do training. Is there a mechanism that you see will be most effective in delivering that?

This is to the ones who have already been out there like yourself, have been working for many years and, unless they have gone and sought it out themselves, haven't had any training in a lot of these areas. They are going to start, as it becomes more visible, to see more

transgender patients, they will see more patients with a range of diversity presenting. How do we make it easier for, not necessarily those training, but those postgraduates? How do we help them?

Dr SMITH - I don't know if this is the solution, but when you do your ACCRM fellowship, you do an advanced skill, so I do anaesthetics/obstetrics. Once you are on this register of having these advanced skills, you can apply to the federal government to get paid study leave. To keep my skills at a certain level, I am paid not totally a full day's wage but a wage or stipend. That is one way of doing it. Because we do continuing professional development, that might be a way of making it not necessarily a compulsory part but some of the options you can do. There's things like audits we do, so there are some things we have to do. If that became a part of continuing development, that might be a way of doing it.

CHAIR - As I understand that, I am a health professional by background and I understand the compulsory professional development requirements. From memory, and it's been a while, different programs or courses attract different levels of CPD points. Is that right?

Dr SMITH - That's true.

CHAIR - So, rather than just singing to the choir and having the people who are much more informed in areas such as empathy or transgender issues, there is a mechanism that you can actually award higher points to some of these programs that may not be taken up. You have got to get the right number of points to be re-registered. Do you understand how that process works, how the awarding of points works?

Dr SMITH - I don't. I have no idea.

CHAIR - Who would know that?

Dr SMITH - There would be someone at ACRRM I could ask about that. I can only speak from general practice but I can see there being problems with asking a surgeon to do an empathy course.

CHAIR - Yes, that is what I am thinking. But if you put a high level of CPD points, if they get 100 CPD points for half an hour's work where all the other things that might interest them are at a much lower level, it's called the carrot and stick approach, to encourage people to take a path. Is there anyone in ACRRM that might be able to answer that question on how the CPD points are worked out?

Dr SMITH - There will be. I will do that. That is point 2 on my list here.

CHAIR - That would be helpful. We can talk to them and they can send us through how that is worked out. It may not be the same in ACRRM as it is in the college of surgeons, for example. It will be interesting to talk to the college of surgeons about that. We might do that.

Ms O'BYRNE - Can I touch on that? It has been raised flippantly a few times that there are sections of the medical profession for whom we do not have an expectation that they will behave with empathy or with a trauma-informed process.

CHAIR - Probably unfair.

Ms O'BYRNE - It may not be the case for all of them, that's probably true. But there has to be a time when we change that expectation. I know that a lot of the induction work for new students now deals with some of that psychological, behavioural and attitudinal work. But how do we deal with that? Many of the experiences we have are, in fact, from people who have been practising for some time, or the evidence that's been provided is that people have been practising for some time from whom we don't expect better. How do we deal with that, or how does your organisation think of dealing with that, whether it's surgeons or anyone else?

Dr SMITH - A good starting place would be universities. All surgeons start at university. But it's not fair to just pick on surgeons.

Ms O'BYRNE - But it's the flippant comment that is made. I've had surgeons say to me, 'The reason I'm really good at my job is that I don't do the other things, I only do this thing'. I accept all of that. But we must have a broader expectation of the experience that people will have in the healthcare system.

Dr SMITH - Again, without sounding flippant, the earlier you get people, the better outcomes you're going to have. This may well be why there is a discrepancy of gender in surgeons. If you lack the empathy, then maybe you do better. If you're more likely to be empathic, then you don't and you leave, you go and have your family or those other things that cause women to not go further in those arms of the profession.

My personal feeling is that the earlier you get people, the more likely you are to form their ideas and form how they see themselves in the profession and their role in it.

CHAIR - We know the arc as a surgeon starts as a medical doctor.

Ms O'BYRNE - The committee has had some evidence around the workplace conditions and employment arrangements of a gendered nature within health care. I remember when I had the Health portfolio being told by a representative body that the problem with the shortage in doctors was all these women becoming doctors because they want to work part-time. How do we shift that attitudinal role about responsibilities that people of all identity have in terms of choosing to work part-time for whatever reason, or for parenting obligations? What work can you suggest needs to be done to ensure that that isn't a barrier for people taking employment or positions?

Dr SMITH - My first point is a question. Do you not think that's changing already? I feel that there's many more people doing part-time work and that's becoming much more acceptable. One of the problems in the submission, or the thing I just said, is that I can talk from experience of working that female GPs are paid way less than men. That's something we need to get to grips with. Again, that partly comes back to training and what training I have had as a man, and how I see my role in health care as a man. I would find it financially easier to work part-time than a colleague with the same experience, knowledge and qualifications as I have because -

Ms O'BYRNE - That's interesting as well, as to how that can be addressed and whether there's any evidence or thought that the committee should take on board around ways of dealing with that.

Dr SMITH - I think that's above my pay grade.

Ms O'BYRNE - Your personal views, perhaps.

Dr SMITH - I honestly don't know. Again, without just falling on the same argument, the sooner we educate healthcare professionals to prioritise partly their sense of wellbeing but also their attitudes towards health care, then the better off we are in their attitudes towards other people.

Ms O'BYRNE - Can I go back to that comment you made before about mandating and whether training should be compulsory or not? It was a bit of a throwaway comment. Evidence shows that unless you really want a change in attitude, it's really hard to change. But is that a reason not to make training compulsory for people who are currently in the field?

Dr SMITH - You could make everything compulsory, couldn't you? You could make race training compulsory -

Ms O'BYRNE - I'm okay with that, too.

Dr SMITH - I wasn't suggesting you shouldn't be, but you might run out of space once you've made everything compulsory.

CHAIR - When they have been trying to look after patients.

Ms O'BYRNE - True, but if the argument of the evidence from this committee is that people are having negative experiences because these skills are not known, what then is the obligation to ensure that at least we've done everything we can to ensure people have an awareness of these sorts of things?

Dr SMITH - I don't think the being compulsory is necessarily a problem. You also have to remember, I guess, that people change over time. Someone who had absolutely no interest in gender issues five years ago will find that it is becoming more and more a part of their practice and might develop an interest in it. People's tastes and mores are changing all the time.

I don't know what ACRRM's official position would be on compulsory training in those different areas. As a health professional, I feel I might be turned off by being told it was compulsory - but that might just be me.

Ms O'BYRNE - Thank you for that.

CHAIR - We have run out of time, Colin. Is there anything you wish you'd said that you haven't, or any insightful recommendations you'd like to put to us before you finish up?

Dr SMITH - No, I may have said more than I should have done already. Thank you for allowing us to talk to you and I hope it has been useful.

CHAIR - We appreciate it, and the submission was very helpful as well, thank you. We will write to you just to clarify those few things, so you can respond when you get an opportunity. Thank you.

THE WITNESS WITHDREW.

Ms JESSICA WILLIS, CLINICAL SERVICES MANAGER, FAMILY PLANNING TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED VIA WEBEX.

CHAIR - Welcome, Jessica. This is a public hearing and is being live-streamed. Everything you say is recorded and the transcript will be published on our website at a later time once available and will form part of the public record. Everything you say is covered by parliamentary privilege while you are before the committee, but parliamentary privilege may not extend beyond this hearing, if you could keep that in mind.

If there is anything of a confidential nature you wish to share with us, the committee would consider your request, stop the broadcast and not publish that aspect of the transcript. Please keep that in mind and make that request if you wish to do so.

Do you have any questions before we start?

Ms WILLIS - I don't think so. That is all understood.

CHAIR - Okay then. Do you solemnly promise and declare that the evidence that you are about to give the committee shall be the truth, the whole truth and nothing but the truth?

Ms WILLIS - I do.

CHAIR - I may have to do this with Lalla as well, if she manages to get back in. There could be an issue maybe with the connection.

Jessica, thank you very much for the very comprehensive submission to this inquiry into gendered bias in health care. The committee members at the table are Dean Harriss, Dean Young, Nick Duigan, Michelle O'Byrne, Josh Willie and myself, Ruth Forrest.

I will invite you to introduce yourself. You are then welcome to add to or clarify any points in your submission and make an opening statement, and then we'll go to questions.

Ms WILLIS - Good morning, everyone. Thank you for the invitation to speak to you today. I am Jessica Willis, the Clinical Services Manager at Family Planning Tasmania. I look after our three medical practices in Burnie, Launceston and Glenorchy that provide sexual and reproductive health - GP specialty services, essentially - to over 16 000 people in Tasmania a year.

As I said in my submission, 96 per cent of our patients are either female or assigned female at birth, and all of our doctors - 25 doctors and eight nurses - are also female. We were motivated to submit to this inquiry because we really do witness, day to day, the disadvantages women experience in our healthcare system - that is, both female patients and female doctors.

I have tried to outline in my submission the areas we see and think women face the most disadvantage. I would probably summarise by saying it is largely a financial disadvantage in the sense of the complex needs that women have throughout their reproductive life and beyond,

and the fact that quality sexual and reproductive healthcare, or things like contraception, pregnancy and abortion, simply cannot be provided in 10- or 15-minute consultations.

The Medicare rebates for these services are grossly insufficient for the amount of time it takes, which effectively results in what I fear is a women's health acts [axe?] that's either paid by the patient or borne by the GPs, who are also overwhelmingly female.

CHAIR - Clearly, the Medicare scheduling is a federal government responsibility. It is not only Family Planning Tasmania that deals with this, but any medical practice where women are seeking that sort of care. With any communications you have with regard to that, have there been conversations federally that you are aware of about this, to try to get some equity into the scheduling arrangements?

Ms WILLIS - There has been a lot of discussion at a federal level. The recent federal senate inquiry quite possibly discussed this topic in an awful lot of detail, because of course it isn't something that is only experienced by people in Tasmania.

In my opinion, we need a two-pronged approach. One is lobbying at a federal level to make sure Medicare rebates for the essential sexual and reproductive healthcare services women need are adequate. There are also some things we could do at a state level and that other states do to go some way to compensate for the lack of MBS Medicare funding for the care that women need.

Ms O'BYRNE - Can you talk about that?

CHAIR - Any of the states you believe are doing it better, could you tell us who they are and what they do?

Ms WILLIS - Sure. For example in ACT and Northern Territory, I think it has been in the last year or so that all abortion care is now free for anyone who needs it. For us that would be a really critical step to reducing some of this inequity and improving outcomes for women.

Ms O'BYRNE - That is MToPs and SToPs, isn't it?

Ms WILLIS - Medication and surgery terminations, yes. In Tasmania, it is fantastic that in the last couple of years we have access to surgical terminations at no cost in all of our public hospitals. That has been an amazing development.

Ms O'BYRNE - It has been a huge amount of work to get them to agree to take out the disadvantage clause, but we did it.

Ms WILLIS - There's always work that can be done but in the big picture it has been incredible for women, particularly those in the north and north west of Tasmania who did not have any access at all. Now we have a slightly perverse situation whereby surgery, which is more expensive to provide for the state and more involved as an experience for the patient, is easier to access than a medication termination in Tasmania. We see people choose the surgical option for cost reasons. It is simply that a high-quality medication termination takes a bit of time to provide. Going back to my previous point, the Medicare rebates don't cover the amount of time that it takes to provide the service.

We would love to see Tasmania follow the lead of territories like ACT and Northern Territory with state funding for all abortion care and, ideally, contraception.. With long-acting reversible contraception, it is often said that the main two types that we use, IUDs and implants, require procedures and they require doctors to have completed additional training. Once again, Medicare rebates don't cover the cost of the time required to provide the service or things like sterilising. It means that those extremely reliable forms of contraception are much harder to access in Tasmania than they should be. That inevitably leads to more unintended pregnancies.

CHAIR - A medical termination pregnancy is, for the vast majority of women, a much less risky procedure. It takes less time to recover from, you notionally get an improved outcome and are more ready to return to work. Women are being almost forced down the path of surgical termination and the expense that goes with that, the inconvenience that goes with that, having to go to a hospital and potentially arrange childcare for other children. You can't do it as confidentially as you might a medical procedure. Without funding to do that, we're not going to see that change, I expect?

Ms WILLIS - I agree. I don't think the outcomes are better with a medication termination, but it is certainly a lot more straightforward, more private, much easier in theory to access in primary health care. It is the preferred option for most people.

CHAIR - If they had a choice?

Ms WILLIS - If cost were no issue. We try to give everyone the choice. Obviously, for medical reasons, some are not suitable or the other.

Ms O'BYRNE - Do you have the data on the number of people who could have accessed a medical termination if provided but chose, due to the cost, to access a surgical one? Are you able to pull that together or is that a really difficult thing?

Ms WILLIS - I don't have any data on that decision because it largely takes place within the confines of a confidential medical consultation. We don't have a record of the number of people who would choose medication termination. I've seen some statistics, and again I'd have to double check this, that in the United Kingdom 70 per cent of all terminations are by medication. In the UK you can even access the medication by post since COVID-19. It's much easier to access in general practice. In Australia it's more like 20 or 30 per cent of people receive a medication termination and the remainder have surgery. There's obviously a big difference there. Ease of access and cost would play into that.

CHAIR - Going back to the Northern Territory and the Australian Capital Territory - they're both territories which get a lot of support from the federal government - are you aware of the funding arrangement that this is provided under? Is it the territory governments which have made the decision to fund the entirety of those services?

Ms WILLIS - That's my understanding. I don't know how it's administered but I think it's block funding. I recently saw headlines in Victoria where the state government has announced it's setting up 20 women's health clinics to provide free comprehensive care and support to people of Victoria. They haven't specifically funded terminations but they're addressing the same problem, that women have these complex healthcare needs that Medicare doesn't cover the cost of.

Ms O'BYRNE - Victoria also provides training in schools for boys and girls in things like endometriosis and those women's gynaecological and broader issues as a compulsory part of the curriculum. It's also supposed to deal with some of the stigma that we experience in all of this.

CHAIR - Going back to the funding model, Family Planning has services in three regions of the state. What do you think might be the answer to addressing out-of-pocket expenses and some women making decisions to have a surgical termination at a greater cost to the health system if you get down to the tin tacks about money? Do you think it would be increasing the funding to a service that already exists or is it building a new SIS service? I am interested in how you think this will work to provide an equity of access service?

Ms WILLIS - From my perspective, Family Planning Tasmania already has a model that works. It provides a high-quality and well-received service in Tasmania. Family Planning Tasmania is definitely not funded as well as family planning organisations in some other states. We are very grateful that we get some of our funding from the Department of Health, but we don't get any funding for our doctors' time - so we are required to pay our doctors' salaries through fees.

We have a mixed billing model, where we bulk-bill patients on low incomes and everybody else pays a fee. With additional funding, I think that model could work and could be expanded to provide services to many more people.

Family Planning Tasmania was recently selected by the federal health department to specialise in endometriosis and pelvic pain, and they've funded existing clinics to provide specialised services for endometriosis and pelvic pain. In my opinion, with some additional funding, a lot of these issues of gender bias and inequitable access to services could be addressed at a state level simply by extra funding to pay doctors for their time - with the understanding that Medicare rebates do not do that. They do not cover that cost.

CHAIR - If there was additional block funding, or however you want to describe it, that would fund the time doctors need to provide things like medical terminations and inserting intrauterine devices or even Implanons, do you think that should preferably come from the state? Or should the state be lobbying the federal government to provide block funding for these kinds of services?

Ms WILLIS - In my opinion, potentially both should happen. We should all be lobbying for improved Medicare rebates for women's health services, but realistically, I also think that some state funding would go a long way to being able to provide a great deal more of these services to people in a way that's affordable.

Ms O'BYRNE - Your submission talks a bit about pain management. We've heard a lot of evidence about the long time to diagnosis, and the misdiagnosis of women's pain in particular. Will the new federal funding that you've received for the clinic be enough to actually allow any outreach? You mention that you are often asked to provide women's health outreach, so does the new funding commitment allow that, or is it too early to tell how that will be structured?

Ms WILLIS - I think it's safe to say that it won't be able to cover the costs for us to do outreach. The funding is $700 000 over four years - and that's for three clinics and thousands

of people. While we might be able to do bits and pieces, I don't think it will allow us to actually establish a sustainable outreach clinic model.

Ms O'BYRNE - Also, you are obviously dealing with a number of women who identify with pain issues. We've heard some evidence around the need for more appropriate leave entitlements, so I'm assuming your GPs are having to write sick leave certificates or sick leave requests for women with pain, or dealing with women who don't access the leave because it simply isn't there. Do you have any suggestions that the committee might consider around ways we might more appropriately give leave entitlement for women, given the nature of women's experience?

Ms WILLIS - I am not an expert in this area, but certainly it's a very strong trend at Family Planning Tasmania that so many of our patients are casual employees, who obviously then struggle with being able to schedule appointments in the first place, because they don't necessarily know their rosters or shifts very far in advance, but also because they're simply not entitled to sick leave anymore. That my impression.

Ms O'BYRNE - That's fine, we are noting a gendered outcome from leave entitlements so far in the committee's evidence. My last question goes to one of the quotes that you had when you contacted your clinical workforce on gendered health care.

When we drafted the original reproductive health legislation, we did not include an exemption that would allow doctors to refuse care, and after much negotiation, we ended up with an obligation that they had to refer if they weren't prepared to provide the service. But from your evidence, and evidence we've had from conversations with others, there's a significant issue in people being able to access the appropriate referral pathway.

I'm just interested in how large you think that experience is. Are you getting a lot of evidence of people being either refused or not referred appropriately, with doctors using their exemption capacity under their individual choice - which of course I have a lot of problems with?

Ms WILLIS - I actually wouldn't say that is something we feel we have experienced that much -

Ms O'BYRNE - Sorry, it says in the submission:

> I often hear about women seeking termination either being outright denied a referral for a termination or being sent for repeated investigations without referral.

And the line about someone being told they were in the prime age group to have a healthy pregnancy and they would regret having a termination.

Ms WILLIS - That's something our doctors have come across, hence the inclusion in the submission. I think for Family Planning Tasmania, from an organisational perspective, the bigger problem is actually simply that it's acceptable for so many doctors just not to engage in the topic of abortion, for example. It's too easy for them to be able to say, I just don't do women's health care, go find someone that does. For me, that's a much bigger problem.

Ms O'BYRNE - The legislation says that they're supposed to find you someone who does. That doesn't seem to be the lived experience that we're hearing.

Ms WILLIS - I would say that definitely happens, although most GPs would at least know a colleague who is happy to provide women's healthcare services, and so they can send everyone in that direction.

For me, that feels like a bigger problem. Again, that doctor who is then not engaging with women's health care because it's not financially very rewarding, and because you need to have additional skills and training, for me it's sort of outrageous that the doctor probably then goes on to earn more money by choosing not to engage with this whole complex area of health care.

Ms O'BYRNE - That's actually quite concerning. Thank you for raising that.

Dr WOODRUFF - Sorry I came in late. Would you be able to talk the committee through the intersection and the differences between the work of Family Planning Tasmania and Women's Health Tasmania, because we'll have Jo Flanagan and others from Women's Health speaking with us this afternoon, and their submission raises very similar and important issues. I just wondered what the relationship between the two organisations was - just as an aside, I suppose.

Also, Family Planning Tasmania still does sex education, so what is your educative role and who you do that with - obviously with school students, but do you also do that with medical professionals, et cetera? Could you just talk about your education?

Ms WILLIS - Sure, I will do my best. My CEO, Lalla Mackenzie, is the expert in that topic, and has been having some connection issues this morning in joining this hearing - but I will certainly do my best, from a clinic perspective.

In response to your first question, Family Planning Tasmania and Women's Health Tasmania work collaboratively. Family Planning Tasmania provides clinical services relating to sexual and reproductive health. The area where we overlap with Women's Health Tasmania quite a lot is in the area of pregnancy counselling. If patients come to us who have an unintended pregnancy and they're not sure about how to proceed, our nurses are trained to provide pregnancy options consultations. We don't have any psychologists or counsellors. We refer people to Women's Health Tasmania. They are funded to provide a pregnancy options counselling service at no cost to women in Tasmania, which is fantastic. That could be before or after termination.

Women's Health Tasmania focuses largely on health promotion and awareness, whereas we are a clinical services provider, the nuts and bolts of running medical practices.

Dr WOODRUFF - Thanks. In your educative role, do you engage more upstream with the medical school and with the colleges in the training that's being provided for new practitioners and professionals and clinicians around gender issues, inclusiveness for people who are LGBTI and gender-diverse, or the gamut of cultural awareness that needs to change in order for women to be properly treated wherever they present in the health area? Obviously reproductive health is your specialty.

Ms WILLIS - We largely don't do that. It's not something that we have a focus on in the sense that's our core operations. We have an education team that provides education relating to healthy relationships and sex education, both in schools and one-on-one with people with additional needs. The problem we've found with our work with schools is that increasingly schools can't afford to pay for that service. In most states it's something that is pre-funded. In Tasmania, the schools are required to pay for the education themselves. Family Planning Tasmania doesn't get funding for those educators. One of my colleagues would have to get back to you with the details, but a smaller number of schools are able to pay for our sex education services.

Dr WOODRUFF - Are you saying that other states provide that funding to schools or to Family Planning Tasmania to do that work? That's what always used to happen. But it doesn't happen in Tasmania?

Mr WILLIS - It doesn't happen in Tasmania. I'm not sure how it's funded, but it's essentially pre-funded, whereas in Tasmania the school is required to find the funding out of their budget, which I think increasingly they can't do.

Dr WOODRUFF - It's your understanding that there would be a large number of schools in Tasmania who aren't able to access sex education for their students?

CHAIR - Specialist sex education.

Dr WOODRUFF - Around reproductive health.

Ms WILLIS - That's correct. I think most schools have access to a nurse in some form, but I guess they're not expert educators and they're not experts in sexual health.

Dr WOODRUFF - So there's also no STI training happening, with specialist people coming in? That used to be a role Family Planning Tasmania had everywhere.

Ms WILLIS - Not that I'm aware of. Family Planning Tasmania provides training for specialist sexual and reproductive health training for some doctors and nurses. They are doctors and nurses with a special interest in sexual and reproductive health, and they're completing their Family Planning Alliance Australia certificate. In the case of nurses, they might be completing their screening training. As I said in my submission, the nurse training component has really dropped off recently because nurses are not able to, for the most part, practise at their full scope and not able to, for financial reasons, provide cervical screening tests or STI screens, which I think is a huge problem we could also address in our state.

The problem with nurses providing some of these essential screening services is twofold. There is no Medicare rebate for nurses so it is not financially viable, and pathology services in Tasmania will only accept requests from doctors. I have just moved from the mainland. I am trained to provide cervical screening tests, which, as we all know, is an essential screening service for women that we want everybody to complete every five years, but nurses are not practically able to provide this service in Tasmania.

Dr WOODRUFF - Do you know if that is a state government policy decision or is that Medicare, the federal government?

Ms WILLIS - I tried to get to the bottom of it. Because they are able to do it on the mainland, it must be something within our state that is stopping them. I don't know whether it's the pathology providers who are requiring doctors to provide a number, I am not sure.

CHAIR - I can probably help with that a bit, Jessica. I don't know whether it's all registered nurses on the mainland or it's nurse practitioners in sexual health, but Tasmania has a really low number of nurse practitioners. There are some sexual health ones who may be able to refer pathology and even radiology in some situations and prescribe within their scope. You have to be a nurse practitioner to do it and we have a very low number of nurse practitioners.

Ms WILLIS - The nurses I have spoken to are not nurse practitioners, they are registered nurses.

CHAIR - They may be accredited then.

Ms WILLIS - It's within their scope and they are indemnified to provide cervical screening tests. It's just practically, in Tasmania, we prevent them from doing it. It's a huge issue that could easily be solved.

CHAIR - It could come down to their training as well as their registration. There could be two aspects to this.

Ms WILLIS - Yes, but lots of nurses - all of our nurses - at Family Planning have done extra training in cervical screening.

CHAIR - But they still can't do it?

Ms WILLIS - Well, they do do them with us, but under the supervision of a doctor. The problem is, in lots of rural and remote places in Tasmania there is no doctor, so they don't have the doctor's supervision that would let them press [address?] the pathology.

Dr WOODRUFF - We could clarify that with the Health department when we speak with them.

CHAIR - Rosalie touched on the outreach clinics that you talk about on page 5 of your submission. You said the cost to government of Family Planning Tasmania providing quarterly clinics in each remote/regional community is less than $10 000 a year. It seems like an absolutely minuscule amount in the Health budget. How many outreach clinics are we talking about and where?

Ms WILLIS - This relates to a budget priority submission Family Planning Tasmania put in last year. We worked with the Child and Family Learning Centres in Tasmania to pull together a proposal for running outreach clinics in eight of the most regional and remote areas. There were seven Child and Family Learning Centres, one was in collaboration with the Aboriginal centre in Smithton, which doesn't have a Child and Family Learning Centre. I could pull up a list like St Helens, Smithton, Queenstown. I'd have to go back to my submission to check the list, but we have eight locations that are rural or remote and also have the established infrastructure, and the partner in the Child and Family Learning Centres that would be keen to host a family planning outreach clinic.

CHAIR - If you could provide the eight sites, it would be helpful. Just to confirm, that $10 000 per annum would fund quarterly clinics to eight locations?

Ms WILLIS - That's $10 000 for each location.

Ms O'BYRNE - Just clarifying that they would also be able to deal with a whole range of women's health issues that present, so they wouldn't be limited? That's quite an all-encompassing service.

Ms WILLIS - Yes. We feel like these places are really crying out for good-quality women's health GP services. We are also extremely keen to provide those services. We have the doctors that would like to do outreach and see the need, but we can't get it to work financially. We employ all of our doctors so we have to pay them for their travel time. We have that cost on top of the fact that the Medicare rebates don't cover the cost of the salary in the first place. With a bit of extra funding we could do a lot in terms of outreach.

CHAIR - On the money side of things - and we talked about this earlier about the medical terminations and surgical terminations - you said that Family Planning Tasmania estimates it could meet current demand for free medical terminations of pregnancy in Tasmania for less than $250 000 a year. Do you have any ballpark figure of how much it costs for the surgical terminations as a total?

We are talking about $250 000 here a year to provide a medical service, acknowledging that not everyone is suitable for a range of reasons for a medical termination. Do you know how much is being spent in our public health system for surgical terminations?

Ms WILLIS - I don't, I'm afraid. Those surgical terminations that are covered by health funds like the Women's Health Fund, I believe they are charged at around $3000 per procedure, whereas a medication termination of pregnancy is $150, including ultrasound, at Family Planning Tasmania. We were lucky enough to receive some funding to introduce an ultrasound service, which has dramatically improved our own medication termination of pregnancy service. It has been amazing. We provide the ultrasound at no cost.

I'm jumping around a little bit here, but for me it is a massive issue for women that there's no public provision of ultrasound in Tasmania. Women require ultrasound for a lot of reproductive and pregnancy-related issues, in a way that men don't typically, until they potentially get a bit older. Our patients cannot access bulk-billed ultrasound services anywhere in Tasmania.

Ms O'BYRNE - I can add that the experience of people who have raised it with me is that even if you can afford it, the waitlist for getting ultrasounds is quite long. So, even if you have access and affordability is not an issue, waitlists are significantly difficult, even on emergencies.

Ms WILLIS - That's true and that is one of the reasons why we had to introduce our own ultrasound service because the wait meant that many people were missing the nine-week legal cut-off for the medication, which ends up costing the Department of Health more with the surgical option.

CHAIR - In terms of the lack of publicly funded ultrasound services, has Family Planning lobbied the Government on offering that service? The majority of the radiology services provided are contracted by the state from a private provider. Is that the issue here?

Ms WILLIS - Correct. I believe in other states you can potentially access ultrasound in the public system, in the public hospitals, but that has not been an option here for us. They won't accept requests or referrals for ultrasound from GPs. That's been the case since I started in this job.

Ms O'BYRNE - You have to be an admitted patient.

Ms WILLIS - Cost is a huge issue and we see people just going without the ultrasounds they need because they can't - an ultrasound is an involved thing to provide and it requires specialist skills. Family Planning Tasmania doctors are trained to provide early-pregnancy ultrasounds but we're not sonographers. So, we could not do an ultrasound to investigate pelvic pain or endometriosis, or any of the other issues people might have. They need to see a specialist sonographer and they have to go to a private provider, and that private provider can obviously set their own fees.

Ms O'BYRNE - Because this is only a recent new investment and engagement, can you provide the data on how many times you have provided an ultrasound service, just to have a demonstrated need picture?

Ms WILLIS - We are providing an ultrasound service now for almost all of our medication terminations and a large number of early-pregnancy appointments that don't turn out to be medication termination. Either the person decides to continue with the pregnancy or they choose a surgical termination. I haven't got the stats in front of me but we provide about 60 or 70 ultrasounds a month at the moment across the state. And that's a growing number as more of our doctors complete their training.

CHAIR - How was that funded? Was that a grant, like a one-off thing, to purchase the machines?

Ms WILLIS - Yes. In response to our budget priorities submission in 2021 we got some funding to look at services to relieve the pressure on the public system, and one of them was introducing an in-house ultrasound service.

Ms O'BYRNE - It has been an excellent initiative.

Dr WOODRUFF - Could I ask a question about the change over time between medical termination and surgical termination choices women are making? You have flagged that cost is an issue which is now, perversely, making it more affordable for women to have the more invasive surgical termination than it is a medication termination, which is a terrible situation for women. Is there anything that you could speak to about the change over the years? Medication terminations haven't been available in Australia for very long, have they, thanks to Brian Harradine.

Other than the things you have flagged here, are there any other blockages for medication termination? Are you seeing any change in the women who are accessing it, age groups,

anything else about the demography or characteristics of women? And is there any other role in terms of education or information that we should be considering?

Ms WILLIS - I am not quite sure which year the medication termination became legal but I do know that until, it was probably 2018, Tasmania had a single private provider for medication termination which pulled out of the state for financial reasons. Only at that point did Family Planning Tasmania decide it had to step in and fill the gap.

Ms O'BYRNE - It was legal from 2013 when we did the legislation. We actually had a piece in the bill about medication terminations.

Ms WILLIS - I think Family Planning Tasmania stepped in to fill the gap but has never received any funding outside of the ultrasound service; it has never received any funding for the service. There is still a lot of misconception in Tasmania. Lots of people think that termination is either still illegal or they don't know it's available in our public hospitals. I feel like there's probably quite a lot of work that could be done there. Most people look to friends and family for advice and support about where to go if they have an unintended pregnancy. If those people haven't updated their knowledge or understanding recently that ends up spreading a lot of misunderstanding and misconceptions about what the situation is legally and practically.

Women's Health Tasmania is doing some work to address that with the Pregnancy Choices website and awareness-raising campaigns around the fact that termination is safe, legal and accessible in Tasmania. Regarding demographics, people of all ages require terminations. I think 50 per cent of women will have an unintended pregnancy in their lifetimes and half of those will go on to have a termination. Contraception is never 100 per cent reliable, so there will always be a need for termination. Half of our termination patients have already had children. Lots of people have a termination when they've completed their family, rather than the traditional stereotype of them being young. I'm not sure if that answers your question.

Dr WOODRUFF - You've stepped in to pick up the slack, but the direction we all want to head is better knowledge and capacity to use contraception and access, affordability and those other issues and power. Family Planning delivers the medication of termination pregnancy service?

Ms WILLIS - Correct. It's not in our core contract with the Department of Health and we don't get funded to do it, but last year we provided over 400 services. This year, thanks to our ultrasound service, we're on track to having increased that to over 600. As the service gets harder and harder to obtain in general practice because of the shortage of GPs and inadequate Medicare rebates, more and more patients will look to specialised services like Family Planning Tasmania to access the service. I see the demand only growing.

CHAIR - Do you know how many GP practices offer MToPs?

Ms WILLIS - Women's Health Tasmania could probably answer that question a bit better than I could. In somewhere like Launceston it would be a handful of individual GPs. On the north-west coast, maybe one or two individual GPs outside Family Planning Tasmania. In Hobart, the situation is better.

In some ways I don't blame the GPs. They're booked up already four weeks in advance, there's no financial incentive to provide the service, so those that do it often have to work over their lunch time to fit people in, because of the time pressures in delivering the service. Good female GPs really have to sacrifice their own time if they want to be able to provide the service.

General practice isn't set up to cater for both the time and urgency that's required to provide the service in a thorough way. Since I've started working at Family Planning, I've been convinced that it sits best with a specialised service set up with the supports in place that people need throughout the service. They don't just need an appointment and a script, they need some support before, during and after.

Dr WOODRUFF - Your submission shows the cost of a SToP to the health system is about $3000 a procedure and people undergoing financial hardship can be reimbursed for an MToP through either Women's Health or the link. You still have to advertise the cost. What is the cost of a medication termination Family Planning has to advertise?

Ms WILLIS -It's $150 out of pocket, plus the medication. The medication depends on whether you have a concession card or not. We have an arrangement with the pharmacy where we buy the medication from them and then we pass on the costs to the patient. That's because it is so important that the patient takes the medication correctly. We talk them through it in the clinic and let them leave with it. It also means they don't have to then face an additional barrier in finding a pharmacy that dispenses the medication.

Our services take about 180 minutes to provide in total, including an ultrasound. The most we get back from Medicare is $114. We charge $150 out of pocket. That would certainly be a lot less than in some purely private practices.

Dr WOODRUFF - Thanks. The cost of the medication?

Ms WILLIS - I think it is $65 if you don't have a concession card.

Ms O'BYRNE - Two of the challenges there are for a medical termination you need to be within a reasonable distance of accessing health services. That's been one of the issues with the mail option. That's an issue for women who need to be able to get to you, which comes back to the reduction of the outreach opportunities. The second is the number of pharmacies that don't stock it and those that won't stock the morning-after pill and GPs who won't provide the morning-after pill. Do you have a picture of that in Tasmania?

Ms WILLIS - I can't talk on that topic with any great insight. I know it can be hard to find a pharmacy that dispenses the MS-2 Step medication, which is pretty shocking. That's the main reason we have our system set up so we don't have to worry about that for our patients.

Ms O'BYRNE - It might be worth asking the guild if they have a view on this.

CHAIR - We are just about out of time. Jessica, thank you for your time today. You have made some solution comments in your submission. If there was another recommendation or something else you haven't said that would work to address the gender bias and the inequality that we see in the system, what would be the key couple of points or the key focuses to address?

Ms WILLIS - I don't have that much to add. It would be some state funding to help women access terminations and long-acting reversible contraception at no cost, similar to ACT and Northern Territory, places like New Zealand and the UK. That would have a massive impact on outcomes and overall costs to the state with regard to focusing on that preventive health. It's not something Family Planning Tasmania provides, but the ultrasound issue is a huge one. That should be addressed.

CHAIR - Thank you very much, we appreciate your time and expertise. If Lalla had something she wanted to pass on to the committee, please let her know that she's welcome to send through anything in writing.

Ms WILLIS - I will do.

CHAIR - We could not link up with her. Thank you very much.

Ms WILLIS -Thank you for your time.

THE WITNESS WITHDREW.

The committee suspended from 12.30 p.m. until 1.30 p.m.

Dr ANNETTE BARRATT, **Dr JULIANA AHMAD**, AND **Dr KATE BENDALL**, AUSTRALIAN MEDICAL ASSOCIATION - TASMANIA, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED.

Dr BARRATT - I am Annette Barratt, and I am the AMA Tasmania vice-president. I am also a general practioner of some obscene number of years. I had my 40th graduation [anniversary?] last year so I am not even going to mention how long I have been in the industry.

Thank you all for inviting the AMA to do a submission into gender and equity. AMA Tasmania consulted with our members across the state, from students through to retired doctors and through all specialties, from general practice through to psychiatry, and everyone was invited to put their comments. Thankfully, we got comments from not just the females, as we would expect, but also from males; from GPs, which we expected, from medical students but also from psychiatrists and other consultants within the hospital system. It was very gratifying to know that they were all putting their hats on to talk about this issue.

Our submission focuses on the general female experiences in health care while acknowledging that gender is a broader issue. We do not wish to limit the scope of the committee and we recognise that it is much broader than just those experiences by females. We are also cognisant that there are other attributes that make a woman more vulnerable to bias, including women with disabilities, Aboriginal and Torres Strait Islander women, culturally and linguistically diverse women, LGBTIQ+ and transsexual gay people; and particularly women from rural, regional and remote backgrounds as well. We know that women in those areas are subject to more bias. We think that it is particularly relevant in relation to intersectionality, people coming from different areas.

In our submission, we focused on the first two terms of reference subjects. However, you will see in our comments that we cover some of the other issues raised as well. The submission also addresses the issue of gender bias of women doctors working within health care and for patients.

My colleagues here will be focusing on the patient experience and I will make some general comments from the doctor's point of view.

AMA Tasmania and the national AMA are making strides to improve the gender balance. I made the comment as we started that the AMA across all its committees, both state and federal, requires a gender balance of 40-40-20, which allows there to be a balance in all committees. In most of the committee, including the federal council and certainly AMA Tasmania's board and state council, we have met those guidelines. We find that is important because people can't be what they can't see, to use that usual simple quote. A lot of the other colleges also have gender balance requirements, such as the College of Emergency Medicine and the College of Psychiatry. They don't always meet what they say, but we find that it's being discussed at all levels. We feel that's important.

The health sector in Tasmania has guidelines for gender balance, but has not yet managed to reach those in all areas. It has certainly improved since the day I started in health politics. Very early in my career, I was often the token female who turned up to committees. I'd be the only person under 30, and I'd certainly be the only one who wasn't a male in a suit wearing a college tie. Things, thankfully, have changed in those years.

That's my opening statement. I'll hand over to Kate and Jules, who are going to take you through a patient experience.

Dr BENDALL - I'm Dr Kate Bendall, a GP in Kingston. I trained at UTAS and I've worked here for 10 or 12 years.

Dr AHMAD - My name is Juliana Ahmad. I'm a GP in Kingston. I did my training in UTAS and I've done all my training since in Tasmania.

Dr BENDALL - As it happens, we work in the same practice. We are both AMA members.

To make it a little more interesting than a plain submission, we thought we'd coalesce some of these examples into a story, where we can touch on both the patient and also her doctor. We risk simplifying things a bit, but I think it's a bit more real to put it like this. This is not one specific person, but the stories that fill her life definitely are real, daily things that we encounter. As GPs, we're fortunate to be let into people's lives, and we hope we can give a little glimpse into this vast complexity and variety that we regularly see.

While we're discussing these two stories, it's worth noting that the impact of gender can be pronounced at any age, level of health literacy and socioeconomic status. Gender brings with it its own health risk factors, impacts on health-seeking behaviour and access to health services. This review is a great opportunity for gender to be integrated into all health policies.

For each facet, we do have a couple of solutions, which we can discuss as we go, or we can come back to them, particularly as some are less relevant at a state level than others.

I guess you'll have some other questions. I don't know if you have a preference for how we do it.

CHAIR - You go through. If you want to particularly bring out a point or a solution, that's fine. We will come back to that if you like.

Mr BENDALL - Maybe we'll just mention them briefly, but not discuss so much, then come back to where you'd like to follow up.

Let's meet Anna first off, and then Dr Jones. Anna is a 16-year-old girl who lives in southern Tasmania and comes from a blue-collar family. Her family of four has about $150 a week left over after housing to spend on food, heating and health. Her teachers have always said she's a bit dreamy, and she doesn't quite meet her potential. They've never raised the possibility of ADHD, even though Anna's brother has been diagnosed, because she's not disruptive in class. She actually never officially gets a diagnosis. We'll keep that in mind, because it affects many aspects of her life and health, as we'll come to see, but it's never formally diagnosed. She becomes sexually active so sees her GP, Dr Jones, for the contraceptive pill. The ones that are funded by the PBS, or the Pharmaceutical Benefit Scheme, cause her mood swings and teariness. Her GP suggests a new pill called Zoely, which has reduced mental health side effects. Unfortunately, because it is not funded by the PBS, it would cost her $29 a month, and her family can't afford that.

A solution here is that there's an option for PBS reassessments of the contraceptive pills available, or maybe even special public hospital subsidies for certain populations.

One evening, Anna gets abdominal pain and her parents take her to the emergency department. The blood tests are reassuringly normal, and she gets referred for an outpatient pelvic scan. The scan is normal, but the pain comes back. She goes off to emergency again. Now there's uncertainty. Is it a gynaecological or a surgical issue? Despite her pain being severe, the two hospital teams disagree over who will admit her. Anna is left to feel like a burden because she sees the two teams arguing in front of her. Eventually the pain settles and she is discharged to the care of her GP, Dr Jones.

Here we wonder what the role is for joint admissions, or at least a clear pathway for admissions, for female abdominal pain to public hospitals. To be honest, I think doctor burnout really increases the rate of teams really trying to push patients back to somebody else - the 'not my problem' kind of thing - so I think doctor wellbeing actually influences things there as well.

Anna leaves school midway through year 11 because she's overwhelmed in classes due to her inattention. She assumes she's just anxious. A bit later, at 20 years old, she works as a cleaner. She has a partner and falls pregnant a little earlier than she planned. She's unaware that her GP offers medical terminations because it's not widely advertised. By the time she realises she's pregnant and gets to the doctor to discuss her options, it's too late for a medical termination, and she decides to continue with the pregnancy.

Here, I think there are some roles for increased public education about the availability and access and process for pregnancy counselling and services in Tasmania. Also, we really didn't work out what her contraception had been, and whether there had been an error, or just one of those unplanned pregnancies that happen.

Anna gets debilitating nausea and morning sickness; this means she uses up all her sick leave and she has to pay for her GP appointments for the medical certificates required for employer for sick leave. Her GP follows the guidelines and recommends an over-the-counter medication called Restavit, which can be given by a pharmacist. Unfortunately, the pharmacist follows the guidelines she usually refers to and doesn't want to dispense that for a pregnant person, so sends her back to the GP.

Here, I guess it's about the coordination maybe between the TGA, the public health service and between pharmacies and hospitals, as literally the first-line option in some guidelines. I spoke to a pharmacist today who said, 'Well, I would dispense it if the doctor had sent them there, but I would never suggest it'. These things give women the run-around backwards and forwards, or they end up just sucking it up because -

CHAIR - On that, if the patient comes with either a script or a recommendation to get Restavit, then the pharmacist will probably say yes.

Dr BENDALL - One experience was that they actually were sent back for a script, but some will say yes.

CHAIR - But if a pregnant woman just turns up and says, 'My best friend has taken Restavit and it really helped her'? No?

Dr BENDALL - Not the one I spoke to today, which leaves the woman feeling, 'Maybe I'm not that bad, or I don't get treatment', or -.

CHAIR - Or even, 'I'm going to harm my baby because of that'.

Dr BENDALL - Yes, 'I'd better not take it because the pharmacist wouldn't give it to me'. You certainly see women who have tolerated pretty severe symptoms and haven't taken anything.

Anna and her partner are financially stressed at the 20-week mark of her pregnancy. Usually an ultrasound scan is done at this point to check the health of the foetus, but the out-of-pocket fee, even with a health care card, is $95. I believe you get one funded scan per pregnancy, so if you had it early, you don't get this one funded. Anna decides to use Afterpay to buy her groceries for two weeks so she can afford the scan.

Our recommendation is increased access to the capacity for public services to offer or outsource, like we do with some other things, bulk-billed obstetric scans.

Anna is nearly due to have her baby when she notices blurred vision. She knows she's stressed, so she rests for a while, but eventually calls the midwives. The antenatal clinic reviews her and agrees that, yes, she is anxious about her first pregnancy. After she re-presents with a headache, it becomes clear that she also has pre-eclampsia, which by this time has progressed to the life-threatening HELLP syndrome. She needs an emergency caesarean section.

Here the recommendation is really just more training for health practitioners that anxiety doesn't preclude a physical issue, and about just recognising those biases. That's definitely a real story that was reported.

CHAIR - And this is in the background of the ADHD that's undiagnosed.

Dr BENDALL - Yes. It could be another reason that things are falling apart slowly.

After her baby is born, Anna has back pain, pelvic pain and pain during sex. Her midwife recommends she sees a pelvic floor physio. Anna finds it hard to pay the out-of-pocket fee to see a private pelvic floor physio, so she'll have to wait three to six months to see a public physio.

The recommendation is to increase access to those outpatient bulk-billed pelvic floor physio appointments. Lots of the physios are limited, and that's just one of them.

In the interim, Anna gets depressed and overwhelmed with her physical conditions and ADHD. She finds it painful to lift her baby. She's struggling to adjust altered routines. Her relationship deteroriates, not helped by sex being painful for her. Her GP, Dr Jones, prescribes her some opioids so she can get by but she has to see her regularly for scripts. Her baby doesn't sleep well and she's exhausted. With insurance, which she doesn't have, she may have been a candidate for the mother baby unit. But she couldn't afford it and we've lost that. For her, it would only be likely that she got a public system bed if things get a lot worse. So she gets through this difficult time with her GP's support but the attachment with her son has been affected negatively as a result. She has found the birth and the arrival of her newborn quite traumatic, and so just hasn't managed to bond with him as well. And she carries lifelong guilt

about this. Obviously, recommendations here are for an adequate mother baby unit. The private option was excellent. It still didn't cover this level of person, but for everybody it would be much better.

CHAIR - It didn't help women in the north-west.

Dr BENDALL - No, not at all. A few weeks ago we would have said broaden the scope, and now we just don't have any mother baby unit and the perinatal service is so stretched.

Dr AHMAD - Her pelvic pain persists, her GP refers her to the gynaecologist at the Royal but they take seven months to see her and when they do, they schedule her for laparoscopic surgery to investigate her for possible endometriosis. Twelve months pass by and they offer her a surgery at short notice. Her partner isn't able to look after their son so she has to decline. Dr Jones successfully calls the booking nurse to explain the situation and they manage to find a suitable time for her. The surgery confirms endometriosis is the cause of pain, now going on for two years. She has become dependent on opioids. She has not been able to work much because of the pain. The doctors recommend pelvic floor physiotherapy, where she again has to wait for a public system appointment. She can't afford the alternative of private fees for multiple pelvic floor appointments even when her GP offers her a chronic care team management plan, which subsidises five visits at $55 each. A possible solution here would be to offer a pelvic pain multidisciplinary clinic with gynaecologists and physiotherapists who offer early management of pelvic pain before surgery, so before a diagnosis.

Dr BENDALL - The pelvic floor physio and also the chronic pain clinic in general tends you to need all the surgical things done prior to being able to have this multidisciplinary approach.

Dr AHMAD - We have a persistent pain unit but they say you have to have your diagnosis first.

There is a precedent for this at the present time, where there is a back pain assessment clinic at the Royal running at the moment, with rheumatologists and physios working together to offer this early assessment for back pain. So, we could create a similar thing for pelvic pain. That would be our solution.

Dr WOODRUFF - We might come back to that if that's all right.

Dr AHMAD - Her partner is the main breadwinner, so it's up to her to take time off when her son is sick. Her workplace requires her to get a carer's certificate for any time off. Our possible solution here is to mandate that a care certificate is not required if leave is less than a week.

Dr BENDALL - Once he's at school, her son gets diagnosed with ADHD. She has a few extra appointments to juggle for him and she has to pick up his medications every week as part of the authority conditions issued by PSB after they noted her partner once came up positive on cannabis in a urine drug screen.

There could be quite a few comments I could make about the Pharmaceutical Services Branch and the process and approvals they apply for ADHD medications, which make it harder to get things done and then it gets made very hard for them, and it's a big challenge for people.

After her son's diagnosis, her GP screens Anna for ADHD, and this is strongly suggestive of ADHD, but GPs cannot diagnose it officially. Anna doesn't see the point given she can't afford a private psychiatrist for an ADHD assessment with an outlay of about $1000. Her husband doesn't see the value in getting a diagnosis, despite the evidence showing she's at high risk of unplanned pregnancy, self-harm, substance abuse, suicide and other physical health conditions. There are no public mental health services that can help her be diagnosed with ADHD or even really take it into account with her other conditions.

Suggestions here are public mental health funding for the diagnosis and management of ADHD. Noting, in my experience, that many of these people are interacting with the services, they're just not getting the right diagnosis and treatment, so they're having endless, ineffective anxiety treatment, so it's not like the system is not actually seeing them.

Dr AHMAD - Her partner becomes controlling of her; her GP asks her the important question of 'How are things going at home?'. Anna says that her partner tries to guilt her into having sex and does not give her money to pay for contraception. Dr Jones suggests she is being emotionally abused. A long discussion ensues and Dr Jones bulk-bills her long appointment about her mental health and family violence as she knows that Anna cannot afford to pay the out-of-pocket fee for the long consult which generally ensues.

Our suggestion here is to have increased funding for long mental health consults and increased remuneration for health professionals to ask our patients and discuss this important topic.

Dr Jones tries to refer Anna to a psychologist but Anna cannot afford the out-of-pocket cost. It would initially cost $210 and, even with a $120 rebate, she can't afford it. Instead, she is on a long waitlist for publicly funded treatment, which is unlikely to offer specific post-traumatic stress disorder treatment. A possible solution here is publicly funded trauma-informed PTSD treatments.

Now, we go on to her GP story, Dr Jones. Dr Jones is Anna's long-term GP. Dr Jones is in her fifties and is going through menopause. She is very grateful she can afford the non-PBS-funded hormone replacement therapy medications as she knows many of her patients can't. She is aware that some of the doctors at the practice don't have a lot of experience with menopause, so they refer those patients to her. A possible solution for this would be a PBS reassessment of the HRT options on the PBS.

Her GP colleagues also refer many patients with complex mental health to her as she is very experienced in this area. She has longer appointments with her patients and covers more issues. But this means she sees less patients and, therefore, earns less than some of her other colleagues. Her patients know to see her when they have complex issues because she really listens to them.. So, again, incentives here are to treat complex patients and just spend more time with patients, be that financial or educational and training.

She attends health professional training on family violence, but notes that there are many more female attendees than men. Again, a proposed solution here is incentives for health

professionals to treat patients who experience family violence, again whether that be financial, educational opportunities.

She considers taking up a leadership role at her local GP organisation but can't afford to take the time off as this is an unpaid position. So, we are hoping to consider paid roles within health professional organisations.

Dr Jones is a contractor in her work and her practice, with means she is not entitled to benefits like sick leave or workers compensation. She gets a cold after examining Anna's son but cannot afford to take the leave she should as it is her third illness in the winter period already. Her practice manager convinces her to do telehealth from home so she doesn't have to cancel her patient list and Dr Jones somehow makes her way through this. A possible solution here is to employ GP positions so they can afford to take time off.

Dr Jones gets COVID-19 and, while she is fully vaccinated, she does not meet the criteria for antiviral medication as she is otherwise well. She is of African origin and while CDC data shows those of African origin are disproportionately affected by COVID-19, this is not considered a risk factor for COVID-19 antiviral medications in Australia. She is also at high risk of developing long COVID compared to her white colleagues. Possible solutions here are considerations of other risk factors in COVID-19 antiviral prescribing eligibility.

She starts to get symptoms of vicarious trauma after one of her child patients is sexually assaulted. She supports the whole family but has to pay for her own psychologist to treat her own symptoms of flashbacks and trauma. She tries to downplay her symptoms as she fears being reported to the medical board for her psychiatric symptoms. A possible solution here would be for funded psychological support and supervision for doctors, employ GP positions, or access to workers compensation for contractors.

She can't afford to work any less, so she decides to go into surgical assisting an orthopaedic surgeon in theatre on Fridays. This pays better than her work in general practice and is a bit of a relief compared to the mix of complex mental health and multi-system chronic disease she normally juggles. One day, she starts getting chest pain and shortness of breath after a 10-hour day at the clinic. She puts up with the pain for a while because she doesn't want to burden her colleagues. When she finally presents to the emergency department, she is told by the doctor there that they have ordered enough CT chests recently.

CHAIR - What was that, sorry?

Dr AHMAD - We have ordered enough CT chests recently. Dr Jones insists on getting a CT scan of her chest to exclude a clot on her lung and this is done after five hours of her waiting. This shows a clot in her lung. Her self-belief, her persistence, her health-seeking, and her high health literacy has saved her life. Someone else may not have been so lucky. Our proposed solution here is the application of guidelines when it comes to presentations of chest pain, for example, the PERC score.

One of her female colleagues dies by suicide. This scares her and causes her to reconsider her options. She considers retiring earlier than she had planned as work has become too draining. She is exhausted after suffering many years of moral injury in the system, advocating for her patients to get the care they needed.

We might need a bit of breather after those cases, they are a bit intense. Feel free to have a stretch if you need to.

I want to show you that these stories belong to real people and believe there are real solutions. We know that some of these decisions may require change in national, state, territory and our local health policies and laws or even culture and training.

Hopefully, we have given you a glimpse into our experiences and our thoughts and possible solutions going forward. We hope that gender considerations are integrated into all policies and their ongoing review and reformation.

CHAIR - Putting a gender lens over all health policy, do you know whether the review of Medicare scheduling started in 2015 and the most recent one have done that?

Dr BARRATT - No gender lens, no. That would be sensible.

Dr BENDALL - There is a specific item number for antenatal care, so you can get paid slightly less for that consult than a normal consult.

CHAIR - Then why would you do that?

Dr BENDALL - It is because you have to bill the most correct item number. Technically, it's antenatal care.

Dr BARRATT - You have to hand the money back if you get caught billing 23s a standard consultation for an antenatal. Even if that person comes in for antenatal and you do a lot of the time on mental health, unless their presenting complaint was mental health, you have to bill the antenatal item, even though it's less.

CHAIR - If they come in for an antenatal check and you discovered they had a UTI that needed treating and maybe something else, what's the coding then?

Dr BARRATT - Antenatal.

Dr BENDALL - It gets confusing and people get nervous. I think technically you can say if they needed to be treated then, then it's appropriate to treat it then. A UTI would be, I think, fair game. If they had - I'm trying to think of something unrelated - a backache or shoulder pain or something that is not dangerous, you would have to work out if you treat it then or ask them to come back so that you can bill the appropriate, normal item number that day.

Ms O'BYRNE - The defining feature being that you had to provide a script or you had to order a test?

Dr BENDALL - No. I think combining antenatal and medical is maybe slightly easier. With a mental health and a physical health item number, it has to be urgent and it almost depends in which order they bring it up. To the point where you think am I allowed to do it if they did that one first then it turns into mental health, or if they did mental health first then they can't have a UTI. Or we'll treat it for free, which we always do but we just can't bill what we

could have billed if the whole consult was for a UTI. It gets so confusing that you end up not wanting to get in trouble so you end up unpaid.

Ms O'BYRNE - Is there an underlying belief that if women are having antenatal appointments they are probably a little in need of psychological support, so that is antenatal support? What leads to that kind of decision-making when rated differently?

Dr BARRATT - Antenatal is meant to be simple.

Ms O'BYRNE - Oh, thank goodness for that.

CHAIR - You'd never go for an antenatal check expecting a problem to be detected.

Dr BARRATT - Yes, that's why the Government pays less because the antenatal appointments are routine and simple. It's just a check-in, really.

Ms O'BYRNE - Because childbirth is a very simple thing.

Dr BENDALL - Yes and no-one has ever worried.

There is a specific item number which I think you can bill twice or three times in relation to one specific pregnancy. It can be before or after if, for example, you have had an abnormal trimester screen or you have had a miscarriage or something, you can bill it sort of three times. That's a longer item number you can do in addition to something else. There is a little provision -

CHAIR - If we get a positive screening test back?

Dr BENDALL - Then you can spend more time with that. Again, there are still some specific requirements, but you can.

Dr BARRATT - That item number was introduced originally as part of reducing the number of terminations. It was originally brought in for doctors to counsel women before they routinely sent them off for termination. It's a particularly useless item number but it can be used in those circumstances.

Dr BENDALL - It is now non-directive counselling.

Dr BARRATT - Yes, non-directive counselling.

Mr WILLIE - On the case studies, Chair. Thank you for providing those. I heard gender bias but I also heard socio-economic status being a factor, bureaucracy being a barrier, misdiagnosis. The last couple of days we have heard quite a lot about doctors' practice in terms of gender bias, particularly with LGBTIQ+ people and women. Do you have any comment on that? Because that did not really come across in -

Dr BENDALL - Doctors' practice in terms of which aspect?

Mr WILLIE - The way doctors interact with their patients. We've had a number of presentations where that's been an issue. Is there any comment on training and best inclusive practice?

Dr BARRATT - The training from the colleges is heading towards doctors being aware of their deficiencies. We know that has improved over the years. When I started as a doctor women's health was treated very differently - it's a little bit of medicine but ignore it, men are more important. That has changed. There are still a lot of barriers from people having the time as a GP to go into all the gender issues. We are humans. Doctors still have their own unconscious biases when it comes to dealing with things that are complex and things aren't in their usual scope of practice. That's why we still have male doctors who don't treat menopause.

Dr AHMAD - It's one of the solutions in our submission. Training should be provided to medical practitioners with a focus on recognising the limits of our knowledge and accepting the need to refer on when those limits are reached. A targeted medical practitioner education program to recognise when they're offering poor care because of gender or other attributes and to recognise sexist or racist beliefs in themselves.

Mr WILLIE - Another thing that was raised through our presentations was when there is maybe a religious belief or some other barrier to providing the care, people aren't being referred. It's not a reflection on doctors.

Dr AHMAD - Though it should be.

Mr WILLIE - I'm sure many of them are doing the right thing.

CHAIR - Not the ones in front of us.

Mr WILLIE - Not the ones in front of us and many of them are probably doing the right referral pathways, but obviously it's happening.

Dr BENDALL - We're lucky to work in a practice that was deemed 'Practice of the Year' last year. I think we do it relatively well. People will do a bit of both. They'll pick their preferred one for their gender-related issue or they'll see the boys for the quick things. A couple of the guy doctors who work with us do lots of trans-gender health. We have quite a complex collection of patients. I feel like we see more of the non-binary, intersex gender kind of stuff than some practices, so I hope that they're feeling cared for.

Dr BARRATT - Your practice has self-selected a group of dedicated doctors. Unfortunately, there are still a large number of practices and practitioners who also self-select to go to places where they're not required to be woke or have their own limitations in their own faces.

That's why we get involved in medical politics, to try to educate those people to change policies, to talk to the colleges, to talk to the educational processes so those doctors are dragged kicking and screaming into this current century, but also have education so as you start as a medical student going through, you're taught to evaluate your own prejudices. We all have them. Everyone has biases and prejudices. We're all human. That education process is starting more commonly now for the medical students through the colleges, through later training.

Mr WILLIE - What do you do in a circumstance where you get a new patient and they've seen a couple of doctors, and they haven't been referred on because of their circumstance and the doctors who are treating them are biased? Do you provide advice on them not getting that referral?

Dr BENDALL - I would tend to be practical. You were never there. What the patient reports to you is never the whole truth for a start. They will always have remembered some of it and not all of it. I would never badmouth the colleague who saw them because you don't know what the story was. I might say, 'Oh, right, that's not what I would have done. I really think you should have appropriate treatment for your terrible hot flushes and anxiety related to menopause and that you shouldn't have been dismissed. Let's work on that now.' Take a breath and go from there.

We're taking new patients. Two doctors down the road have retired, leaving them doctorless. That practice is not caring for them so there's a flood of people. There are all sorts of things like, 'Oh. No-one did that?' or 'They stopped your HRT because of this? Hang on ' - endless stories like that.

Dr BARRATT - With the reducing numbers of general practice it is going to get worse because it takes time to do good medicine. One of the things we were bringing through in our example of Dr Jones is that the disproportionate burden is on the female doctors. There's good evidence that female doctors earn less because we take longer appointments and bill less. That's not putting a halo on women, it is just the way the practice works. Most female doctors will see 15- to 20-minute appointments, which means you can only see three to four an hour.

Dr BENDALL - And regularly run an hour late because someone actually tried and had just been at the same time.

Mr WILLIE - If you have to do training and all these other things -

Dr BENDALL - I had to cut my hours short to come here. But it's good to do.

CHAIR - We provide you with food and water. Going back to the training, you mentioned in some of your comments about how there's an improved amount of training now, including with medical students. We've asked this question of a few today as to what training is provided as standard, that everyone has to do as part of their undergraduate degree and postgrad or post-fellowship. Can you talk us through what happen now?

Dr BARRATT - I'm not an expert. I don't do undergraduate teaching at the moment, but I do know that it is included.

CHAIR - What training?

Dr BARRATT - Certainly in women's health, but also training in knowing your own limitations. I know there is more training in that and actually recognising it. There is certainly training in self-care and colleague care, but I don't know the specifics.

CHAIR - With all due respect to those on the other side, we have heard that there are some medical professionals who need some empathy training.

Dr BARRATT - Quite a few.

CHAIR - Is that something that's part of this stock standard that everyone does?

Dr BENDALL - Yes, consulting skills, clinical skills and supervised practice, feedback and all of those things.

Dr BARRATT - I have examined in those areas for medical students and marked on their empathy. The empathy and listening skills of the doctor are certainly one of the criteria for marking in the OSCEs and the spoken exams. That's in every exam, from surgery through to psychiatry.

CHAIR - For the specialist training?

Dr BARRATT - This is undergraduate training and also specialist training. So, it is there.

CHAIR - Once you focus on GPs, who are at the coalface of everything, in terms of fellowship, is there then any compulsory training or do you have to do your CPD in whatever area?

Dr AHMAD - There is no compulsory trainings. This is practising in empathy or practising in recognising your own bias, there's no firm training in that. I would love there to be. But when we reflect on the ability of a doctor to offer empathy in a consult, I don't think it is just down to training. If I had to reflect on a consult, how much time do I have for this patient and I am really burnt out myself, the last patient of the day and at the end of a long day, this is doctor burnout. The first signs of burnout are depersonalisation and reduced empathy.

If you look at the repertoire of things I've had to learn as a GP, hard skills are important. How do I treat someone with high calcium? What sort of chemistry should I be looking at for this patient? Whereas a soft skill like empathy, which I like to think I practise a lot of, wouldn't be personally on the top of my list of things that I had to do.

I would be pleased if it was made mandatory, I have no problem with that. I think that it is much more than training that would determine my ability to show empathy to a patient.

CHAIR - What else besides training would help in that?

Dr BARRATT - A healthier workplace.

Dr AHMAD - I think a healthier workplace. Other doctors and I have talked about how we've had to dig into our savings because recurrent losses due to COVID-19 is a reality. Financial stress or being burnt out and with COVID-19, obviously, seeing patients with respiratory illnesses. I think it is multifactorial. Training is an important aspect.

Dr BENDALL - It is clear that if you can cut out a bunch of skin cancers or do lots of repeat scripts, you would be home richer and more rested. whereas the relationship that keeps general practice going is the relationship that is the wonderful part of general practice, but it's slow and it's hard. I was an hour late this morning, even though I only did four hours' work

because I cut it early, yet the walk-in and the chest pain. It's slow and you get to the end and it is exhausting and to think well, that earned slightly less than it would have if it was even.

CHAIR - Going back to the back pain multidisciplinary centre, you might not know the answer to this, but I am interested in what decisions - I think it's a fantastic idea, it should happen in more conditions.

Dr BENDALL - It has come and gone as well a couple of times. I think it is back again.

CHAIR - What were the drivers for the establishment of it?

Dr BENDALL - Really good evidence.

Dr BARRATT - Maybe a patient sitting on a waiting list waiting to be assessed by a surgeon who was never going to need surgery. Having them seen by a physio who can assess that that person is never going to need surgery takes them off the surgeon's waiting list.

Dr AHMAD - Or a rheumatologist, who is as valuable as a physician - a rheumatologist and a physio.

CHAIR - I was wondering whether there was any gendered impact? Were there more men presenting with back pain than women?

Dr BARRATT - I suspect there were more women. I worked in the hospital at that stage and there were actually more women.

Dr BENDALL - The kind of chronic pain and link to women - I could not say the numbers but I think it ends up more women.

Dr BARRATT - I was working in the hospital system at that stage. The gynaecological clinic was mooted but we could not get the funding. We mooted the the idea of a chronic pelvic pain clinic.

CHAIR - But it all came down to lack of funding?

Dr BARRATT - There wasn't the funding and there wasn't the incentive from the head of the department at that stage and it went nowhere.

CHAIR - So we've got, on and off, a back pain multidisciplinary model that is funded.

Dr BARRATT - Which works really well when it is funded.

CHAIR - But we haven't been able to get a multidisciplinary pelvic pain centre.

Dr BENDALL - Sometimes they will end up at the chronic pain clinic. It is like once you have failed the other things, as you would end up feeling because you do have pain, then you may see the physio and psychologist and sort of wrap-around.

Dr BARRATT - The chronic pain clinic only accepts people who have exhausted all investigation and treatment options.

Dr BENDALL - As opposed to if we could intervene earlier and manage it a bit and teach you skills to manage while you also maybe have some surgery if you need it, you would probably do better and it may be cheaper and more productive.

Dr WOODRUFF - It is hard once someone is on the track of pain to retrain those pathways.

Dr BENDALL - Those pathways are there, even if you cure it. They will probably still have pain even if there is not a skerrick of pathology.

Ms O'BYRNE - We did that bit of work up the north-west some years ago where we did concentrated physio with 50 people who were on the waitlist for knees and we took 60 per cent of them off the list. The evidence is there in regard to if you do those investments earlier and surgery is not a good outcome, surgery is not where you want to be.

Dr BARRATT - I don't know what the code for that one was, we had a code or something.

Ms O'BYRNE - Yes, but it those kinds of earlier interventions, particularly with chronic pain conditions.

Dr BENDALL - For us to get these people to a physio, obviously a cohort of our people will take themselves to a private physio. That is great, or chronic disease funding like team care arrangement-supported physio. But some of these ones basically won't go, they just want to see the surgeon.

Ms O'BYRNE - Because they have been told that is what fixes it?

Dr BENDALL - Yes, and they can't afford the gap. And the physio for the hospital is so much around follow-up after surgery rather than preventing surgery. The odd one gets in but it doesn't seem like it has to be that way.

Dr WOODRUFF - Did you ask questions about ADHD?

CHAIR - We touched on that.

Ms O'BYRNE - We were talking about if you have someone who comes and says, 'My other doctor did this and it was hopeless and they didn't talk, blah blah'. Is there a point where there is a pattern of referral where you would then act? As you say, you only know what the story is that you hear, but if you hear one story versus 10 stories about the same colleague, particularly around the gender response, which is the interest of the committee, is there a point where you would then take an action? Is there a pathway for that, or is it just too complex?

Dr BENDALL - A colleague of mine had a complaint made against her by somebody else, but that was the reverse. They certainly didn't have a story and that was a fairly vengeful patient. So, maybe with that in mind, I would be very loath to, for example, make an actual complaint because I know how hurtful it is and how on earth do you get that information clearly? But if the notes are transferred or I thought it was a dangerous thing, I guess I would probably want to call the insurance company.

Dr BARRATT - And the other thing that is different is if you think the doctor is impaired.

Ms O'BYRNE - Which is a whole different conversation. You talked a little bit about the lack of mandatory training and you have highlighted there is already really packed days that are full and every time you take points out on training. The earlier intervention training in new graduates is really exciting and important but we have got a whole host of people who have never done any of that training. Is there a place for a mandatory training? I know that one-off training does not necessarily change everything, but at least it is that point of you 'knowing our limitations' - I think is the phrase that you used - around really trying to identify those. People who go to training often have already identified they want the training or need the training, and they are not the ones we are targeting. Is there a view on that?

Dr BENDALL - I don't think I would have enough evidence about how to train the right people for the right things, but I guess it is worth noting that so much of the training I do, I think that, 'Oh, that looks interesting, I will cough up the money to go to Melbourne for that conference' or there is something run by Primary Health Tasmania that is free or there is the occasional thing you get paid for and you think, 'Wow, this is ground-breaking'. Most of it is at our expense or at least at our time out of family time, so I guess what is mandatory, what is expensive, all of those factors.

Dr BARRATT - And general practice is sorely under the pump.

Ms O'BYRNE - Appreciating that absolutely, the other thing then goes to general practice being under the pump and women working part-time and when they are returning from work after having children, and the entire employment framework that operates around that. I will go back to when I was health minister some years ago and I was told by a representative body, which may or may not be sitting across the table from me, that the problem with doctor shortages was all these women who want to work part-time and have babies. That was exactly the language, and we are not talking a hugely long time ago. Whilst we are seeing more women being able to work effectively, bizarrely, what is the circumstance now and what needs to be done to make sure that you have a better ability to not be discriminated against in your employment?

Dr BARRETT - You need variability in the methods for employment. At the moment, most GPs are contractors, which means there are no sick leave, no holiday pay, no workers' comp, except for what you pay yourself. We need more options for salaried professionals to be able to opt in and out. In Tasmania we are about to start the trial of a single-employer model for single GP registrars to give them that security, to match the general practice registrars with the hospital-based registrars for the first few years of their training, for sick leave, holiday pay, workers comp.

CHAIR - These are moving between two different sectors, too, like working at ED and then out into the GP practice -

Dr BARRETT - They will still be staying with a single employer, which is of benefit. We know a lot of GPs do not want to be employees, which is fine.

Ms O'BYRNE - There are those that do though; we are seeing a lot of much larger practice models -

Dr BARRETT - We need the option and there aren't enough options, but we need sensible options. We know they won't employ GPs at - there was a health centre some time ago that ended up seeing two patients a day because they were on a salary so it didn't really matter. So, we need flexible modelling. We need options which allow doctors to be supported and it will mostly be women who want to be able to have an employment with a guaranteed salary while they are child-raising. They may then want to go back to the private sector later.

Dr AHMED - There is an alternative model of having a percentage of billings, so a lower percentage. You still get a percentage of what you are billing but some of it gets taken away to be reserved for your super, holiday, annual leave, that sort of thing.

Dr BENDALL - I am on that because it was a leftover from the previous management which they did not want to get in trouble with the tax department with employees and all of that, and so I am technically still an employee, which just means I don't have to think about super, which is amazing, but for everybody else it is a pain.

CHAIR - If you went somewhere else -

Dr BENDALL - Yes, no chance. No-one else has that and my rate is lower but at least it eases out.

Dr WOODRUFF - Did you ask the question in relation to ADHD? Apologies -

Dr BENDALL - We read a case story and she essentially had lifelong undiagnosed ADHD because she couldn't have paid for it.

Dr WOODRUFF - As you have correctly said, Tasmanian mental health services provide an assessment and diagnosis for children with ADHD and they provide nothing for adults. So would you recommend that they would be the appropriate service to extend that and provide that? Do you think they should be doing that work for everybody?

Dr BENDALL - Most definitely.

Dr WOODRUFF - So you are not recommending another body?

Dr BENDALL - No. It would be nice to access it. Out of the handful of patients I can think of, maybe half a dozen or so are highly engaged with the public health system because they are sick, but their ADHD is not taken into account. That's my working diagnosis. One has just had an involuntary admission for psychiatric issues, one sees a chronic pain clinic and respiratory problems and has missed a bunch of appointments. It is impacting their care but no-one will talk about it.

Dr WOODRUFF - My other question is around Medicare. You have raised it a number of times in your submission. At the end, there is the recommendation from John, about being able to claim GP management plan item numbers for medical issues related to pregnancy and breast feeding. That would subsidise visits to private or public physio to help treat mastitis with private physiotherapy, ultrasound or create a new section specific to pregnancy and

breastfeeding. Also, in relation to the extraordinary situation that you have raised in the difference in ultrasound prices for scrotum ultrasounds and breast and pelvis ultrasounds.

CHAIR - That blew the top of my head off.

Dr WOODRUFF - Truly extraordinary. There is indeed a difference.

CHAIR - One is much easier than the other.

Dr WOODRUFF - And you get paid more for it. How do these things change? We got a change of government federally, so one would like to hope that there will be more openness about these sorts of issues, particularly women's health issues and Medicare disparities and so on. What do you think about the Tasmanian Government and their role in advocating on behalf of these particular changes? Okay, the AMA has been doing that. Did you mention whether you got a good reception?

Dr BENDALL - We have representatives on the review who are very keen for things to become more gender equitable. I know one of the representatives on the task force is the national vice president who is a young female GP who is brilliant. So we are trying.

Dr WOODRUFF - Do you know or have you already said what the time frame for that review is?

Dr BENDALL - End of this year. It is coming up with some solutions, but whether there would be any -

CHAIR - It's almost constantly under review.

Dr BENDALL - It needs to be. The solutions offered are often confusing and not always helpful, so it's hard to have hope but I hope that it will be useful.

Dr BARRATT - It needs to be something more than we got last time - 51 cents I think was coming in November for our standard consultation. Hopefully it will be more than that.

Dr WOODRUFF - We heard from a previous testimony to the committee about the valuable role of nurse practitioners. I don't think it was clear to us when NPs are able to prescribe, if they are accredited and trained, or do cervical screening.

Dr BARRATT - It depends on their training, it depends on what they have been accredited for.

Dr WOODRUFF - According to Family Planning Tasmania, even with accreditation and training, in Tasmania as compared to other states, that is not a possibility. That does not sound like a Medicare number? We'll get some more information later on.

CHAIR - Can I go back to the - I am not sure of the recommendation number or solution number - but the joint admissions for women who present with abdominal or pelvic pain? Are you aware of that happening in other places?

Dr AHMAD - No. I asked at a doctor forum yesterday whether that was happening anywhere. I think even there was a female surgeon present who said 'I would not be up for a joint admission, I think they should just be under one team'. So perhaps the solution may be a clear pathway for women with abdominal pain to be admitted into hospital, rather than just saying that they have got to fight it out. If they just said it has to be a gynaecology admission until surgical things are excluded, rather than there being pushback because it is unnecessary if there was a -

CHAIR - Yes, because the fight happens in the ED -

Dr BENDALL - Yes, the worst part is the patient feeling like the problem as well as having a problem.

Ms O'BYRNE - Sometimes they get admitted as general medical and then from the ward base they then try to drag in those other services as well, which gets -

CHAIR - Your suggestion I think was that if that does not work because there is too much pushback from certain professions, if they were admitted as a gynaecology patient first and then exclude other matters.

Dr BENDALL - Yes, so the classic is something like a pregnant person with appendicitis. That is actually a surgical issue. They just also happen to be pregnant.

CHAIR - Does that patient then get transferred to the surgical team or do they currently stay -

Dr BENDALL - I think from history it would have been a surgical team. But it gets tetchy because they suddenly get nervous because they are pregnant.

CHAIR - They do not like digging around, do they?

Dr BENDALL - Even in general, I think, even without being pregnant, there tends to be this sort of joke, well, they have got a uterus or they've got ovaries, it could be that.

Dr BARRATT - Every pelvic pain in a female is PID.

Dr BENDALL - It is definitely worse with overworked people who just want to say it is not their problem. There is somebody else; it could be your problem.

Ms O'BYRNE - A lot of the evidence we have heard was about people who present with significant pelvic pain simply being disregarded entirely because 'women just need to harden up' and 'all women go through this', and particularly we have had some evidence around endo and PCOS and those sorts of things. How would a joint admission structure work for those women? Quite often they are not treated at all. They are just sent home with Panadol.

Dr AHMAD - It needs a clear pathway for it to happen rather than have them having to fight it out.

Ms O'BYRNE - Which it seems to be, from much of the evidence we've had.

Dr AHMAD - It's just like, abdominal pain, general surgery. It's a matter of male or female. If it ends up being a female problem then you involve gynaecology.

Ms O'BYRNE - One person who gave evidence said she is very relieved when they start not knowing and call the gynaecology team down to ED before they do an admission, because at least they know what is going on, but that does not upskill the staff in ED to deal with these issues in an appropriate way.

Dr AHMAD - There's an inconsistent pathway -

Dr BENDALL - and inconsistent communication between the teams. Ideally, you know which thing it is and who it belongs to, but I guess they need the pathway more so for when there is uncertainty. If it's clear it is clear.

Ms O'BYRNE - We had one where the doctor in ED told her to go and sit against the window where the sun was coming through because then the heat on the back would fix her significant endometriosis pain.

Dr BENDALL - I think any admission or referral for some of these people is a better start because, absolutely, the amount of people who just get turned back were like 'Oh, your pain is settled now even though you needed Endone. Now that the Endone has worked, you can go home. See your GP.'

Ms O'BYRNE - The other thing is that for things like endometriosis, you don't often get a diagnosis unless you have had the laparoscopy and many people are considered 'possible' and therefore there is no treatment pathway for 'possible'.

Dr AHMAD - There should be a treatment pathway -

Ms O'BYRNE - Not in EDs and not even with all GPs also, unfortunately, because so many of them, as you have identified, are not spending that time -

CHAIR - So what should the treatment pathway look like?

Dr AHMAD - It should be a multimodal approach. Something like hormonal contraception - period control, pelvic floor physiotherapy - they are worth their weight in gold, but you need three, four or five, six assessments. You need six or seven physio appointments to help manage your pain.

Ms O'BYRNE - Which is an expensive process again. One of the big issues with this kind of response is that you really do need to be cashed-up.

Dr AHMAD - With some of the surgicals being outsourced to the private facilities, if that could be done with the public processes that will be amazing. So that is something that could be considered.

Ms O'BYRNE - That would make a difference.

Dr BENDALL - This is just off the top of my head but a little bit of physio - pelvic floor sort of stuff - happens, for example, in like group antenatal classes. Not to say that every person

with endo could just go to a group class, but I wonder about the roles of some of those things. Maybe you have an initial assessment, but some of it is education and support. You wonder what could be done a bit more efficiently rather than an individual expensive consult.

Ms O'BYRNE - But if one of the things for endometriosis is infertility, you're not necessarily going to end up on that pathway as well, are you?

CHAIR - In terms of the availability of physios that specialise in pelvic health, are there many outside of Hobart?

Dr AHMAD - I would have thought there would be some up north.

Ms O'BYRNE - There are some, one or two.

CHAIR - Do we have numbers at all? Do we know?

Dr BENDALL - No.

Ms O'BYRNE - Some of the good GPs are at Women's Health and The Bubble actually; similar to our other GPs, they maintain their own list.

Dr BENDALL - They only refer to them here, so -

Ms O'BYRNE - Do you find a lot of GPs running their own lists in the absence of a referral point, where you can go, well here are all the services that are provided?

Dr BENDALL - We've got an address book in our practice that we keep up to date of who you use for those and which. A couple of the private obstetric places have a physio there as well.

Ms O'BYRNE - Would it be useful if the Health department provided a portal that people could upload that they run those services, or would that not make a difference?

Dr BENDALL - There is some of that through Primary Health Tasmania, and it's never up to date, but there is some for everything. I think keeping up to date with the private options is not so tricky. I think it's getting the public options that's near impossible.

Ms O'BYRNE - Because they just don't exist.

Dr BENDALL - What I was saying as well about the group setting, I wasn't necessarily saying antenatal care or antenatal therapy for the endometriosis, I was sort of wondering, are there actually other ways of delivering the care, like group sessions.

Dr AHMAD - Then the real story is, the woman can't attend because she's caring for her child who's got a cold that day, so she has to go to an appointment in a month's time so, it really delays care, being responsible for another human being.

CHAIR - I think we're about out of time. Is there anything you wish you'd said that you haven't?

Dr BENDALL - I think with ADHD, maybe my cohort has self-selected as well, but it's constant and it's just so saddening when you think there's a 15-year-old, there's been a 74-year-old in the past week, there is no chance these people get a diagnosis. The 74-year-old led a delegation to China, and yet feels dumb because she feels like she just has this trail of various things and yet, is amazing. There's no support that you can access, like psychology or medication. And this 15-year-old, you see this life and wonder what is this going to look like?

CHAIR - Same with autism.

Dr BENDALL - At 15 it is getting late, but some of the 'naughty boys' will get diagnosed, to be vastly generalised, but the girls probably won't, and the women definitely won't. It's so impactful, so I think that's really big for me.

CHAIR - Thank you very much for your submission and your time today, we appreciate that, and we'll invite Women's Health to the table. They'll have all the answers for some of the questions we've had.

The Witnesses withdrew.

Ms JO FLANAGAN, CEO, AND **Ms ELINOR HEARD**, POLICY OFFICER, WOMEN'S HEALTH TASMANIA, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED.

CHAIR - This is a public hearing of our Gender and Equality Committee, looking at the gender bias in health care. Thank you both for your submission and for coming today to provide some further evidence. Everything you say before the committee is covered by parliamentary privilege, and that may not extend beyond the hearing. If there's anything of a confidential nature you wanted to share with the committee, please make that request and we can consider that. Otherwise, it will continue to be broadcast and the transcript will form part of our public evidence on our website. Do you have any questions before we start?

Ms FLANAGAN - Good afternoon and thank you very much for the opportunity to present to you. I'm the CEO of Women's Health Tasmania.

Ms HEARD - I'm Elinor Heard, the Policy Officer at Women's Health Tasmania.

Ms FLANAGAN - The inquiry speaks directly to our work, as its remit is to be a statewide community-based organisation for women's health. Our work is very much about supporting women's engagement and agency in and around health. We do this by providing a helpline, referral and advice, free counselling, health promotion workshops and classes, and targeted health promotion campaigns. For example, we are running a campaign at the moment addressing period poverty by providing free period underwear to people on low incomes. We do community health literacy and we have brokerage funds to cover sexual and reproductive healthcare costs. We also work with government health and community sectors to identify opportunities for health service improvement and reform to overcome barriers to equitable health care. As much as possible, we base our advice on primary research, which allows us to represent and amplify the voices of Tasmanian people.

The approach that we take in our work was reflected in our submission. We presented a sequence of case studies, stories which have come to our attention through the workshops and counselling work that we do and through the helpline. What we wanted to do was reflect the gendered nature of health outcomes for women in Tasmania and the role of the healthcare system in producing these. We hope that the scenarios show you the gendered impacts of health for women in Tasmania in all its overlapping ways. It's a determining factor across a lifespan. The relationship between gender and biological sex in reproductive health is an example of that. We see it as bias within health system responses, and we see it in the social expectation that women be responsible for the health of individuals and families collectively.

What we'd like to do today is take the opportunity to do two things. We want to build on the discussion and the recommendations put forward in our submission, and we want to talk a little bit about some of the contextual factors influencing health outcomes in Tasmania, but specifically dive into three areas of health care that we want to draw attention to. That's maternal health care, abortion health care and mental health care. Secondly, we want to talk about best-practice responses to gender bias in health care.

To start, just to talk a little bit about the state of Tasmania's health system, which you've been immersed in, firstly, we have to acknowledge the state of our health system overall. From the perspective of many of the service users at Women's Health Tasmania, the health system has significant gaps. The specific pressure points we hear about over and over are the

impossibility of finding GPs who bulk-bill; the difficulty locating GP practices that will accept new patients; long waits for GP appointments once a practice is found; the wait time and inaccessibility of psychiatrists, psychologists and mental healthcare generally, especially in regional areas and in adolescent mental healthcare; the wait time for paediatrician appointments and associated wait times for cognitive assessments such as ADHD and ASD assessments; and the out-of-pocket costs for all of the above.

Women tell us these factors are leaving them and their families in crisis, but we can't stop working for women while we wait for these problems to be fixed. We have to continue in spite of the cracks in the health system, but we felt that it's important to note that healthcare reforms, especially those that are cultural or clinical in nature, are less likely to land in a cohesive and sustainable way while our health systems and workforces are stretched to breaking point.

We also want to acknowledge that health and health care don't exist in a vacuum. ABS data show that Tasmania's population health outcomes are interwoven with the state's overall experience of complex and sustained disadvantage. You would be familiar with the statistics. We just chose a couple. We're the state with the highest population of people with a disability, the highest level of smoking and obesity, the highest pre-term birth-rate, and the lowest levels of literacy, educational attainment and income.

The composite case studies and stories shared in our submission reinforce the truth that our health is indivisible from the conditions in which we live work and play. Improving those conditions is integral to improving the health and wellbeing of our communities. We all know that health care is secure housing, health care is a liveable income, health care is a pathway from temporary to permanent residency and so on. But together with the case studies, it also shows that health systems in Tasmania are predominantly gender-neutral or gender-blind by design, and as a result they can fail to meet the complex and interconnected needs of individuals, families and communities. Internationally, gender analysis or the idea of assessing any planned health intervention or legislation or policy or program, by looking at its implications on people of different genders, is an accepted building block in doing responsive health care and we would suggest Tasmania has both an opportunity and a responsibility to elevate health service planning and delivery with a commitment to gender-responsive health care that better meets the needs of women and people of all genders.

We want to dive into three areas and Elinor is going to talk about mental health care.

Ms HEARD - Mental health care is an example of a sector that has been largely gender-neutral in which gender-responsive approaches are now emerging. Specifically, we are seeing gender-responsive healthcare strategies for men begin to emerge, particularly in suicide prevention, but we are yet to see equivalent gender-specific responses for women. In Australia, anxiety and depression are the leading causes of disease burden for women. According to Beyond Blue, more women than men experience high levels of psychological distress. Women aged 18-24 years have the highest rate of psychological distress of any age group. This contributes to what is sometimes called the gender paradox in suicide. Although many more men than women die by suicide - approximately 75 percent of suicides are male - women have higher rates of suicidal behaviour than men, including ideation, planning and attempts, and women are hospitalised for self-harm almost twice as frequently as men. Evidence suggests there are gender factors that play here with the Australian Longitudinal Study on Women's Health on finding links between women's high rates of psychological distress and the prevalence of violence and abuse across the lifespan.

ABS data show one in six women have experienced abuse before the age of 15. Since the age of 15, one in six women have experienced physical or sexual violence from a partner and one in four have experienced emotional abuse. Australian Professor Jane Fisher has collated global research confirming that intimate partner violence is a clear and consistent predictor of depression, anxiety, trauma symptoms, suicidal ideas and substance abuse among women, wherever they live. There is a lifetime deficit in mental health associated with these experiences. We urge state and federal governments to heed this evidence and provide funding for women's mental health responses that recognise the influence of gender in experience of mental ill-health, including the cumulative impacts of gender-based violence across the lifespan.

I want to reiterate the point made in our submission and that Jo mentioned about the absence of community-based mental health care options in regional areas of Tasmania, particularly for young people and women, who are still very often the primary caregivers and find themselves acting as de-facto managers. They tell us that this role really contributes to their own physical and emotional fatigue, anxiety and depression.

Ms FLANAGAN - I wanted to talk about maternal health care. We are concerned about the state of maternal health care in Tasmania, and our concerns are based on anecdotal information we have received from clients over the last five years. They include problems finding GPs who are knowledgeable about pregnancy and pregnancy care pathways; problems gaining access to specialist midwifery programs; service responses during the COVID-19 pandemic, specifically with the withdrawal of services during the pandemic; what appears to be premature discharge of new mothers and infants from the hospital to a lack of support in appropriate housing; lack of support for women experiencing maternal exhaustion and difficulties with breastfeeding; poor access to GPs post-birth for new mothers and infants who cannot get appointments and are referred to emergency departments after the birth; limited access to CHaPS services, lack of access to allied health supports - for example pelvic floor physiotherapists and psychologists who work with women experiencing birth trauma - and we're also concerned about the very high rate of birth trauma that we are seeing in our counselling services - that's trauma associated with child-birth complications, interventions and outcomes.

Ms O'BYRNE - Are you seeing an increase or is it a consistently high rate? Or have you noticed just an increase?

Ms FLANAGAN - We began a service offering that about four years ago and it's been consistently running at high levels. These problems are amplified for women who are on temporary visas. The background to that is a review of the coverage provided by overseas health insurance that removed pregnancy from the conditions covered, which was a highly gendered decision. The effect is that women are not covered for pregnancy costs. In Tasmania, we are fortunately able to support women who want to terminate the pregnancy, but if women want to continue with the pregnancy, they face the full cost of delivering the baby in the hospital and the stay in the hospital, and their antenatal care and postnatal care.

Ms O'BYRNE - The current Health minister has told me that applications can be made in order to cover that. Is that something that you've seen done successfully?

Ms FLANAGAN - We have seen it done successfully, but our point is that it's on a case-by-case basis. What we see is a consequence of not being able to reassure these communities that women won't face costs or upfront charges. Women are delaying or avoiding antenatal health care, avoiding care for gestational diabetes or rationing their insulin, and discharging themselves from hospital prematurely. Obviously this is not just an academic question, this poses very real risks for the lives of women and infants. The Government has been responsive to advocacy on behalf of those people, but as I've said, it's a case-by-case basis.

CHAIR - That is not just migrant women, that's low-income women who are doing the same sorts of things, too, isn't it? They might not manage their gestational diabetes, might ration their insulin -

Ms FLANAGAN - They can access that through the public system. A woman on a temporary visa potentially pays separately to see a diabetes nurse, plus any specialist who might need to see in the antenatal healthcare clinic, plus -

Ms O'BYRNE - Education costs as well, once they get to school, because -

Mr WILLIE - The CHaPS has an impact on education outcomes for kids as well, let alone the mothers' and fathers' anxiety and appointments.

Ms FLANAGAN - The CHaPS nurses?

Mr WILLIE - Yeah, their appointments are being missed across the state.

Ms FLANAGAN - Which is also -

CHAIR - Are you talking about all parents here, not just migrant parents?

Mr WILLIE - Yeah, all parents I'm talking about.

Ms FLANAGAN - There are also the risks to the mothers and babies because they pick up important issues, not just about developmental delays, but they're also screening for family violence and that kind of stuff.

To briefly touch on the Mother and Baby Unit, as the previous speaker said it wasn't the response that we needed for that level of need in the community, it didn't reach into the north and north-west. We needed to work towards a better model, and we appreciate that it wasn't of the Government's making but three beds in a paediatric ward is not an appropriate response, and we want to work with the Government on the development of a more appropriate and statewide model. The clinicians involved with the Mother and Baby Unit have identified a very successful community-based model called the Tresillian model, which sounds like it would work really well here.

I just wanted to say on maternal health care, because of our concerns, we have just begun work on a research program where we are scoping what is happening around maternal health care in Tasmania, and talking to people with experience of having delivered a baby in Tasmania in the last few years. We will be coming back with a sequence of recommendations out of that soon.

CHAIR - When do you expect to have that done?

Ms FLANAGAN - By October we are hoping to have preliminary findings.

Ms O'BYRNE - We may still be sitting by then.

Mr WILLIE - It depends if there's an election.

CHAIR - If the war starts then we will definitely be.

Ms O'BYRNE - Having said that, it's the sort of information that would be really valuable.

Ms FLANAGAN - To talk now about abortion health care?

CHAIR - Before we go on to that, just in terms of what we've seen up in the north-west, you were talking about birth trauma earlier, and it was pretty clear from what was happening in the North West Private Hospital in the provision of public maternity services, that there were significant staffing issues. Women weren't getting the time spent with them to deal with some of the debriefing that should happen after every birth, and there was a complete lack of any continuity throughout their childbirth experience.

Do you hear much about that and do you have recommendations around improving outcomes for mothers and babies, and families generally, and if the mother and baby are doing okay, the family is likely to do better? I am sure there are staffing challenges at the LGH and the Royal as well, but they have been pretty profound up there.

Ms FLANAGAN - Yes, we hear really positive reports about the midwifery group practice model, but it is almost impossible to get into it. You have to almost ask for a referral into it at about the point where you discover you are pregnant, by six weeks.

CHAIR - Or when you are planning.

Ms FLANAGAN - I am not aware of what the specific issues were in the north-west, but the kind of things that women talk about is the lack of autonomy, the difficulty in communicating with the healthcare staff in the antenatal process. That is amplified if they are not English-speaking or they are from a different cultural background or anything like that. There is sense of losing autonomy and losing decision-making all the way through, lack of continuity of care. The research shows that is the single most critical factor in supporting good outcomes for women from maternity care.

CHAIR - They were the things I was talking about. What do you see are crucial parts to ensure that women and children are not disadvantaged through any policy reform? If you put a gender lens over it, like you said earlier, are these the sorts of things that should be identified during that process?

Ms FLANAGAN - Regarding the gender lens, there is also the experience of people who are gender-diverse who are coming through this system, for whom it can be challenging, being in what is framed as a women's environment. Certainly, what we are hearing from them is the health system is not yet geared to being responsive to what their needs are.

Ms HEARD - I was speaking with the advisory group for the new piece of maternity care research that we are doing. My sense, from speaking to somebody who is working in the midwifery practice with the Royal, would be that this notion of having recourse to discuss the care that you have received or the concept of the debrief, certainly around your experience, would be beyond what is currently received.

I cannot remember the name of it, K10 or whatever, the psychological wellbeing form, but I am not aware of there being consistent practices around providing more than that. We have recently joined a new births trauma group so within that group, all the experiences there are people who have had less than positive outcomes regarding their own wellbeing in the process. That might be a little bit unrepresentative, but certainly there are people in that group discussing their challenges and then trying to pursue a process to have any feedback or recourse.

CHAIR - What I think I am hearing you say is, according to the women's accounts that you have spoken of, there is no dedicated formal process of debrief after every birth. As a former midwife, I can't assume that what I observe to be a straightforward, normal birth to in fact, be a straightforward, normal birth from that woman's perspective.

Ms HEARD - Yes, absolutely. A very normal experience is that experience in itself is entirely abnormal for the person who has gone through it. It may be within the bounds of what is considered a safe and successful and positive birth experience, but it still may be experienced as a highly traumatic event.

CHAIR - It is only through a structured process that those sorts of things can be picked up.

Ms HEARD - Yes, and I suspect the kind of recommendations that we do make out of this report are very likely to be that kind of thing.

Ms O'BYRNE - Is there much of a circumstance where, particularly if there is a child, where it is assumed that this is a normal process that they have gone through and it is afterwards when they are piecing it together that they realise that their experience has been less than what they should have been able to expect, is that much of a thing?

Ms HEARD - The expectation was raised again in the group today around the idea that it all speaks to the diversity of expectations. If people don't expect a particularly high level of care and perhaps everybody is labouring, excuse the pun, under the kind of recognition that services are extremely stretched and that possibly those kinds of things that feel like they're going above and beyond but perhaps would be good practice, are beyond expectations when we move into any particular health intervention at the moment.

Dr WOODRUFF - Thanks for this. It is a really great submission. I like the way you have done the case studies. It really brings things to light, and the recommendations flowing from that. Who should be responsible for doing the cultural diversity and gender-inclusive training that you recommend in a couple of places?

Ms FLANAGAN - The NGOs that work in that space have developed excellent training packages that draw on lived experience and have consumer representatives engaged in

delivering the training, so Working it Out and the Migrant Resource Centre would be very capable of delivering training through the Royal Australian College of General Practitioners.

Dr WOODRUFF - This is what we've heard from other places - don't reinvent the wheel and add another layer, because they've got the specialist expertise. Obviously, there are people who are working as practitioners now and there are people who have been trained for future work as practitioners. Does Women's Health Tasmania have any relationship with UTAS and practitioners?

CHAIR - School of Medicine.

Dr WOODRUFF - Yes, the School of Medicine, also Nursing.

Ms FLANAGAN - Not with Nursing. We host UTAS students every year to come and have part of their training on our worksite.

Ms O'BYRNE - Some, obviously, rather than a full rotation.

Ms FLANAGAN - Yes, it's just a component. Getting into the curriculum is very hard.

CHAIR - You wanted to go on to termination, so I won't interrupt you.

Dr WOODRUFF - I have another question and then we should go on to terminations.

It was in relation to the case study 2 with Carmel, the first trans patient that a practice had ever seen. You said that she was somebody who was accessing health care and she had pain and nausea and then she went to hospital and was diagnosed with depression and given a leaflet with a number with counselling services listed. Three of the four services were faith-based organisations that Carmel thought could be transphobic. She rang the fourth service and is on a waiting list to have an appointment in three or four months time.

You also say women speak about their distrust of church-based medical and other institutions and report examples of refusals of service by GPs because they didn't agree with transgender identities. Are you aware of whether those faith-based organisations get government funding and support?

Ms FLANAGAN - We're talking about a wide swathe of services there, and reflecting on the *7.30 Report* last night about Calvary Hospital in the ACT.

Dr WOODRUFF - I haven't seen that yet.

Ms FLANAGAN - We do have a private health care system that is largely delivered by a faith-based organisation, which makes decisions about what services they will provide and which they won't, which impacts heavily on women and their choices. If we're talking about counselling, then we're talking about not-for-profit counselling services -

Dr WOODRUFF - That's what I thought, which is, again, a different category.

Ms FLANAGAN - I'd answer that in two ways. There's a wide variety of sources within the faith-based organisations and some make a very concerted effort to present a secular front

and ensure their services are delivered in a secular fashion and that's made very clear to staff who might seek to work for that organisation because they have a sense of mission. It's clear that this is not a workplace in which you can do that, but there are other not-for-profit organisations associated with faith-based communities where the mission is a very integral part of what they do, so that's the truth of our very diverse community sector system. But a number of counselling services are concentrated in faith-based organisations and you can't deny that the perception for parts of the community is that these aren't going to be welcoming places for them.

Dr WOODRUFF - From what you're saying, it's more than a perception, it's a stated mission of those organisations that it would be aberrant to provide support in that area because it doesn't line up with their faith.

Ms FLANAGAN - No, it wouldn't be a stated mission.

Ms HEARD - It feels like it's background conflict, however, and I guess these kinds of experiences also speak to the fact that regardless of what happens in practice there may be a mistrust based on historical experiences and I guess the same goes for people who have experienced institutional abuse. Continuing to fund some services to provide those is not going to feel safe for a lot of people.

Dr WOODRUFF - You are saying that at least in the north, in this case study, that there is a deficit of organisations that are perceived to be safe and inclusive for trans people to get that sort of counselling.

Ms FLANAGAN - I think trans people would say there is a deficit statewide. I brought a copy of our research into the health experiences of the LGBTI folk in Tasmania and there were stories of people driving enormous distances to try to get appropriate responsive health care.

Ms O'BYRNE - But even with faith-based organisations that are very open and say they will take everyone and are very secular, the reality is that the staff who work there probably come with a level of bias or a conception of how they might engage. That would be something that we do see a bit of.

Ms FLANAGAN - Being secular does not mean being skilful, knowledgeable -

Ms O'BYRNE - No, so it is still a training issue in terms of being empathetic or trauma-based.

Ms FLANAGAN - I think as a community we are on a massive learning curve and it is just not fair on trans people that they should be expected to be our teachers. We should be skilling ourselves up.

Ms HEARD - I think the AMA spoke to the fact that you can equally encounter these prejudices anywhere in the community generally or the primary care workforce. We were saying the other day, if this is new knowledge that hasn't been part of professional development to date, then it is a learning curve -

Ms O'BYRNE - It is unpicking years of imprinting as well.

Dr WOODRUFF - Working It Out in this instance as a community organisation is playing the biggest role for the state. They have got all the heavy lifting to do in this area and it has been pointed out to us previously that they are not resourced enough to do the breadth of areas of upskilling that is required.

Ms FLANAGAN - We have talked about these issues in the health context and it would require resourcing because, to be credible to clinicians coming in as trainers, you need to put the work in and develop the training packages.

Ms O'BYRNE - One of the points that was raised earlier today or yesterday was around the amount of qualified trainers in any of these spaces anyway. Even if you do as an organisation choose to provide or access, are there appropriately trained people for it as well? Is that something that you would see in your experience? We say that they should do training but where is that training, who is providing it and is it accessible?

Ms FLANAGAN - In any of those areas, those organisations, to my understanding, are funded to do that work. In our experience -

Ms O'BYRNE - Sorry, attracting staff to do the jobs.

Ms FLANAGAN - Oh, well, that is a problem across the sector.

Dr WOODRUFF - Were you going to go on to something else earlier?

Ms FLANAGAN - I was going to talk about abortion health care, which brings us back to some of the conversations we have been having. I have to acknowledge Michelle's presence on the committee because the Reproductive Health (Access to Terminations) Act, which is your legacy, has been an extraordinary thing for Tasmania and it gave us one of the better regulatory frameworks for abortion in Australia -

Ms O'BYRNE - Thank Ruth for taking it through the upper house for us.

Ms FLANAGAN - Yes, it is a terrific achievement, but it must have been very frustrating for you to see that legislation does not always translate into accessible, equitable or non-discriminatory abortion health care. We went through that poor access to services but now we lead the country with surgical abortions available throughout regional public hospitals. The recent Senate inquiry into this and other parts of the country shows that people's rights to these services through public hospitals are highly contested, so I feel that we can't take for granted what we have here in Tasmania and we have to be watchful to make sure we don't lose it.

We are not immune to the other problems highlighted in the inquiry, which showed that across Australia there are workforce problems, poor access to GP services and gaps in rural areas where there are no GPs trained to provide medical abortions, and we have the same problems here in Tasmania. So, specifically about workforce for surgical terminations, the number of specialists competent to do abortions to later gestations is limited and the size of our population means that the number of abortions coming through is limited, meaning that people do not build expertise and we have -

CHAIR - When you say later abortions, what gestation time are we talking about on that frame?

Ms FLANAGAN - Well, it can be above 13 weeks, so the three -

CHAIR - Above 13, yes, we need to be clear because whilst that is the second trimester, it is still pretty early.

Ms O'BYRNE - In context of the lobbying that we get that tells us that we are allowing late-term abortions one week before the date the child is born, yes.

CHAIR - I could tell you what I was told, but not -

Ms FLANAGAN - Okay, so it means that one of our tasks is to be ringing the hospitals and checking what gestational limits are available at each hospital, because it can change quite quickly with one staff movement and -

Dr WOODRUFF - What do you mean it can change? This is in public hospitals.

Ms FLANAGAN - Because if a doctor leaves who was confident to go to 14 weeks and the locum is there and they are only confident to go to 13, suddenly it changes, which makes it a terribly confusing landscape for clients and for people trying to advise on pathways.

CHAIR - Through to the GPs who are referring.

Ms FLANAGAN - Yes. We have quite good access to medical abortions in the cities in Tasmania; in terms of national comparisons, we are quite good, but we have really poor access in remote areas, like really poor. We manage a website called Pregnancy Choices Tasmania, which is a directory of sexual and reproductive healthcare providers and it is accompanied by a 1800 phone line. Not every GP who provides medical abortions wants to be listed on our site, because some of them do not want to take referrals, and this is where you hit the -

Dr WOODRUFF - Because their lists are too long - they are closed anyway.

Ms FLANAGAN - Yes, it is only a service they provide to patients of their practice. Some of them do not wish to be listed publicly because they do not want to take community referrals, but they will take them from us, so our workers can see those numbers, but some are listed as public and are willing to take referrals, so we have 21 practices listed as willing to take referrals.

Ms O'BYRNE - Can I just ask, are you able to tell us how many would be not public listings that you would be aware of that you would make a referral to?

Ms FLANAGAN - I would have to take that on notice. We also have anomalies where we might have a GP in an area, but there is not a pharmacist who is willing to stock the medications required, so a woman can get a script for a medical abortion but have to drive quite a few hundred kilometres to actually get it filled. In some places we have a pharmacist but no GP.

CHAIR - Without disclosing too much, can you give us a breakdown of where they are?

Ms FLANAGAN - I can send this electronically. The clear deserts are around the Furneaux Islands, obviously, but the north-west, the west coast, the north-east, the east coast, and the far south, Meander, Kentish, the Midlands and the Highlands, and around the central coast.

Ms O'BYRNE - And that is both GPs and pharmacies or either/or?

Ms FLANAGAN - Either/or. In Smithton, for example, we have a pharmacist but no GP, so part of the work we are doing with our website is not only that we are in weekly rota ringing these providers and writing to them, but we are also doing site visits like cold-calling, dropping in and then encouraging them to look at the website and get a sense of security about what it is and hopefully join up to be on it.

Ms O'BYRNE - That is a frightening thing, too, that you get your script, you go to your local pharmacy because you think you are all within that framework, and that is when you discover that it cannot be accessed and sometimes they have a little sign saying they are not doing it. I automatically go in and tell them I am never shopping there again and wander out. But some of them you don't know and it is quite a confronting experience. I have spoken to some women when they found -

CHAIR - It is also outing yourself.

Ms O'BYRNE - Yes.

Ms FLANAGAN - And I think, if people have not had some exposure to the process, they do not realise how time-limited it is. Women have days to get organised, get the money for it, get it happening.

Dr WOODRUFF - How does your list mesh with, also, Family Planning Tasmania's provision of medical termination? You have that list, that is GPs, but they also -

Ms FLANAGAN - Family Planning is in there as well, yes. Our Women's Health Fund covers the medical costs of medical terminations for any women for whom there is a financial issue around the cost of it, so certainly anyone on a concession card and anyone else who is asked the question, 'Does this cause you financial difficulty?', if they answer yes, then it is covered by the fund. About half of our referrals come from Family Planning and half come from private GPs.

The other point I wanted to make is that the Women's Health Fund is also a fund that we can use to assist women who are in financial difficulty to access long-acting reversable contraceptives. Initially, we were offering it to women after an abortion because they are with a doctor and it can be done if they're having a surgical termination while they are unconscious, which can be attractive to people. We now have expanded it to any women on low income who would like to access it. They can also access the Youth Health Fund for this if they are under 25. This is absolutely remarkable in the national context; there is no other state that is providing something like this. Having said that, we always see room for improvement and any system which requires an assessment of financial hardship creates barriers and it is embarrassing to have to say yes, this causes me problems and I need access to this.

There are also gaps. There is no financial assistance to cover contraceptive costs for women who are in difficulty for whom these contraceptives aren't appropriate and they need a different form of contraception. We are not currently paying for prescription birth control but it would be such a great thing if that were available. Providing it free is a growing public policy response around the world. British Columbia just announced that they were going to be doing it for their population. The UK does it, as do Norway, India, France and developing countries, so countries like India and some African countries are doing it.

Dr WOODRUFF - Wow, what cost would it be?

Ms FLANAGAN - I don't know.

Ms O'BYRNE - One of the arguments is once you are purchasing in bulk and distributing through central points, you can reduce the costs quite a lot. I think that is one of the ways they've been able to manage it. I think there's a World Health [Organization?] gender meeting coming up this week that is talking more about that, about public policy around it.

Ms FLANAGAN - We know that cost is a barrier to accessing contraceptive care, which then leads women into needing higher-cost interventions if they get pregnant with an unplanned and unwanted pregnancy.

Those were the issues that we wanted to talk more about. I wanted to pick up on a question that you asked the AMA - what if there was a portal for endo services? I'll point out that Pregnancy Choices Tasmania is a portal for a whole range of sexual and reproductive health services. We also include long-acting reversable contraceptives where there are women doctors, where there is wheelchair access - there's a whole list of criteria.

Ms O'BYRNE - One of the people who spoke to us yesterday morning was a doctor who keeps their own list of services because there isn't a centrally accessible one. I was interested in when you set up your provider list, is it people you are confident have access and you may not necessarily trust them, or a generic one, or is it a more broadly accessible one? The endo was more of a lead-in from the previous commentary as well. I didn't know that yours did.

Ms FLANAGAN - Yes, we are promoting it to service providers as a tool that they can use as well, but again, hidden in this problem is people not wanting to advertise what they have because they don't want new patients coming in. Another comment that I would make, reflecting on the discussion that you had with the AMA, is that we hear a lot about the effect of 15-minute appointments in terms of trying to provide cultural change with doctors or provide empathetic healthcare, when they've only got 15 minutes to confirm a pregnancy, explain the pregnancy choice options, reassure themselves that the woman is giving informed consent, organise referrals for blood tests and scans -

CHAIR - There is no time to ask questions.

Ms FLANAGAN - Yes. If they are gender-diverse and there's sensitivity around the fact that this might be a quite different experience -

Ms O'BYRNE - You can't do all of those jobs in 15 minutes, let alone the additional work.

Ms HEARD - To touch on workforce, we are fortunate to have a highly skilled and dedicated health workforce in Tasmania that is going above and beyond to provide service continuity in the context of ongoing high levels of public demand and staff shortages. Our submission lists recommendations for health workforce development in a number of areas relevant to women's health including trauma and mental health, sexual and reproductive health, abortion care and conscientious objection - which also came up with the AMA around whether or not that has been well practised -, cultural diversity, transgender health family violence and reproductive cohesion.

Also on that workforce development topic, the national conversation around scope of practice for health professionals involved in the delivery of women's reproductive health care was promising, including expanding the role of nurses and pharmacists in the prescribing and dispensing of contraception and MToP benefits including freeing up under-pressure GPs, increasing the accessibility of common healthcare interventions and allowing health professionals to utilise their skills more fully. We would certainly encourage the Tasmanian Government to consider undertaking its own nurse- and pharmacist-led reproductive healthcare trials.

I will go straight on to health literacy. We know the Tasmanian Department of Health says that more than three out of five Tasmanians do not have adequate health literacy. We see this impacting women's health in key areas. Again, sexual and reproductive health, preventive health, especially for culturally and linguistically diverse women and health system navigation. Health workers have noted the varying range and quality of sex education offered across Tasmanian communities by government schools and correspondingly varying levels of reproductive health literacy in school-age people. This is highly relevant for a state that has one of the nation's highest teen pregnancy rates.

These issues may be exacerbated by self-reported low levels of reproductive health expertise in the Tasmanian GP workforce with relatively few GPs providing specialist sexual and reproductive health services, such as medical terminations of pregnancy and IUD insertion and removal. As we discussed, there are other factors there around the billing options. Staff also observe low levels of preventive health literacy in Tasmanian women, particularly women with low levels of confidence and agency navigating health services. Practice models like our own, where non-clinical health workers provide health system navigation and coordination support, play a key role here. We urge further investment in locally based health workers across Tasmanian communities and regions.

Dr WOODRUFF - Important.

Ms FLANAGAN - We wanted to talk about the model of women's health services because they have proved a very effective gender-responsive model of health care. Women's health services deliver gender appropriate, affordable and accessible programs because they are designed by women for women to meet the health needs of women. They are built on principles and practices which we think are broadly applicable across the health system. They ensure that they encompass a women's lifespan and reflect women's multiple roles. For example, not just reproduction capacity around that. They promote greater participation by women in decision making about health services and health policy as both consumers and providers. They recognise women's right to be treated with dignity in health care environments and that includes providing privacy, seeking informed consent and observing confidentiality.

They affirm that women have different experiences of health and healthcare because of our different socio-economic status and migration status, our age, our religion, our ethnicity. All of those different things that impact on our lives. Women's health services acknowledge that informed decisions about health and healthcare require accessible information as Elinor was talking about, targeting different socio-economic, cultural and geographic groups. They use evidence-based practice, data and research about women's health. Women's views about health and strategies which most effectively address women's health needs. It is being done and it could be done more broadly.

Our last comment would be that gender inequities are not going to right themselves just through the weight of good intentions. We need investments in equity initiatives to ensure gender equity across the system.

CHAIR - If you were the health minister, Jo, or if you were going to tell us what you think the health minister should do if you cannot put yourself in the shoes of the health minister easily, what would the first important body of work that you would do to progress a lot of these matters? I hear you say that they are happening. We are still hearing stories every day that we have hearings, about the bias, the inequality, the not being heard or believed stories. What is the important starting point to really make the biggest difference, from your perspective?

Ms FLANAGAN - We see good work happening and we see strategies that pinpoint all the things that need to be done and come up with ideas for how to do them, but it's not easy or quick work. They need to be progressing. We need to have a commitment to the long term and invest for the long term. I think that is really important. There isn't a magic wand around this.

Having said that, if I could pick one thing, I think the model we have at Women's Health Tasmania is a simple thing but it's really effective, which is having a non-clinician advocate, in a sense, a person that someone can ring and say 'This is my issue, where do I go? Who do I talk to? What do I do?'. Our worker can help them navigate their way. They're a pathfinder through the system. They're starting to develop these things in the aged-care system. I forget what they call them, pathway advocates or something like that. I think in Tasmania in the environment we have, with the level of disadvantage we have and the poor health literacy we have, that's what people need. They need someone they can go and talk to who will help them find their way through the health system. We do have services and we do have things that are happening and we need to have people who have expertise but people aren't finding their way to them.

Ms O'BYRNE - I absolutely agree that the more disconnected you are from those frameworks, the harder it is, but we regularly see very competent people struggling to navigate the system. The system is inherently complex, whether it be aged care or possible provision or service access. All of it is complex, let alone if you're not used to seeking support, or not familiar with those environments, or even the language that's used.

Ms FLANAGAN - Australia is massively bureaucratic and we're just really bad at it. We've created these systems that we need intermediaries to help us deal with. We have a social welfare system that is set up to advocate for people, on people's behalf, with Centrelink and with public hospitals, because people themselves can't do it. Nevertheless, that is the situation that we're in.

As you were speaking, I was thinking about a focus group I ran in Rosebery, and I asked, 'If we could do one thing for you, what would it be?' They said, 'Could you just get someone here that we could talk to that can tell us who to ring or what to do?'

CHAIR - The Rural Health inquiry had a recommendation about engaging what we called health advocates, which is the sort of role that you're talking about, and maybe people who are retired nurses or other health professionals who may be burned out or suffering from PTSD or whatever, can actually provide well-informed knowledge to the person seeking access. So, a woman comes in with an unplanned pregnancy early on, so that that person would know 'this is where you can go, let's help, ring this number and get some advice from Family Planning or Women's Health' or whatever it is. Even very competent people, when they're faced with a highly stressful and challenging circumstance that could turn their life upside down, then all common sense can go out the window at that point.

The Government hasn't said no to that. Do you think that's a really important thing in helping people navigate?

Ms FLANAGAN - I do. I'm sure a number of us have had the experience of trying to assist their parents with aged-care systems and the role of people in helping us navigate that. There are even commercial responses emerging to these kinds of gaps, aren't there? Like the bed brokers who charge you to help you get your parents into the aged-care system.

Ms O'BYRNE - But also interpreting information. If you hear information in a point of crisis, you don't hear everything, and if you're there alone, or you have a language difficulty or a cultural difficulty, the ability to walk away as well-informed as you should be - it's really hard.

Ms FLANAGAN - Yes. That would be my one thing.

CHAIR - Do you think that sort of role should be really brought in, not just to help people navigate, say, the acute health system, but the primary health system and every other system? It is a system of systems, really.

Dr WOODRUFF - I think what you're saying, Jo, is that that's Women's Health Tasmania does for women -

Ms FLANAGAN - For the people who find their way to us.

Dr WOODRUFF - and then there's the whole health system, let's say, which needs advocates for women in other specialties.

Ms O'BYRNE - But there'd be women who would not find their way to you.

Ms FLANAGAN - Well, for priority population groups, for the people that we identify that have greater difficulties in navigating their way through.

Ms O'BYRNE - But even then finding their way to you can be quite complex.

CHAIR - Particularly if they live on the north-west coast or on the islands, they don't see you.

Ms FLANAGAN - Yes. All the other strategies have to keep being progressive at the same time.

Ms O'BYRNE - Abortion law can have the best structures but no-one knows how to get it or it is not provided in the right way, it does not matter.

CHAIR - The law is right but the policy is not.

Ms FLANAGAN - To give an example of the kind of work our health workers do at its most basic, for example, a woman leaving a domestic violence situation might have no documents and a lot of work is being done to help her get a Medicare card and the cards she needs in order to access the health system again. Quite often, people don't actually know what their issue is until they've talked it through with somebody. They might be contacting us saying, 'I'm so anxious I can't stop shaking', but actually the issue is family violence so what they need is legal advice. The health system can become a huge door for so many issues but having people meet someone at the door and help them head in the right direction -

Ms O'BYRNE - That is what our political officers do a lot of. We don't know the answer but we often know who the person is who knows the answer. But once again, you've got to find your way to that point and with an increasingly isolated society that's becoming harder.

Dr WOODRUFF - Yes, except that there are communities that talk and it is about directing people. It might be that someone ends up at the Multicultural Council of Tasmania or Working It Out and they get referred through to you for some of those issues. It's about better connectivity.

Ms O'BYRNE - We see a lot of people who don't have any of those connections established and there must be many that don't make it to us who are completely disengaged from the frameworks we offer.

Ms HEARD - In our submission we talked about the value of having some of those health workers or advocates close to local communities and regional communities for the reason that those health pathways also might look slightly different in those places, especially if it comes down to one clinician moving or something. Suddenly that picture is quite different. So having that kind of place-based knowledge as well as sector-wide understanding is important.

Ms O'BYRNE - It is a good submission, thank you.

CHAIR - Thank you very much. We appreciate the time and the submission. Was there something we were going to get you to send us? You are going to email us that map -

Ms O'BYRNE - You took on notice the question of non-publicly listed providers and I guess if we're still in operation in October when your work is done, it would be great if you could share that with us.

Ms FLANAGAN - We might have a different piece of data that might answer that question for you. All medical terminations, the drugs are provided by Marie Stopes

International and they train the providers, so they keep the data on it. We have 127 active prescribers in Tasmania.

Ms O'BYRNE - For medical?

Ms FLANAGAN - For medical terminations, yes.

Ms O'BYRNE - Is it possible to say over what number of locations? Because I am thinking you might have one practice that has eight.

Ms FLANAGAN - When I said 21, that was practices not individuals. I don't know if I should give you these or send them to you electronically.

CHAIR - Send it through electronically.

Ms FLANAGAN - This Marie Stopes data shows you that Tasmania has the worst access in terms of people living in remote locations.

Dr WOODRUFF - Does it give the number of terminations that are accessed each year?

Ms FLANAGAN - No, it doesn't say.

Dr WOODRUFF - There must be a Medicare number.

Ms FLANAGAN - Abortions are spread across four Medicare item numbers. And it has been a long debate -

Ms O'BYRNE - About appropriate data. But also people have been frightened to share it because it has been used against services in the past as well.

Ms FLANAGAN - There are a few Australian jurisdictions that collect data on abortions. Western Australia is 10 years down the track and is able to track patterns in terms of what's happening. I thinkthe fact that we don't is a real problem. It means we can't plan our services.

Dr WOODRUFF - You mean surgical and medical, we don't collect the data on that?

CHAIR - Surgical we would because [inaudible] -

Ms O'BYRNE - Not necessarily because the procedure can be used for other reasons. D&C is not always used for terminations. That's how they're still categorised.

Dr WOODRUFF - But medical termination of pregnancies? We don't know. That's really a problem.

Ms FLANAGAN - Women's health advocates are nationally divided on this, too, because they're worried about lists getting out there.

Ms O'BYRNE - Because they are used against services. I know that when we didn't have readily accessible options here, they were just being listed differently in hospitals so that

they could be provided. There was a level of protection provided by that. It's a complex one because of the campaign against access.

Ms FLANAGAN - We regularly produce reports on the health needs of particular population groups. We've got one here on women on temporary visas, women who are experiencing homelessness, LGBTIQ+ women, and rural and remote women. I can send electronic links to those.

Ms O'BYRNE - One more question that has just occurred to me: as we're in a cost-of-living crisis, are we seeing changes in people's access? You started by saying all those issues are health issues. As things are becoming harder and harder, are you in a position, have you got tracking data or is it anecdotal data to say whether you're seeing more presentations or less?

Ms FLANAGAN - It's anecdotal data coming through our helpline. I haven't seen a parallel with the cost-of-living crisis, but a shutting down of access to primary health care over the last four years, I would say. We just recently had a woman with a new baby and other young children who was told by her local GP clinic that she couldn't access them because she had a bill at the clinic. No other clinic in her area would take her and she had a sick baby, so we used our donation funds to pay her bills. I saw the invoice when it came in. It was $188.

Ms O'BYRNE - There are rules about refusing care. Anyway, never mind.

Ms FLANAGAN - I think we're seeing a clampdown across the board in terms of access.

Ms O'BYRNE - It's scary. They aren't actually allowed to refuse care.

THE WITNESSES WITHDREW.

The committee suspended from 3.32 p.m. to 3.41 p.m.

CHAIR - This is a public hearing and all information you provide to the committee will be transcribed and on our website. Everything you say before the committee is covered by parliamentary privilege but that may not extend beyond the committee hearing, so keep that in mind if you speak outside of the committee.

If you want to share any information of a more personal or confidential nature, you can make that request to the committee and we would then stop the broadcast and alter the way we take the evidence that way, but otherwise it is all public.

I will introduce you to the committee members: Dean Young, Josh Willie, Michelle O'Byrne, Ruth Forrest, Rosalie Woodruff, Dean Harriss, and Nick Duigan may be back shortly.

Mr JACOB ROBERTS WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you for coming.

Mr ROBERTS - Thank you for the opportunity and invitation to present today. I feel very privileged to represent the men of Tasmania from both the personal and professional perspective. As per my submission, there are a few varying themes and points that I am particularly passionate about and demonstrated some evidence and statistics about. I do have some additional points that I would like to add as we go for time and relevance.

As a registered nurse and clinical nurse consultant for 12 years, as a father, as a husband, as a brother, as a son and as a male, I feel personally and professionally obligated to advocate for my gender. I feel that men historically and currently do not advocate well for themselves. I saw this opportunity to go into bat and raise some areas of concern issues that I have, not just relevant to Tasmania and the state but nationwide.

A lot of the points of concern issues that I raise aren't just state-based. Many are broad and complex in nature and have no easy answers. But I have a few suggestions in a few areas of concern that I think the committee could address moving forward.

In relation to the terms of reference, I would like to build on a quote from the Premier that I found from the Long-Term Plan for Healthcare in Tasmania 2040. He said:

> There is no higher purpose for government than ensuring the wellbeing of future generations.

I feel like for these issues I am raising, there's no short-term fixes but we need to start now, we need to do a better job than we are doing. I have a young son that I do not want to have to have to face these issues with or have better access to resources and supports for him. In that Long-Term Plan for Healthcare 2040, it was concerning that parents, or adjectives thereof, was mentioned once and gender was mentioned no times. That is a concern for me given the fantastic nature of that plan and a lot of the key outcomes hoping to be achieved, the strategic directions. There are no specific mentions of parents, families or gender, which I think is crucial given that we know there need to be different approaches depending on gender.

CHAIR - One would assume from that, Jacob, that there had been no gender lens put over that document.

Mr ROBERTS - Not that was evident to me. There are more broad, vague statements that can be then potentially broken down into gender or other roles. But as it stands, they are kind of bigger picture, broad, vague, in my opinion.

Ms O'BYRNE - Do you think that is because there was a focus for a while on things being gender-blind and that, somehow, that made it equal which, of course, the two don't necessarily connect? Do you think that might have been the way it has been approached or do you think it has simply been they have not, or do not appear to have addressed it?

Mr ROBERTS - I think it is an omission. I can't accurately comment, I suppose, on the perspective of those that formulated around gender blindness.

Ms O'BYRNE - But as you are reading it?

Mr ROBERTS - I just don't think it was considered; I think it was an omission.

CHAIR - We can ask them about that when they are in front of us, anyway.

Mr ROBERTS - I hope it wasn't, given examples of lived experience of gender bias in health care. From a personal perspective, I have detailed in my submission around being a young father, a health professional with a background in mental health, in emergency nursing, in looking after children, engaging with midwives and health professionals. It was really difficult to attend every appointment, which I did, and be as supportive as I could. Often at times when I would get there, the environment, the language, the structure, the seating, the energy in the room was that I was the plus-one, it wasn't a family unit, it wasn't a team, it wasn't a non-birthing parent in the room. It was like, 'It's good that you're here, you can sit over there'. There was no screening or assessment for me, there was no real concern for my wellbeing, in my perception. I have friends and colleagues that have shared this as well. They do everything they can around work to get to these appointments to be supportive, to be engaged, to educate themselves, to advocate for the birthing parent. We still have a long way to go in making that space more inclusive, engaging and supportive.

CHAIR - Did you find that it persisted through the labour and birth, or were you more included in that process?

Mr ROBERTS - I put myself in that process. I think with my professional background, I could advocate and engage. I think, given the personality of the midwives involved, that if I was standing back, they would have dragged me forward. I think it is probably an individual personality thing around who is there at the time. There were COVID-19 factors as well around visiting hours and things like that, but I was still able to make all the appointments, so COVID-19 was not a factor to actually attend. But I know a lot of people have battled with that, not just men, but non-birthing parents around visiting. Potentially, as I say this, maybe telemedicine could be a supportive option for non-birthing parents. We don't have the COVID-19 restrictions that we did but I don't think that was a common tool.

Mr WILLIE - Were you referred to other programs at all through that time? When I was a first-time expecting father I went to this program run by a long-term midwife, Ronnie, and it was called -

Mr ROBERTS - Beers and Bubs.

Mr WILLIE - Beers and Bubs, and it was excellent and that changed -

Ms O'BYRNE - Did you just go for the beer or was it genuinely just for the beautiful baby?

Mr WILLIE - There was a whole lot of expecting fathers and it completely changed the experience. I am wondering if you were referred to anything like that.

Mr ROBERTS - Yes, I was, by a midwife, but also by friends that had been. I actually got to go as a return dad. I don't know if you got to do that at all?

Mr WILLIE - No, I never went. Three times in, you are less and less -

Mr ROBERTS - What I mean by that is the first-time dads, they invite you back to be the guest speaker, six, nine, 12 months down the track.

CHAIR - To tell the truth about the reality.

Mr ROBERTS - One hundred per cent. That is a fantastic -

Ms O'BYRNE - Do you know if that happens statewide?

Mr ROBERTS - I know Ronnie runs it out of Hobart, I don't know that there are north or north-west ones around that.

Mr WILLIE - I think he is retired now. Somebody else has taken over.

Mr ROBERTS - Great. As long as it did not drop off. It is a fantastic initiative, one that I loudly promoted to anyone I could and was happy to go back and support.

Dr WOODRUFF - You said you do not get any screening assessment or any support. What would you have liked?

Mr ROBERTS - Great question. I was going to build into that down the track. For me personally, general wellbeing checks, mental health screening would have been appropriate. My mood and my sleep, how I was feeling about things, my anxiety around the pregnancy.

CHAIR - Change natally and postnatally, you are talking about?

Mr ROBERTS - Yes. I remember postnatal appointments where my darling wife, Katie, got questionnaires around her wellbeing and things like that. I was sitting next to her and did not get offered that and I was really struggling at the time. Katie was flying and doing really well. I wanted to snatch it out of her hands. I wasn't encouraged and I did not have the confidence -

Ms O'BYRNE - To say 'Let me have a go'?

Mr ROBERTS - Yes, this is what I say and this is why I am passionate about this. I am educated, I have worked in the healthcare sector in mental health, in various roles of health promotion, and sitting there in that seat, I didn't have the confidence to speak and advocate for myself in that space. That is saddening for me.

Ms O'BYRNE - That would be true of most people, I think.

Mr ROBERTS - I think so. But it brings it home when it is -

Ms O'BYRNE - When it is happening to you, it is a different experience.

Mr ROBERTS - Yes. That is not to say all midwives and all child health appointments are like that. There are some fantastic CHaPS nurses out there that very much engage and include dads in those screening processes, and even the home visits. I probably wasn't vocal enough in advocating for myself.

Part of what I have talked about, role delineation, stereotypes, stigma and communication, I wasn't one to burden my wife with where I was at because we didn't sleep for two years.

CHAIR - If someone with your background, experience and knowledge is disempowered enough not to say, 'Hang on, it would be helpful if I could do that', there are very few others that would, I would think.

Mr ROBERTS - Yes. Part of my research around this is what concerns me more going forward. It was only this month that Perinatal Anxiety and Depression Australia (PANDA) released a statistic that 67 per cent of expecting dads are stressed and 61 per cent are having anxiety and panic attacks. All of these things pre-natal increase the depression postnatally. We have increasing rates of this but I haven't seen any increase in resources to tackle and highlight this for the issue that it is - that one in 10 men, at a minimum, will have mental health issues. These are the ones we know about.

Dr WOODRUFF - You are talking about it as an issue for fathers-to-be, for their mental health at the time and also after the birth, the impact on their mental health. For that person, just in terms of looking at the risk factors and the interventions that might be needed for that person. The obvious inference is that you are talking about the impact on the partner and the family and child, the whole family. It is the person, yourself in your own instance, but also the family. Therefore, to get better health outcomes for the family; ignoring the partner and their experience is missing the opportunity to improve the outcome for the whole family.

Mr ROBERTS - Yes, and all the evidence supports that as well. All the evidence supports that that individual will deteriorate. There are increased risks of divorce, there are increased risks of disconnection with the child, there are increased risks of mental health for the child and the birthing partner.

Ms O'BYRNE - The evidence shows that?

Mr ROBERTS - Yes.

Ms O'BYRNE - With your experience working in mental health, do you see high rates of that being identified or do you see high rates of that which should be identified and where that connection is not being made?

Mr ROBERTS - Yes, great question. In the Department of Psychiatry, the in-patient, it is the pointy end of acuity, it's really high. We know the majority of people are in the community that I don't personally engage with. But I am seeing more men and more recent fathers and non-birthing parents in the acute sector, in the high acuity. I don't see the screening for that whole period, ante- and postnatally, their risks of increasing deterioration in mental health - people with chronic schizophrenia, mood disorders and personality disorders. There isn't this awareness of this high-risk period if you're a non-birthing parent to say you are at high risk of deteriorating and then putting the family -

Ms O'BYRNE - 'What supports do we need to put around you?'

Mr ROBERTS - Yes.

CHAIR - Keep going, sorry, we've interrupted you.

Mr ROBERTS - No, I love questions. Thank you.

Ms O'BYRNE - It's a good sign because it means we're interested.

Mr ROBERTS - I'm glad you're interested and keen. That's why we're here.

Looking at some Tasmanian statistics, we know that 80 per cent of suicides in Tasmania are men. We know that there's lower socioeconomic issues in Tasmania; we know there's greater rural discrepancies, which the previous group mentioned as well. We know that there's a six-year life expectancy gap in gender and it's devastating that we haven't been able to bridge that, not that that's for me or this committee to do.

I lost a friend to suicide two weeks ago, out of nowhere, and that is still pretty raw and that's shaken up my community around that. It again highlights my professional desire to contribute and advocate on boards like this because there are still far too many men who are flying under the radar, not accessing services or not being heard or supported.

We have lots of initiatives. Mitch and Stay ChatTY have been fantastic, and there are quite a lot of other initiatives out there. The bridge is bringing it to the men because we know the men aren't going to the resources that are out there. There are a lot of great resources out there. I believe part of the issue is we need to take it to the men and where they are, and that is primary health centres, if you can get men into a GP or able to afford one. Good luck with that.

Ms O'BYRNE - Workplaces?

Mr ROBERTS - Yes, workplaces are key and there's been a lot of work around that. OH&S staff, workplace supervisors; safety, there is a lot more encouragement with, say, mental health first response and mental health first aid, which is fantastic. I'm not sure of the gender

differentials in those courses. They are quite generalised. I teach in the Mental Health First Response course and we don't deliver any differing approaches to differing genders.

CHAIR - The programs provided are gender-blind?

Mr ROBERTS - The one I'm involved in. I can't comment on others but there are others that may have different strategies for different genders.

Ms O'BYRNE - I'm familiar with one that's targeted for people in the fly-in, fly-out industries, which is predominantly men, but that's a rarity.

Mr ROBERTS - I know the Australian Men's Health Forum has some and there are other resources around that but some of them may not be -

I've worked with UTAS previously and taught there, and in a lot of the educational content around health, there's very few gender approaches and perspectives. There are all the stats and the differentials but there's not a lot of differing approaches around that.

CHAIR - Coming back to your point of taking services to men or helping them to walk in the door, you make the point under accessing healthcare services:

> Health services should avoid blaming men and making assumptions about their behaviour, and focus on solutions rather than the problems.

That was from Healthy Male Australia, Engaging Men. Can you talk a bit more about how you see that playing out in practice - the blaming men and making assumptions?

Mr ROBERTS - Straightaway I think of how men are presenting and that is late and that is down the track and that is very unwell; that is self-medicating on substances and alcohol, pornography, social media, add/insert here. And then being blamed for taking no responsibility or accountability for their health, or the situation you find yourself in because they haven't been supported or accessed early intervention. That's where I feel that there's that potential blame around that.

Dr WOODRUFF - You mean that men in that situation get judged for their coping mechanisms with their situation, which they find intolerable and, for lots of reasons, don't do something that is healthy about it?

Mr ROBERTS - Yes, and we see that more broadly in all aspects of health care, that men are more reluctant to access health care and primary services: men present later, men present when they are more unwell. There can be that judgment of, 'Where were you six months ago? -

CHAIR - Besides this not knowing where to go - and you talk about the stoicism and the self-reliance and trying to fix your own problems, because part of that is the stigma, and all of that - how do you see the best way of overcoming that? It's a gendered thing, there's no two ways about it. So, how would you see that being turned around? Is it in the attitudes of our medical professionals, or is it in the way boys are raised?

I'm just trying to think where the root is because you've got to start somewhere. When you can't fix all the big problems, you can look at how we can stop people falling off a cliff in the first place.

Mr ROBERTS - Yes, that is the question as to why we are here. If there was an easy answer, then we would go to that.

My point would be early-intervention fatherhood, and getting that family unit supportive and together, preventing any deterioration of mental health in the antenatal and postnatal periods. We know there are negative follow-on effects if we don't handle that space well, which then flow on through society and generational gaps.

There's been a lot of work in schools, we're getting better at identifying mental illness and have more resources, so we're seeing more statistics around that. But my passion - and it's a longer term strategy - is promoting that culture at home and supporting fathers. My big push that you'll see I talked about was around the parental leave scheme.

Ms O'BYRNE - What about circumstances when both parents are non-birthing parents, so when we have two fathers? Do you see that there is a different level of support provided there? Is there an acceptance that we need to provide? I am just wondering how much of the response is because we just think parenting is all a woman's thing, or whether we recognise that when both parents are non-birthing parents.

Mr ROBERTS - Great question.

Ms O'BYRNE - I love the way you validate me, that's very kind.

Mr ROBERTS - Sorry about that -

Ms O'BYRNE - No, I love the way you do it, it's a very inclusive practice.

Mr ROBERTS - Thank you.

Ms O'BYRNE - I'm asking because I've seen it in same-sex couples before, when the non-birthing parent is a woman, there tends to be quite a bit of engagement of them. I wondered whether or not we're seeing the same sort of behaviour when both parents are male.

Mr ROBERTS - I can't comment; I haven't engaged in that space.

Ms O'BYRNE - I apologise -

Mr ROBERTS - Please don't apologise. I wish I could answer that better. I suppose it's the change in societal acceptance. We're seeing more same-sex couples, we are seeing more non-birthing parents in different relationships in different family structures now.

Ms O'BYRNE - If we are prepared to recognise the support required by a same-sex couple where they're both women, or cisgendered women, then why can't we provide that to a male parent? Not helpful for the committee because you have no view.

Mr ROBERTS - I apologise for not being helpful.

Ms O'BYRNE - It does lead into that access to parental leave because it becomes part of that problem.

Mr ROBERTS - We can go to that and then swing back around, depending on time and when you've had enough.

In my research I realised that as of 1 July the parental leave is changing, which I wasn't aware of. I have concerns around that. I think it will further alienate non-birthing parents. My understanding is that the 18 weeks are going to extend to 20 weeks but be a combined period of time rather than the designated two weeks for non-birthing parents. Given the evidence that we have and the historical nature of this sense of providing for families, and non-birthing parents, particularly men and fathers returning to work, there may be an increased reluctance or judgment around accessing those two weeks when the birthing mother could have that period of time. That's my own view. In Australia, 4 or 5 per cent are stay-at-home dads, and I don't see that changing with this leave scheme.

I see by 2026 it is going up to 26 weeks, which is fantastic, and I would love to see more. There are fantastic leaders in this space, particularly Finland, Scandinavia, that do two years. A lot of cultural practices are that the dad will then do the one to two years because we know 80-plus per cent of brain development is within those first two years. To have that time, those relationships, those connections is huge. We don't have that. I had two weeks of no sleep then tried to return to work and come back and support the family. That's it, which I think is poor.

Australia is better than other countries and we are very fortunate to have something at all but this is an area, if we want to encourage the family networks at that key period, at that high risk of mental health deterioration and screening of support. Having men or non-birthing parents, most people that I associate with and chat to in Tasmania can't afford minimum wage for two weeks at the moment with the cost of living. Yes, you have two weeks as an option, you can access other forms of leave and a lot of people do. But there are people I know who are delaying or putting off having children at all because they're concerned about the cost of living. They are also concerned that they can't get by on that two weeks of minimum wage. That is a real concern.

Ms O'BYRNE - That goes back around to the gendered nature of wages. That is often the reason men go back to work and women don't.

Mr ROBERTS - They are earning more.

Ms O'BYRNE - Lower wages in these circumstances.

Mr ROBERTS - Yes, that is a big factor of the dads that I know and talk to - they earn more so it is better for them to go back to work.

Ms O'BYRNE - A financial decision rather than a parenting one.

Mr ROBERTS - Yes.

Ms O'BYRNE - You talk a little bit about your own workforce and the gender break-up of that workplace. What do you think could be done to encourage greater gender diversity in your profession, because as you say, that leads to changing attitudes and behaviours?

Mr ROBERTS - There is that historical nature around role delineation and gender delineation with caring roles, and things like that. We are slowly seeing increasing rates of men in the nursing profession but it is still very slow. We still have a long way to go with doing that. I have tried to advocate for that in some work with Healthy Male Australia, which I'm involved in, around doing health promotion work for men to consider care fields and specialties.

I remember when I was studying nursing, going to footy training and things like that - half the blokes laughed at me and there was a lot of criticism and judgment from the other half, like, 'That's bloody fantastic, mate, well done'. I wasn't fully supported and there was still that judgment and that was 15 years ago. I think we have come a long way from that. There is a greater acceptance with men, particularly nursing, in the health workforce. It has never been an issue with medicine; that is a male-dominated area that is now changing with more women.

Ms O'BYRNE - When you get down to aged care, the lower salary makes a significant difference for men.

Mr ROBERTS - Correct. When you've got the option of an apprenticeship or studying and not earning for three years and then having a HECS debt to then go into something where you are going to earn half of what you could have as an apprentice, that you then have to build into, there's no comparison for a young bloke when they're trying to put food on the table.

CHAIR - That is why we want to see more women take up apprenticeships.

Mr ROBERTS - On that, there was a really interesting statistic I learnt, I am going to misquote it, but it was maybe 50 per cent less men or boys graduate college in Tasmania than women. I related that to educational outcomes into health outcomes in accessing the healthcare fields. That then flows on to health literacy, which is obviously a key area and strategic direction the Government is looking at. We know that literacy levels in Tasmania are very poor and health literacy ones are even worse. Given the pressures on the acute sector particularly, which we are all familiar with, communication isn't the priority and health literacy assessment, and teach-back and different approaches aren't done well. That flows on. I feel like education is a part of this, encouraging men and boys to finish. But it's really hard when you are competing with apprenticeships and carrots of money dangled in front of you as an option. I don't know around waiving HECS for nursing or healthcare fields. I would love to see that. That might entice -

Ms O'BYRNE - I know in Coolum Council, Queensland, one of the aged care facilities is saying, 'We will pay your HECS debt if you come work for us'. But the salary is still so poor that people aren't doing it.

Mr ROBERTS - That is probably a chat for another time but there's a large issue nationally between states and territories fighting over students and graduates and dangling a lot of financial incentives to recruit.

Ms O'BYRNE - Rather than a massive investment in the things that are actually the barrier to people's employment, which is usually wages and training pathways.

Mr ROBERTS - Correct. Just trying to get the numbers on the floor because a lot of places can't staff their day-to-days.

CHAIR - You have talked about a big picture, acknowledging that we can't fix that right here, right now. If you were the Health minister, you have talked about education here, so that's over there, another minister is responsible for that. Where would you start to have the biggest impact on the removing of any gender bias, whether it's towards or against women or towards or against men?

Mr ROBERTS - I was almost going to say, 'Thank you, that's a great question' but I didn't want to be patronising.

Ms O'BYRNE - Sorry, I didn't mean you were patronising. I was making a point that we talked a lot about inclusive care today and validation is a big part of that, so you were doing best practice.

Mr ROBERTS - I was worried that you were going to ask me that. That is such a great question. Particularly if we think of Tasmania, I would try to advocate for an increase in accessibility with telemedicine and with nurse practitioners. That's where I would start for that. Having them more accessible, given the scope of practice that nurse practitioners have. And not just phone lines. We know that people Google everything first and are presumed experts in their own care. But particularly men respond better to telemedicine and being able to look someone in the eye and read the non-verbal cues, rather than pick up a phone and dial someone. If we had these sorts of options, that is something I would advocate for.

CHAIR - On that, I have often heard it said, and I'm happy to be corrected on this, that men often find it easier to talk shoulder to shoulder rather than face to face. It's a bit like kids - they'll tell you stuff in the car when you can't directly eyeball them. In terms of that, do you think that telehealth itself could be a barrier? You have a screen, your face is there, their face is here.

Mr ROBERTS - I appreciate what you are saying and I agree. I have heard that term. I haven't used that term because I don't particularly like it but there is some truth there. Men are more comfortable being superficial and their therapy is going to the pub and talking trash and watching sport and whatever they're into. Massive generalisation, sorry. Whereas women are more likely to express and acknowledge their emotions with each other and connect on a deeper level, I think. So there is that face-to-face, shoulder-to-shoulder.

With the telemedicine perspective, I feel that there isn't that barrier, potentially, that there may be more comfort in disclosing. I am not an expert in telemedicine so just off the cuff, that is one of my suggestions that people may be able to access or consider. People Google all these things and there are a lot of great resources that come up -

Ms O'BYRNE - There's also some scary resources.

Mr ROBERTS - Yes, and there are a lot of misdiagnoses and a lot of labelling. But, if you were to speak to someone, if that option was there to speak to someone or book in an

appointment to chat to someone face to face, because you can't get into your GP for six months and you have got to pay $100, which you cannot afford, but next week you have got a nurse practitioner or a counsellor or someone with mental health experience or background, if that is the theme - I am going down the mental health pathway, but it is a generalised theme and I think it probably reflects the accessibility in general to primary health services.

Ms O'BYRNE - In terms of the telehealth experience though, sometimes you get the personal engagement that you want but with a barrier that allows you to feel a little safer. Is that something you think is more what men would be looking for? Telehealth works better than sitting directly speaking to someone because that may be a bit more confronting if that's not your lived experience and how you share your concerns.

Mr ROBERTS - I think men would be more likely to be more vulnerable, which is essentially what we are needing.

When I went to my GP *x* number of months ago for a mental healthcare plan, he did not look at me the whole time because he had to write his notes on what I was saying to write the referral, to say 'thank you very much, there is your five minutes; I have got 10 people in the waiting room'. I was like, 'I am advocating for myself, this is my request of things that I want you to do for me. Here is the list, tick it off, thank you for my plan and my referral.' But there was no face to face, there was no turning the body, there was no 'How are you going?', there was no connection. I didn't need that in that moment because I said, 'This is what I need'. Then I asked him for something else and he said, 'Oh no, you will need a double appointment for that', and I said, 'I booked a double appointment'. So I was organised and I still had to -

CHAIR - The old stereotype, they finally turn up at the doctor's, they are in the surgery and they have made a single appointment because that is what they thought was necessary and adequate, and what people do. Then they want to raise the second issue, which is the real issue they are there for -

Mr ROBERTS - And you would have heard, I am sure, shared over the previous screenings, that people are weighing you up. They are assessing: how vulnerable can I be with this person, how engaged are they with me, how much can I trust them to make myself vulnerable? So, I come in with a dicky shoulder and I muck around for 5-10 minutes and we talk about the footy and whatever else. And then they say, 'See you later', and that is when I am comfortable with you now to say, hey I'm having a tough time. And GPs are like, 'Sorry, I have to reschedule you in for 30 minutes next week because I can't see you now. Are you safe to go home? Okay, we will follow up next week.' Or the two weeks, or whatever you can, because that is the reality of it. That is what happens. Unless they sit down and give them that time, and then they push their day out and they are doing 10- to 12-hour days and things.

That was probably not surprising, but also a bit concerning for me with these poor GPs getting absolutely slammed that their model of care is to type notes as you talk to them, if you go and see your practitioner, because they do not have time to sit with you and go, 'Yeah, that sounds rough, or tell me more about that'. They are like, 'Okay, I will write for this' -

Ms O'BYRNE - And then when you find one that does do the whole 'sit back, let's talk about it', they are so hard to get into because every appointment is 40 minutes.

Mr ROBERTS - Yes, and I am yet to find one that I can get into that will give me that time. These are systemic issues and they are not gender-specific issues, but they do highlight -

Ms O'BYRNE - They play out differently for genders.

Mr ROBERTS - Yes, that's right. We know men are reluctant to make themselves vulnerable or articulate where they are at with all of these things. There are a lot of online screening tools that people can use and they will often present having done these and say, 'Hey, these tests are telling me that I have got this or I am at high risk of that'.

Ms O'BYRNE - The online screening tools, employers use them to screen prospective employees, so there is a comfort in using them. But you don't see them more readily available. Would you see them anywhere else in your work practice, could you see those screenings?

Mr ROBERTS - I am thinking more mental health screening tools.

Ms O'BYRNE - Yes, they use them when you go to apply for a job, they often do those now.

Mr ROBERTS - The scope of practice of a registered nurse or a health professional is that you are treating people holistically, in theory, and screening for that, but I note the 'in theory'.

CHAIR - We are out of time, but if there is something you think of when you get home you wished you had said, or if you find something else that is really relevant, you are welcome to send it through to the committee. We welcome any further comments you have to make, if there is anything you feel like 'I really wish I'd said that and I haven't', feel free.

Mr ROBERTS - There's two final points I would touch on, please. Domestic violence towards men is underscreened, undersupported and underresourced. I think that is a larger cultural thing, but there are a lot of men I see in emergency, that I see in in-patient mental health units who have been assaulted and abused domestically who don't articulate that, or they are embarrassed or guilty or reluctant to do so. I think they are an isolated group and that they need additional support.

CHAIR - Through the health system or broadly?

Mr ROBERTS - Both, but I think it needs to start in the healthcare system. But I think it needs a start in the healthcare system. We need to be acknowledging and advocating for these people and supporting them, and that will flow out into broader society. I think it's one in six women and one in 16 men; and one in five women sexually assaulted or abused at some stage of their life and one in 20 men.

CHAIR - It's not insignificant.

Mr ROBERTS - No. I don't think most people would acknowledge or be aware that one in 20 men have had that.

Ms O'BYRNE - There's some new data on children as well, the ratio of male to female children.

Mr ROBERTS - I have never shared with anyone that I was in a previous relationship where I was assaulted by my partner. That's not something I ever sought help for or have ever shared with anyone because we don't live in a culture or society where blokes can say 'Hey, this happened, what do I do about it?' That's unfortunate. Given my experience and expertise in the areas that I work in, and I still have done nothing with that.

My final point comes back to health literacy, which I think is the key here. It's surprising to me that 57 per cent of Tasmanians view their health as excellent or very good and 75 per cent of men are overweight or obese, and 50 per cent have one or more chronic conditions. So, there's this complete gap, this complete lack of awareness of what being healthy actually is. I think that flows on to mental health on a broader scale. They associate, 'I might be physically healthy and physically fit and well, I go to the gym, I exercise', whatever else, but can be suffering a mental illness and not associate that with their health. With all the stats that we see for men, particularly around mental health, they are completely underrepresented, in my opinion. I have an additional submission I might share with you.

CHAIR - You can either leave that with us or email that, whichever is easiest.

Mr ROBERTS - This is from the Australian Men's Health Forum rating scale from 2019. I'm not sure if you've come across that yet in this committee.

Ms O'BYRNE - We had the Men's Health Forum speak.

Dr WOODRUFF - They didn't give that scale.

Ms O'BYRNE - No, they referred us to some of the data.

CHAIR - Men's Resources Tasmania came and spoke to us about their work.

Mr ROBERTS - They're a separate body but they would resource -

Ms O'BYRNE - They draw their research down from -

Mr ROBERTS - Yes, they work closely together. This essentially rates Tasmania as seven out of eight for men's health in a broad range of categories. I find that disappointing.

Dr WOODRUFF - Good or bad?

Mr ROBERTS - Seven out of eight bad. ACT, Victoria, New South Wales, SA, WA, Queensland, Tasmania, Northern Territory. It's listed from all these categories. I can leave that with you.

Dr WOODRUFF - Who is that body?

Mr ROBERTS - The Australian Men's Health Forum.

Dr WOODRUFF - Who are they?

Mr ROBERTS - They're the overarching governing body for the country advocating for men's health resources.

Dr WOODRUFF - Not the Australian Men's Foundation, which is what MRT were talking about?

Mr ROBERTS - Knowing Men's Resources Tasmania, they do use a lot of resources from Men's Health Forum. I haven't heard of this other body you mentioned. There is also Healthy Male previously and [indistinct 4.23.18], which I've quoted quite a bit in my submission. I'll leave that with you to finish that.

CHAIR - Thanks very much.

Mr ROBERTS - Thank you, everyone, for the opportunity.

THE WITNESS WITHDREW.

The committee adjourned at 4.24 p.m.