IN CAMERA

THE JOINT SESSIONAL COMMITTEE ON GENDER AND EQUALITY, PUBLIC HEARING SCHEDULE, MET ON WEDNESDAY, 14 JUNE 2023, PARLIAMENT HOUSE, COMMITEE ROOM 1, TO TALK ON TASMANIAN EXPERIENCES OF GENDERED BIAS IN HEALTH CARE.

The committee met at 9 a.m.

CHAIR (Ms Forrest) - Thank you, Sarah, for appearing before the committee. We've received your confidential submission and I understand you want all of this evidence to be taken today in camera. I'm sure you understand this, but that means that none of it can be used directly in our report at all. It can inform our reporting. I might make a request at the end that if you would be willing to consider any of it being used as publicly available information after you have had access to the *Hansard*, that might be helpful. We will see how we go.

Ms BOLT - If we're having a general conversation then I'd probably be quite happy for a lot of it to be public.

CHAIR - We can provide you with the transcript later once it's available for you to identify what areas you should be happy with. Otherwise it just means we can't use any of it.

It's a confidential hearing, it won't be broadcast. It will be transcribed but form a separate part of our record and will not be made publicly available unless you give permission to do so at a later time. Everything you say is covered by parliamentary privilege, which may not extend beyond this room. I think you are aware of all the other matters related to committee hearings. Did you have any questions before we start?

Ms SARAH BOLT, ANTI-DISCRIMINATION COMMISSIONER, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED.

IN CAMERA

Ms BOLT - I'm Sarah Bolt, the Tasmanian Anti-Discrimination Commissioner. The submission speaks for itself largely. There may be questions you'd like to ask that would give a broader context to the issues that are raised in it. Most of what we've seen and heard is anecdotal. The reasons for that are probably an element of concern itself. That's why people are fearful of providing complaints through complaint mechanisms.

The reasons for that are fairly clear for lots of people, particularly the issues that are faced by a lot of women within the healthcare sector. I think a lot of the issues faced by women are more sexualised and intimate in why they may be seeking medical intervention, such as pregnancy, domestic violence, obesity, abortion; sex workers are predominantly women, victims of rape are more likely to be women. Women are generally more sexually vulnerable. Cultural procedures, and this is in Tasmania, such as female genital mutilation and cultural issues around menstruation are issues of guilt and shame and embarrassment, and then subject to potentially derogatory comments within the healthcare system when seeking health care.

Yesterday I was up at [redacted], but it's across the board, and it was very clear that when you make your appointment they prefer that children do not come. That

creates a huge barrier for women who are trying to get medical care or attention if they can't take their children with them. Often they'll put the appointment off.

Certain places have childcare facilities available. There are places where children can be, like a play corner or something like that to keep them occupied and supervised while the parent sees the doctor or the healthcare provider.

The reason this is confidential is that Tasmania is a small place and a lot of the examples provided would be easily identifiable with people, particularly within the transgender community. That was the confidential element of the submission. Having considered what we've just talked about before, a lot of it in relation to why there are biases, I think it would be prudent that that is on the public record so that can be amended in due course.

Before I go on with a monologue, there might be some issues in the submission that you might like to expand on or discuss further?

CHAIR - I might start on that. You talk mostly of anecdotal issues regarding making complaints. From my experience, with most constituents I assist with this sort of thing, I direct them first back to their health provider, which is what you're supposed to do. That can be another form of trauma. If there's no resolution there, then to the Health Complaints Commissioner. I don't usually think of the Anti-Discrimination Commissioner as an appropriate mechanism. Can you talk us through the number of complaints you get that relate to these gendered healthcare matters? How do people end up coming to you and what path have they trod on the way?

Ms BOLT - Underreporting of complaints is always a real concern. I think it's sometimes because people are referred in a direction that's going to cause them more grief than was intended. There is a clear misunderstanding by members of the community and also advocacy groups as to the pathway through the anti-discrimination legislation. Gender is clearly an attribute, as is age. Older women are more vulnerable.

[redacted]

Older people are also vulnerable to gender biases in the health care system. The Anti-Discrimination Act is probably, in many instances, a better mechanism than even the Health Complaints Commission, because the nature of the legislation is beneficial and it is restorative. It's geared to the healing of a relationship and an understanding of the parties as to how that relationship may have become fractured. That's particularly important when you're looking at regional areas. As you mentioned before, places like Flinders Island or King Island are small and the access to providers is limited.

It is also a confidential process. Another reason why people are often hesitant to make complaints is because there's a fear it will become public and they'll become known within a community to have complained.

There's also the David and Goliath aspect of it, 'It's just me and will I be believed'. The Anti-Discrimination Act is relevant to the attributes and the provision of services of the health provider.

One of the impediments to smooth complaint handling is that a lot of the facilities are under the Tasmanian Health Service, which is a government body. It is not an exemplar when it comes to being the model litigant. Instead of looking at a conciliatory process in the first instance, it tends to be combative and drawn out, rather than just coming to the table. Because the Anti-Discrimination Commissioner doesn't have the power, in any event, to make a determination on questions of fact or law, what you're dealing with is a possible breach - and when it goes further, it then goes to the tribunal, where those matters and the veracity and credibility of evidence and those things are tested.

To answer your question, I think people have a general misunderstanding of the Anti-Discrimination Act. It is restorative in its purpose, and it is a confidential process. Also, a complainant can withdraw from that complaint process at any time - so long as it's not obviously out of duress. So, you are not locked into a legal system. Often, people think once you're in it, you can't get out very easily, if that makes sense.

CHAIR - I know it is difficult for people to make complaints, particularly when they know they are very likely, or almost certainly, going to have to re-engage with that particular health service again - particularly when you are in a smaller community and you have no options but to engage with that.

In some circumstances it's not clear that it was gendered, for example, an adverse outcome has occurred that notionally shouldn't have happened, which is a judgment call - unless they are able to demonstrate in some way there was a gendered aspect to that. Pain management is a classic example. We've had evidence and heard that women's pain is often undertreated and underinvestigated. Then I had a gentleman whose wife came to me a while back saying her husband's pain was completely ignored. So, making the claim that someone's pain wasn't adequately treated on the basis of their gender wasn't something they would necessarily think of. Also, would that be difficult to establish?

Ms BOLT - If it was just a general pain, it would be. But if it was a pain that was associated with a condition that was for women more than men, then you would probably get the link in that sense.

The other issue is that when a complaint comes in, it is assessed. If it was pretty clear that the pain was just pain management generally that would apply to anybody, and the complaint was rejected, then that service provider would never be made aware of the fact that a complaint had been made in the first instance.

Ms O'BYRNE - On the issue around identifying particularly women's pains - endometriosis, for instance, takes an average seven years, depending on how good your practitioner is at diagnosis. If you believed you were being treated in a gendered way and you didn't have a diagnosis, how does that work? The queues for a laparoscopy are ridiculous.

Ms BOLT - I think it would still be something that was linked to what typically and primarily relates to women, and those sorts of pains are symptomatic and they follow a pattern

and all sorts of things. So, when you're actually assessing that complaint, I think it would be fair to say that it does give rise to a possible breach of the legislation.

A beneficial thing, though, even of a complaint throughout this process, is that the outcome is one where you may have an apology, but particularly in issues when it is around gender and sensitive matters, the outcome of that matter might be training, such as trauma-informed training, for example. Then, trauma-informed practices are introduced within the organisation, or there may be training with Working It Out or other organisations that can give specific knowledge to the practitioners, who often simply in their everyday life don't meet or interact with people who may have characteristics that are different to their own, which then gives rise sometimes to complete unconscious bias in commentary and also treatment.

Mr WILLIE - I am interested in how your act interacts with professional standards and registration of medical professionals, whether you have reporting lines to those bodies?

Mr WILLIE - So, quite possibly a medical professional could have multiple complaints and processes through your act and the Professionals Standards Board, whichever applies, would never know?

Ms BOLT - I think you would know in the course of the investigation that a matter has already been dealt with. If there is an agency, or a mechanism that is more adequately suited to dealing with that matter, then we would not proceed with the complaint. It would usually, and often it does, come out in the course of getting a response or further information from the complainant in an employment matter, for example, that it's also being dealt with in Fair Work. Therefore, the matter would usually be withdrawn because it would be inappropriate to look at a situation where somebody could arguably get two bites of the cherry in their complaint.

Mr WILLIE - The other thing that happened yesterday was, we heard from doctors and user groups that it seems quite often that a medical professional might refuse care on religious grounds or whatever else, and then they're not referring them to another medical professional. Do you have any understanding of how widespread that is?

Ms BOLT - Not really. We've had matters in relation to hospitals, particularly those that have a religious ethos, but there doesn't appear to be a referral mechanism to someone who will. Or if a particular doctor has got some conscientious objections to treating somebody because of their religious views, there doesn't seem to be that I'm aware of, but what we can do is, I will refer you to someone else.

CHAIR - That's legally required under the -

Mr WILLIE - Or any accountability around that, by the sounds of it.

Ms BOLT - No. There are exemptions under the legislation in relation to religious belief, but it is a problem and it has been identified as a problem with certain hospitals in Hobart, particularly around transgender matters, birth control and abortion, for example.

Mr WILLIE - Are there jurisdictions that do that referral halfway better and with better accountability?

Ms BOLT - I can't answer that as to whether there are on the mainland. There's probably pockets that are exemplars and pockets that are just woeful.

CHAIR - Can I go back to Josh's question briefly on interaction with AHPRA? While we're dealing with health professionals here - if they're not registered they shouldn't be practising but let's assume they are registered - you, as an individual, could make a reference to AHPRA. You could also encourage the aggrieved party to do that. [redacted]

Ms BOLT - [redacted]. But sometimes you can have two disciplinary actions going concurrently simply because the outcome would be significantly different, potentially. Some mechanisms can only deal with a disciplinary outcome that is *x*, whereas within the anti-discrimination train you might then get things like training and policies, amended policies or more contemporary policies. There are circumstances where they will travel down the same path. But the point is, you wouldn't be going down the same path if you were going to get two lots of compensation, for example.

Ms O'BYRNE - Do you keep data on the percentage of gendered complaints around gendered reactions or responses in health care?

Ms BOLT - No. Some of the examples, and there's so few of them, really, that it would be quite easy to point to how many complaints were gendered. But I think, as referred to in the submission, more of our complaints don't come from the user but come from people within the health system, so staff matters and employment matters.

Ms O'BYRNE - How often would your complaints lead to an investment or an obligation for training to be part of the resolution? From all the evidence that we've heard, the best thing to do is to provide training.

Ms BOLT - In relation to complaints against employers, I would say that training would be at least 80 per cent of one the elements of a resolution. That may be a one-on-one training with the person who has breached the act, or the organisation itself will undertake a training program.

Ms O'BYRNE - My last question is one we touched on a couple of times from yesterday's hearings; where the burden of proof lies. You say the process is around getting a result, getting an agreement, getting a restorative justice pathway. The Canadian legislation, the Equality Act, has an obligation for employers or workplaces to prove that they have done the right thing. How different is that? Would those kinds of elements make a difference to the way that you would approach things, or is it quite a different framework?

Ms BOLT - Yes, it would be a different framework. But there are still the vicarious provisions under section 104 that link into an employer - that they have done everything to make sure it is a safe workplace and also that their staff understand their obligations in relation to how they provide a service.

Ms O'BYRNE - Other than a complaint, how is that enforced?

Ms BOLT - The vicarious provisions?

Ms O'BYRNE - Yes.

Ms BOLT - It is not. It is just something that you would hope that every organisation would mitigate their risks by having adequate training policies and procedures.

Ms O'BYRNE - Which clearly is not the case if we look at some of the significant evidence we have received already.

Ms BOLT - That's right, and -

CHAIR - Maybe the training is not effective. There are two aspects here: either they are not delivering it or it's not effective.

Ms BOLT - I think the issue around unconscious bias, a lot of people just behave in a way that stems from historical attitudinal beliefs, an air of self-entitlement, a feeling of being untouchable. It is no different than some of the outcomes in the Motion for Respect report, which is transferrable around any area. That is where, within the medical profession itself, just like the legal profession, there is a culture of open secrets where people always know who the protagonist is and everybody just carries on, 'That's just the way they are'.

CHAIR - Until someone stops it.

Ms BOLT - Yes, until someone just - it is interesting how few people realise that gender-based discrimination and some biases are illegal. That is the same thing that we have talked about. Dyson Heydon was a classic example where you get an eminent judge who delivers the law and delivers outcomes and penalties every day, yet does not understand that his behaviour is unlawful. That is where you get a lot of wake-up calls when people from professions that are held in such high regard come to a conciliation and then you will see the lights go on often, because it is a realisation that 'what I have done is not just awful, it is unlawful'. Then we need to set about making sure that will not happen again. But it takes a brave person to bring a complaint when you have the system seemingly being so moneyed around it and -

Ms O'BYRNE - What is the phrase? 'You don't sue the profession.' We all grew up knowing that is the issue with complaints about doctors, that you do not sue the profession.

Ms BOLT - But if complaints mechanisms were made more known, even in a clinic, for example, if you go to the doctor's clinic and it had something that was there like: 'If you have a complaint about any aspect of this service, contact this number' - and it might be our number or it could be the number of the Health Complaints Commission - if a clinic itself emboldened

people to be able to speak up about the fact that 'how I've been treated has left me feeling concerned or worried', that in itself might be a reminder to people who work within that organisation.

Ms O'BYRNE - It may be too early to tell, but I've noticed that public hospitals now have an awful lot of information about patients' rights, charters and who you might complain to. There's been a concerted effort to put pamphlets and fliers and notices everywhere.

Have you seen that there's been an impact from that? Is there a lessening of complaints, or is it too early to tell? Is that something you would even measure?

Ms BOLT - It's too early to tell. A lot of the anecdotal information that we hear might come from the Migrant Resource Centre, Women's Health, Working it Out or members of the LGBTQI+ community who are happy to talk about this. Even those agencies are often reluctant to refer a matter.

CHAIR - You talked earlier about the matters women might seek health care around that are sensitive, loaded with shame, all those things. They're very unlikely to see the QR code on the wall and 'Make a complaint here' sign. You don't want to see people and you don't want people to see you, so you try to be as invisible as you can as a health consumer accessing services in that way, particularly if it's in a public place.

Are there better mechanisms for making the complaints process more visible? A lot of people won't see it there. If they do, they won't remember it. Not many people are going take out their phone and take a photo of it straightaway.

I'm thinking about making it public in other places. Have you seen that done anywhere? Is there anywhere that it is done well?

Ms BOLT - I haven't seen it done anywhere or heard of it done anywhere. Notices related to 'discrimination is unlawful' may be better suited within staff rooms. It's a warning to people who work within the area as opposed to the participants who are seeking the service. That might be something that someone looks at, that there are consequences for these behaviours.

CHAIR - Do you think some of that behaviour needs to be described? [redacted]

Does that sort of thing in tearooms need to make it clear what we are talking about?

Ms BOLT - One would hope it wouldn't have to be too clear. However, 30 years later we're still having to spell out what ageism is, sexism is, racism is and sexual harassment is and to break down years of stereotypical thinking around matters.

There's a Teflon attitude by a lot of people who have power and influence, [redacted]

Ms O'BYRNE - I used to run a labour market program for unemployed people when they were going back into training programs. We would run a day simply on the way you are

allowed to behave in a workplace. We had to frame that language around not judging you for having these views, but these are the things that will get you sacked. It had to be quite descriptive. You had to show examples of things. People were genuinely shocked because of all those years of those being normalised in life.

CHAIR - That's the point I am making. Does it need to be fairly explicit?

Ms BOLT - I don't think it has to be explicit. You might start with training on what empathetic thinking is, so they engage empathy for a moment to think about what it must be like for that person to be in that vulnerable situation.

Here's another example of gendered bias. Obesity is a problem that faces both men and women. In one hospital, not here, with 75 per cent of the births in that hospital, the women require a harness to be able to lift their hips off the bed. I know for a fact that is usually a cause of great derogatory comment. It would be very rare that that would be directed at equally obese men or if the father of the child or children is obese. There tends to be a much more negative slant placed upon obese women who are giving birth to children.

That's just the way thin people might think when they see people who are not so thin. They immediately go into this negative. When someone is giving birth to a child and then comments are made that are not pleasant, like 'drag out something or other because we have another heffalump', I can't recall exactly, they're comments that would probably not be pointed at a male. They are usually spoken by men as opposed to women. That was in that particular hospital.

That's an example of something people might even think is not awful, it's just a throwaway line.

Ms O'BYRNE - This committee will be making recommendations. If you were looking to this committee to recommend things that would substantially make differences, what would you hope to see?

Ms BOLT - Definitely trauma-informed training. Everyone is time-poor, but training needs to be from the top down. Typically departments send staff to get training, but rarely do senior executives attend those training sessions.

Empathetic thinking. I have been around the medical profession for some time, but there is something unique about the absence of empathy in a lot of practitioners. I'm not sure why that is. Some are fantastic, then there are others, typically people would say surgeons, who do the job and then visit the patient after they have done the surgery as if the person were just another sausage in the sausage factory. Regardless of who the patient is, there has been a physical assault on your body, they've usually had some form of emotional trauma, yet they don't get the dialogue or interaction often.

CHAIR - In my experiences in health, we have a lot of people from different cultural backgrounds who choose to become obstetricians and appear to lack empathy entirely. That's a strange profession for people in that setting. You talked about mandatory training for managers in hospitals. Are you aware of how well that is taken up by senior medical people? You can drag a person to training, but if they are not going there with an open mind you run

the risk of them bunkering down thinking, 'That's not me they're talking about, they're talking about that person over there'. Mandating training doesn't always have the effect that you want.

Ms BOLT - Sometimes I'm a bit of a cynic in the sense that the more training you provide, the better skilled people become at being able to discriminate carefully because you know what not to do. Training, if it happens, and if you have people who think they're a bit beyond it - also needs to be creative, so it's an experience that's quite different and probably quite visual, and all of those things, as opposed to being lectured at. That doesn't go down well at all.

Also, within the university part of the medical degree, I think it's important that there is an element within that degree that specifically looks at discrimination, and unpacks what unconscious bias is, and the importance of empathy and all of those things in a profession that is meant to be caring in nature. That doesn't happen within the medicine school of medicine.

CHAIR - It doesn't happen at all? They don't have anything on that?

Ms BOLT - Not really. We've done a couple of sessions with new medical students, but it's been a bit ad hoc, and it's not embedded in that.

CHAIR - It's not a core subject as such.

Ms BOLT - No.

CHAIR - What about nursing and other allied health students?

Ms BOLT - No, we haven't much training in that area. We have done quite a lot of training within the Tasmanian health system, and some of that within nursing. Usually, and increasingly enough, like most things, training tends to happen after there's been a calamity or an incident, then it's 'Oh, we'd better do some training' - whether it's in the induction process or wherever.

It's like everything. Unless you have every strong leadership from a ministerial secretary or head of agency leading the whole thing, it's not really going to go anywhere. The same with the safe complaint mechanisms and pathways for people who work within the system and also users of the system.

What is also always disappointing to me is that rarely do you see accountability or consequences in a transparent way for really poor behaviour. In fact, people tend to get moved, rather than dealt with, simply because, as some people would say, we're not going to sack them because they know where the secrets are hidden, and they're a loose cannon if they're out, so we'll simply move them somewhere else. The old buried secrets are a bit of a prohibiting factor.

CHAIR - Ultimately, surely, we should be looking to try to remove anyone, uncover any buried secrets and deal with them, shine the light on them and then prevent them. I accept the history, I know the history. I've lived in the history.

Mr WILLIE - It's what happens in the school system all the time, too, when the principal or performance manager ends up with a red flag on them, they can't get them out of their schools, so they don't do it.

CHAIR - Commissioner, in your role, where complaints have been made and there is a recommendation for training, do you follow up to make sure that's occurred, or is it just a given that will happen?

Ms BOLT - No, it's usually within a particular time frame, and then we would chase it up. The agreement would go from the investigation conciliation officers, the trainer would be notified, and then you'd chase that up if it hasn't happened within, say, six to 12 months.

CHAIR - So then you would -

Ms BOLT - We would follow up.

CHAIR - Is there any mechanism that you or anybody can use to actually measure the outcomes of that?

Ms BOLT - Not really. I suppose you only see what the recidivism rate is like for that particular industry or agency.

Ms O'BYRNE - Can I ask about the quality of training? One of the things we found - and schools probably have a very limited budget - they'll take it when it's free or cheap, and not necessarily have any understanding of where they might sit in terms of the efficacy of their training program. We've talked before about whether you almost need a lighting system to say, 'This particular training is royal gold, fantastic, we encourage you to do it', right down to 'We have no idea who these people are, it's entirely up to you, stand or fall, these are the risks'.

Would that be a useful thing? Yes, you can get training, but the quality of that training and the appropriateness of that training to the setting would have to have an impact as well.

Ms BOLT - As I think they were saying at Estimates, recruiting trainers is a difficult thing, particularly when they go off to another agency because there's a higher band level and you're a bit limited about matching that - but I definitely think training needs to be changed remarkably in how it is delivered.

I think I've been very clear in our training delivery that you just don't get married to a PowerPoint presentation, or just sit there while someone rote-teaches you what they know.

We are looking at doing a whole lot of improvised-acting scenarios with the Playback Theatre, which would be filmed and can be played out, so people can deconstruct or reconstruct an issue as to where that might be falling within the legislation or how it might impact upon that person, so it makes it quite real, because otherwise I think you just lose people. You'd certainly lose me in front of a PowerPoint.

There are some areas in which I think we wouldn't even have the expertise to give training that was really relevant to that particular anti-discrimination - whereas if there are unique people who have some credibility within that sector, people are going to listen to them.

As far as the fees go, we are pretty cheap. A whole day, for example, would be under $1000 by the time you pay that out, because they usually do a package deal - as opposed to people who are charging $5000 a day. There are a lot of situations where it might just be senior

management, and often I would go and do that and I don't charge - I'm just happy people want to have that conversation. Also, there is a lack of good trainers in Tasmania.

CHAIR - [redacted] do you think there is an important place here for bystander training as well?

Ms BOLT - Absolutely. As we said in the report, bystander intervention is absolutely lacking. The reasons behind the lack of bystander intervention are pretty much that people fear what the reprisals are going to be, who the person is that they just observed doing something, where the power balances lie.

There is also a very real misunderstanding of the protection of victimisation. One of the things we keep on saying is the fact that, if you were to lodge a complaint - or if you were to support somebody in lodging a complaint, or if you were to support somebody even thinking about lodging a complaint - and then life turns out to be a little prickly for you as the bystander, then you also have a right to make a complaint of victimisation under the legislation.

Again, that just shows people are a little bit unclear about the scope of the act.

Mr WILLIE - With complaints, you said people are reluctant when it comes to health care. What sort of percentage are your overall healthcare complaints, as part of the broader complaints that you receive?

Ms BOLT - It would be very low. The biggest area of complaints for us is in the areas of disability and employment, as opposed to the health sector. I think that is also heightened by the points Ruth and Michelle made earlier, that it is hard enough to get to see a doctor or to actually get access to health providers.

Ms O'BYRNE - And then if you complain, you are not going to get your treatment.

Ms BOLT - Or suddenly you are the one that has turned into the problem, and you are sort of banned from coming to that clinic because you are exhibiting behavioural difficulties and so on. That does happen where people say, 'I can't get to see the doctor', and when we make inquiries about that, we hear they are very difficult or they have been abusive - whereas that person has only been frustrated or wanting to get a message across, and then they have nowhere to go.

Ms O'BYRNE - Their files are always marked. The next time they turn up, their treatment is different because their files are marked as being aggressive or emotional or having psychological issues. There is a bit of evidence of that, too.

I well remember an AHPRA investigation that the people on whom the complaint was made copped a fair bit in their local community.

Ms BOLT - Absolutely.

Mr WILLIE - Something that was suggested yesterday was when we were talking to different groups about inclusive practices for LGBTIQ+ community members and it seems like that is pretty informal at the moment, it is kind of word of mouth. There was a doctor we spoke

to who created a list and was sharing that in Facebook forums and stuff. But would you support the Health department publishing a list of inclusive practice?

Ms BOLT - Yes, I think that anything that encourages inclusivity is a positive thing. You have to remember, too, the whole transgender, gender identity issue is, relatively speaking, so new. It took people over 200 years to get over the idea of having same-sex marriage and then in seven years - that's really what it has been. If you look at Tasmania, it has been -

CHAIR - In 1997 we decriminalised -

Ms BOLT - To show how quickly it has changed, I remember when I was at a meeting when I came back, for the first time, in 2017. Someone suddenly said, 'Can everyone go around the table and introduce themselves with their pronouns'. Nearly everyone's face went ashen, like, 'What do you mean?' because that was absolutely new. So you got that non-binary aspect of sexuality that came in, that was all very new, from 2017 onwards. But the whole transgender birth certificate, debating everything, is relatively new. For a lot of people, they genuinely struggle with accepting it and then you have people who are on that pathway, who are navigating a process which is fraught with unconscious bias, usually, and also curiosity or whatever it happens to be, as opposed to just dealing with that person with a genuine issue of concern that they need to help navigate the way through.

CHAIR - We did raise this with Equality Tasmania, we talked about that. We've had legal same-sex relationships now for not as long as we could have, but a fairly lengthy period of time in the big scheme of things, compared to the gender law reforms. I asked them if they thought there was less discrimination, less barriers to lesbian or gay people, as opposed to transgender or non-binary or intersex people, who are really only becoming recognised as an important group of members of our community. Is that just a time thing that people don't see it as a threat to them? Some people see it as a direct threat to them, people I have talked to say it is a direct threat to them. I'm not sure how, but -

Ms O'BYRNE - We are still dealing with gendered healthcare responses on the basis of being a woman, let alone all of the other -

CHAIR - That's right. If we have taken so long to get anywhere near some response for women - notionally, we have come some way, I'd like to think we have. We have but there's still a long way to go. For gay and lesbian people, a little way. And a minute way for trans and other people who have different challenges.

Ms BOLT - A positive thing, though, is that people who go through gender identity or transgender are such a small proportion of the society but are getting a lot of airplay and a lot of media coverage. I think that's a good thing. It's not as if there is such a tiny group of people so we are just going to keep it in the corner. It has been pushed out onto the open stage and that is a very positive way of educating people and demystifying it, and also allowing people to have their lived experiences told. And then, 'Oh, gee whiz, you're just an ordinary human being', as opposed to something that remains a bit ooh, ooh.

CHAIR - What do you say is key, then, to hopefully not taking as long to deal with the gender bias in health care for people who are non-binary, who are transgender? Surely, we don't have to go back and do it all again to make a difference here. What do you think are the key aspects of that?

Ms BOLT - It comes back, I guess, to education, positive media coverage and really good advocacy by organisations. And I think the key organisations have to be very conciliatory in their approach, as opposed to being viewed by some as being combative and hostile. That, in my observations, turns people away, as opposed to a kind and respectful way of understanding the whole issue, particularly around transgender.

Similarly, the education system is such a complex area where you are having a whole system where suddenly someone turns up and they're there as Sam and now they want to be Stephanie and all of that, and how the schools are managing all of that.

Mr WILLIE - Some do it well, and some do it not so well.

Ms BOLT - That's right. And then you throw some religious elements into it and it throws it all into chaos, or you get people who have got their own religious views or the absolute refusal to use the pronouns the person wants, and so on. Again, that takes good leadership within the organisation to make it happen.

Ms O'BYRNE - And in schools you can tell. It's led by the principals all the time, those reforms. You talked about endometriosis before, which is one of the examples that you get quite a lot, particularly now women are starting to identify. One in nine Australian women have endo, seven years to get a diagnosis on average. And the wait times for any kind of action are very long because of the cost of them. That's exponentially larger if you're a woman of colour and exponentially larger again if you're a woman of colour with a disability.

Where do you start unpicking all of those different factors to make sure that we're getting the best pathway, from your experience? Women are rejected when they go to the hospital with pelvic pain because it's a woman's issue. If they're then of colour, they're often dismissed again, and if they have a disability, they're dismissed again. Where would you address those ones? Or is it just back to training, back to training, back to training, until they're informed?

Ms BOLT - Yes. Each of the examples is unlawful discrimination based on either someone's race or disability within a service-providing setting and, again, people need to realise that they are engaging in unlawful activity. But I don't know how you deal with it.

CHAIR - One of the challenges would be empowering those particular individuals to make a complaint in the first place, or to raise it. You talked about advocacy. Advocacy can be about educating the public but can also be about supporting the individual. Do you think there's enough advocacy that supports individuals?

Ms BOLT - I think there's not enough advocacy groups that even know about the legislation to better support their group.

Ms O'BYRNE - Isn't that the difficulty, too: we have this issue with women's pay, we say women to need to speak up about getting paid. The burden of having to solve things always falls on the person on whom the greatest pressure is placed and the greatest lack of power is placed. If our focus is always on informing them and telling them that they should speak up and they should advocate and they should call things out, we are just continuing to put more pressure on people as being somehow almost responsible for their circumstances because they haven't spoken up. Where does our focus lie, I guess that balance between our focus in people

knowing what their rights are, but also back to your original point about organisations and senior people in organisations actually following the law, understanding their obligations and delivering on those? If you were looking at a circumstance, where would you place most of that responsibility?

Ms BOLT - Again, it comes from a leadership position. It would be very helpful if people saw complaints as a good thing and a positive thing. Nobody likes to have a complaint made against them, particularly if complaints are made in bad faith - and there are people who are just recidivist complainers, so you've got all that. But genuine complaints, if you look at history, it's only been because of complaints that changes have been made. It goes right back through the time of women complaining about their rights and the right to vote or not to vote and the right to be able to continue to work. If the disability sector hadn't been a loud voice in complaining, you'd still have people sitting in a wheelchair waiting to be able to cross the road because they cannot get their wheelchair down. If Aboriginal people hadn't complained, we'd still be sitting back where we were 50 years ago.

If organisations encourage people to complain, or have complaint boxes, or whatever it happens to be, often a complaint will highlight the fact that the organisation's policies and processes are not contemporary and there is a real lack of understanding of certain issues that would make everybody's life a lot happier if they were followed. People view complaints as a negative. I see complaints as a positive and necessary mechanism to bring about positive change.

Ms O'BYRNE - Maybe that is the pivoting language around the process. The Aboriginal community is really tired of explaining racism, what it does and how that makes them feel. It's always their job to do it. They don't want it to always be their job to do it, because there is a fatigue that comes from advocating and explaining.

CHAIR - And despair.

Ms O'BYRNE - And re-traumatising.

Ms BOLT - We put that out all the time, that if you get a complaint you don't have to shudder. It's a matter of restoring the balance, allowing people to move on and learn from a situation and to change for the better. That's something that maybe in every area, people could look at how this industry has improved. A classic example was Mitsubishi. The people working in the car industry who complained were nearly all Asian people because all the desks and all the conveyor belts and everything were all built to an Australian standard.

Ms O'BYRNE - I am with them there.

Ms BOLT - But it was as a consequence of that that adjustable workbenches and everything changed. If they had not complained, a lot of people would still not be employed. You'd need to be six feet tall to be an air steward or in the police force. There is a plethora of examples which we just take for granted now that are only as they are because people complained.

CHAIR - Media coverage around complaints needs to be framed that way - this is the way to make change.

Ms BOLT - In a positive way. Complaints about someone who has done something really heinous is different to someone complaining about a process that has caused them a disadvantage. That's where most of it tends to stem from.

CHAIR - Thank you very much, Sarah. We'll send you through a copy of the *Hansard* when it's available and if you could identify any parts of it and your submission that you're happy to have made public. We recognise there are some parts in there you certainly won't want to. It would be helpful for the committee to use the information you've provided to form parts of our report and recommendations.

Ms BOLT - Absolutely. Upon reflection, given the nature of this conversation, most of this would be available, except for the examples.

CHAIR - Yes, if you want to go back and have a look at that and come back to Fiona through that process, that would be really helpful.

Ms BOLT - Thank you for your time, everybody.

THE WITNESS WITHDREW.

The committee suspended from 9.59 a.m. to 10.02 a.m.