PUBLIC

THE PARLIAMENTARY JOINT SESSIONAL COMMITTEE ON GENDER AND EQUALITY MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON THURSDAY, 12 OCTOBER 2023.

TASMANIAN EXPERIENCES OF GENDERED BIAS IN HEALTH CARE

Hon. GUY BARNETT MP, MINISTER FOR HEALTH, **Mr DALE WEBSTER**, DEPUTY SECRETARY, HOSPITALS AND PRIMARY CARE, **Mr GEORGE CLARKE**, DEPUTY SECRETARY, COMMUNITY, MENTAL HEALTH AND WELLBEING, AND **Ms SALLY BADCOCK**, ACTING DEPUTY SECRETARY, POLICY, PURCHASING, PERFORMANCE AND REFORM, DEPARTMENT OF HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Welcome, Minister, to the public hearing on our inquiry into the gendered bias in health care. We appreciate that you have not been the Minister for Health for all that long and that this submission was done prior to your taking on that ministry; but, hopefully, your team will be able to assist where you may not have that detail. I will ask you to introduce members at the table.

Mr BARNETT - Thanks very much, Chair, and thank you for the opportunity. It is a pleasure to be here. I acknowledge Premier Jeremy Rockliff, the former minister for health, and also the Minister for Mental Health and Wellbeing. On my right is the Deputy Secretary, Dale Webster, and Sally Badcock and George Clarke are on my left and right respectively. Perhaps they could introduce themselves and we will go from there.

Mr WEBSTER - I am the Deputy Secretary, Hospitals and Primary Care in the Department of Health, at the moment.

Mr CLARKE - I am the Deputy Secretary Community, Mental Health and Wellbeing.

Ms BADCOCK - I am the acting Deputy Secretary for Policy, Purchasing, Performance and Reform.

CHAIR - Thanks. Minister, if you would like to make some opening comments and then I am sure the committee will have questions for you on the matters you raise.

Mr BARNETT - Thank you very much, Madam Chair. As the still new-ish Minister for Health, it is a great honour and pleasure to be here and I acknowledge the former minister and Premier and Minister for Mental Health and Wellbeing, Jeremy Rockcliff. I would begin by saying that the Government is committed to providing all Tasmanians the right health care in the right place at the right time, and we realise the issue of gender inequality and gender bias in health care is a complex issue. We also know this is a national issue. It is not one that is unique to Tasmania, and the underlying causes of this issue will require collective action within communities and across all levels of government. I want to state from the outset that a person's gender should not influence access to health care.

Health services should be available to all Tasmanians, no matter who they are and where they are from, their religion, race or gender. As a Government, we are committed to

understanding, identifying and addressing the causes and effects of both unconscious and explicit gender bias in the Tasmanian health system. As I mentioned before, this is a national issue but as part of our commitment to delivering equitable and inclusive healthcare services to Tasmanians, we are taking a number of positive steps to address these matters.

The Tasmanian Government's long-term vision for health services over the next 20 years, the Long-Term Plan for Healthcare in Tasmania 2040, includes a focus on ensuring the health system better engages with Tasmanians in decisions regarding their health care. This includes demonstrating respect for their preferences, needs and values to ensure the services provided to all Tasmanians are safe and culturally appropriate. In collaboration with key Tasmanian Government agencies, the Department of Premier and Cabinet developed Tasmania's Health and Wellbeing for Women Action Plan 2020-2023, which is focused on progressing actions to improve women's health and wellbeing.

In December 2022, the Tasmanian Government released its Tasmanian Women's Strategy 2022-2027 which sets out the Government's commitment to achieve gender equality. We are also prioritising a range of targeted measures to meet and support the unique healthcare needs of women. This includes perinatal and infant mental health services, new state-of-the-art facilities for womens' health services at our major hospitals, population and cancer screening programs, including BreastScreen Tasmania and the National Cervical Screening Program, and funding to support Womens' Health Tasmania and Family Planning Tasmania to deliver their services.

In relation to the issue of gender equality, the Tasmanian Government delivered its first Gender Budget Statement as part of the 2022-23 state Budget. Importantly, the Tasmanian Gender Service was established in 2018 to provide multidisciplinary person-centred care. The Department of Health is currently considering the ways that sex and gender information is collected, recorded and managed in its information and communication technology systems. This will aim to identify opportunities to adapt systems and processes to be more inclusive.

The department is also implementing a consistent statewide Gender Accommodation Protocol based on the success of an existing protocol at the Royal Hobart Hospital. This will support patient privacy and involves minimising mixed-gender accommodation in Tasmanian Health Service hospital wards and units.

As a government we know a positive culture is vital to delivering high-quality patient-centred and inclusive health care. In December of last year, the department launched its One Health culture program, to realise the vision to achieve culture change to deliver a health system where everyone feels valued and supported, and which provides positive and patient-centred environments. The program is also about transforming the culture to be more inclusive and respectful to deliver the best possible health care for the Tasmanian community.

We also acknowledge the important efforts of Our Watch, which promotes the embedding of gender equality and preventing violence where Australians live, learn, work and socialise. The department is working to embed gender equality into business-as-usual processes through the development of annual action plans. By implementing cultural improvement iniatives like this, the department is taking action to address any underlying systemic, cultural or individual gender bias within our health system that could present barriers to accessing health services.

Through the important work of Healthy Tasmania, we are also ensuring there is a greater focus on delivering health and community services that are more inclusive and responsive. This includes providing training and support to staff to ensure health services are delivered in ways that are culturally safe and inclusive, for priority population groups including those within the LGBTIQA+ community.

I would like to close by reiterating our Government's commitment to provide high-quality health services that are effective, inclusive and equitable for all Tasmanians. Our vision for the health system here in Tasmania is one that is integrated, collaborative and patient-centred, where all Tasmanians feel safe and respected. We welcome any learnings from this inquiry that will contribute to an increased understanding of areas of health care in Tasmania where gender bias may be more prevalent and what actions can be taken in response. Thank you.

CHAIR - Thank you. I might pick up on one point and other members may also have questions. You spoke in your opening statement and in the submission that was provided about the One Health culture program. That sounds good in principle, but I am interested in how it is actually rolling out. It is all well and good to have strategies or programs, but what is it actually doing, and how is it actually addressing some of the well-described gender biases and things experienced by the people in our health system?

Mr BARNETT - Thanks very much for that. I spoke on that in the remarks and the submission and will pass to my deputy secretary, Dale Webster, to speak to that matter.

Mr WEBSTER - Thank you. The One Health culture program started a couple of years ago now. It started by focusing on our leadership and providing a new type of training, Aspire Training, to our upcoming leaders. In addition to that, it also runs across a number of streams. The minister mentioned we have specific LGBTIQA+ respect training, which we developed with the LGBTIQA+ community, specifically the members who are part of the health reference group. The nature of that training is that it is about the individual people within the community telling us their stories and telling us what respect means; rather than us defining respect from the health side, having our patients tell us what respect means and how we should behave in relation to them. We have done the same with our Aboriginal cultural respect training also. That is very much the members of that community telling us what respect means when they come to our health services and that is really important. As part of that, for instance, if you go to a health facility in Tasmania, you will find there are rainbow flags present, but there are stickers on doors that actually welcome the community, because one of the feedbacks we got was there is nothing that says we welcome the LGBTQIA+ community. It is little things like that which are actually built into the One Health culture program; it is multifaceted. It is also about building capability so we recognise there has been deficiency in training around gender bias, at universities through specialty colleges, generally even through GPs. The idea is we need to build capability and that's why the training has been rolled out with 2500 people now having done that.

In addition to that, it is also about our reference group. It is a really important avenue for us to receive feedback from the community to take back to our clinicians, to say there has been a problem in this particular part of the service and let's work on how we actually respond to that. There is feedback from Equality Tasmania. They do research and have commissioned research which is fed back to our staff to build their capability based on that research. There is that side of it.

Workplace values and behaviour - again, the minister talked about us being patient-centred. That is a very deliberate change in language from a couple of years ago where we were talking about clinician-led and patient-centred. We really want to say that clinicians still need to do some leadership, but let's actually put the focus on patients rather than the phrase 'clinicians'. Those are the sorts of things we are in the process of, adopting values developed at the LGH as part of the work done with them on the commission of inquiry. We will roll those out across. We actually can say we are looking at compassion, accountability, respect and excellence. We deliberately put in the word 'compassion' there because we believe that it is essential as a health service we show compassion to the very many groups that are coming to us.

Health, safety and wellbeing - a lot of our staff are members of the community also and we need to make sure that is built into our staffing profiles. And, of course, a whole lot of systems and processes on complaint management and those sorts of things, which obviously have started and were focused in the recent commission of inquiry, but we need to make sure those are available in all areas where we have complaints.

CHAIR - I hear what the minister was saying about the LGBTIQA+ community; there is a really clear and unequivocal gender bias against women in our health systems, which is a much wider cohort than the LGBTIQA+. How are you are managing that? I am sure you have been through the other submissions. There are two recent ones we got published, hopefully with time for you to read them, but if you could talk about that as well -

Mr WEBSTER - Yes. Sorry, I focused in on one aspect -

CHAIR - That is fine, but it is obviously bigger than just one group.

Mr WEBSTER - Yes, exactly. Indeed, as the minister said, we are very mindful of budget submissions and we will all need to comment on gender and how we are dealing with gender issues within our budget submissions. We have specific services available, such as the Women's' Health Service and those sorts of things we have specifically put in. We are developing women's and children's precincts across our hospitals. We have achieved that in Launceston, it is semi-achieved at the Royal Hobart Hospitals and it is in our forward planning for the North West Regional. We are very mindful of having environments specific for women and welcoming of women within our settings. I know you visited the new antenatal clinic that -

CHAIR - I haven't, no. I wasn't invited to the opening.

Mr WEBSTER - I am sorry about that. The new antenatal clinic that we recently opened at the North West Regional, again, an environment that's about women telling their stories rather than a health service environment and I know the minister's recently been there. The artwork has been developed by women, and artwork developed by Aboriginal women as well, the naming of the facility and the rooms that are in that - all of it very mindful of creating an environment that women feel comfortable in rather than a more sterile hospital environment.

Again, the Women's and Children's Precinct at the LGH has been very mindful that this is an environment that primarily has to be welcoming of women and children.

CHAIR - Following up on that, it's probably easy to identify maternity and pregnancy care as an issue that affects women. It's easy to establish a women's service there that includes

all levels of maternity care. We know from the evidence that there are a number of other areas where women are poorly dealt with. One of them is cardiovascular disease and the fact that research has not included women in a lot of these situations.

We also talk about chronic pain. We could talk about endometriosis in that, which is a specifically and a peculiarly female condition. This is where I want to know what our health culture is going to do to take the blinkers off some of this so that when a woman does present with an atypical cardiac or some sort of infarct or something like that, how do we ensure that we don't overlook it?

Mr WEBSTER - Where it comes in is with that building capability. Your inquiry and submissions, and in fact the first couple of days of hearings, are things we can learn from that because they're the stories that we hear from the women. We then feed that back into our One Health culture saying, 'This is the experience of our patients within our service so what do we need to change?'.

Chronic pain services, which are traditionally - and I'm going to have to say the word which I always stumble over - musculoskeletal, have focused in on that. We've talked to our pain network, you need to broaden out. Chronic pain isn't just that; it needs to go broader than that.

One Health culture is about generally saying, 'We don't have one type of patient, we have so many types of patients'. If we are patient-centred, we need to hear all of their stories so that we can design services that meet. The reminder will come from our budget submissions from this year. We have to look at the gender lens so when we look at demand in the pain area, that will force us to say, 'Well, what are the needs of women in that space? What are the needs of men in that space? What are the needs of LGBTIQA+ in that space?'.

It's the idea of taking the feedback that we get and putting it into our service capability and our service development.

CHAIR - You're hearing from the lived experience of the patients, which is great and important. How do you hear from a woman who has fronted up with a heart attack, then been misdiagnosed because she doesn't have the typical male symptoms? Put that one there and then, as I understand it - and I am happy to be corrected if this has changed - but we don't collect data on miscarriage. How can you understand the women's lived experience of miscarriage when we don't even collect the number? Things like that.

Mr WEBSTER - Again, that is part of going through our datasets and saying what do we gather, what do we not gather, and you've identified miscarriage there. That's going to be hard for us, as a state, to gather but we should be gathering it within our health service when we're aware of it.

CHAIR - It's the most common pregnancy complication.

Mr WEBSTER - Exactly. There are a number of datasets where communities have identified to us that we're missing data, so we are learning from that again. We've got to build that into our dataset. As we go into our electronic medical record of gender over the next period, we have spent a lot of time looking at the level of data. For instance, we have looked at our need to gather both sex and gender data, rather than just gender data, because there is a

need within the health service. We're making sure, going forward, we're gathering the right information in those sorts of categories. Yes, when we identify that the missing data we can't just say that's it's missing, we can't do it. We have to make sure that as we're updating our systems we're actually picking up those missing things.

On the other side, it's really important that we do have a patient safety reporting system that picks up all of those sorts of errors and we go back and do root cause analysis. So, where we've missed that heart attack because of a missed diagnosis, the root cause analysis comes up through the system to say we need to retrain or build capability in the ED relating to the other symptoms that were missed.

CHAIR - Maybe the paramedics too, not that they are making a diagnosis but they may be prioritising their resources.

Mr WEBSTER - In all of this, it is the capability across the entire health service from the initial contact, which is through a paramedic or through a GP. We've got to share this information with the primary care sector, which is not generally our sector, but we've got to share it back to the GPs and those sorts of things. I used the LGBTIQA+ training and the Aboriginal training; we've made that available outside the department to GPs' surgeries and things like that, so they can have access to that as well.

Dr WOODRUFF - Minister, welcome as the Health minister. It's the first time I've had a chance to speak to you formally in that role. I wanted to speak about unplanned and unwanted pregnancies and the responsibility, the work the Department of Health is doing, to support women who are in that situation. And, importantly, the work that is being done to provide women with reproductive health education and information so that they don't get into that position, and to provide responses when they want to have an immediate response to an unplanned pregnancy.

I can see there's a couple of things mentioned in the submission under Women's Health Services. You said that recently the Department of Health has established the Tasmanian Gynaecology and Reproductive Health Network to enhance the experience and quality of health care for patients accessing gynaecological and reproductive health services. You've also said that there's an action plan with strategic priorities to improve women's maternal, sexual and reproductive health.

I have two areas of questions. One is, what is the quality and extent of the reproductive surgical terminations that are being provided in Tasmanian hospitals, and which hospitals? Also, are we hearing concerns about women, particularly in regional areas, not being able to access surgical terminations or is there -

CHAIR - And medical terminations.

Dr WOODRUFF - Well, that was a separate -

CHAIR - Okay.

Dr WOODRUFF - So, actual surgical terminations, the availability and the numbers of women who are using that, and any information that the department has collected about women not being able to get access to those terminations in a timely manner.

The second area is about medication terminations, medical terminations, and the availability of medical terminations. Is it only through a GP? Is it promoted through the Department of Health services? How do women find out that information?

Mr BARNETT - Thanks very much for the question and it's good to be here as Minister for Health. You made reference to one of our chapters in the submission, Women's Health Services, so thank you for making references to that on pages 8 and 9 of our submission, which is a public document. The other section I think is relevant as well is on the Health and Wellbeing for Women Action Plan on pages 10 and 11, but they are quite detailed questions regarding those matters, so I'll pass to deputy secretary Dale Webster.

Mr WEBSTER - Regarding the statistics you asked for, we need to take those on notice. I don't have them ready to hand today. What I would say to you is we do attempt to have that equity across the state of access to surgical termination. If it is regional and they do not have access there, we do actually facilitate movement around the state to achieve that, so there is that.

In terms of people missing out, again, we do not necessarily have that statistical. This is why the network is important. When we talk about the networks, they are not internal just to the Tasmanian Health Service. We invite the community, general practitioners, et cetera, to be parts of those networks because the -

CHAIR - Are Family Planning Tasmania in that network?

Mr WEBSTER - Yes. Outside people are a part of the network. The idea of the networks is to improve the health system overall. Our cardiac network includes people that do not actually operate within the Tasmanian Health System. All of our networks, when we put them in place, are actually broad health system networks, not health service networks, and that is important. The network is about actually growing the knowledge of issues across the whole health system, not the health service that we operate. It is important to emphasise that, which gets us access to more information. That is when we start hearing from the regional areas through the network there is a gap and is when we can start addressing it. That is the nature of the networks and they are a really important part of our framework.

CHAIR - To be specific then, which hospitals?

Mr WEBSTER - Specific, you want which hospitals, how many and then if we are aware of any one that is not being able to access, the statistics on that also?

Dr WOODRUFF - Yes, it is the case that women in regional areas or women living in Hobart or Launceston may not want to go to the nearest hospital to have a surgical termination because they want to keep that private and they might go to another part of the state. That is fine and normal. Sometimes women would want to actually leave Tasmania, but if you could give those to us by hospital and over the past couple of years, that would be great.

CHAIR - You don't have that information now, which hospitals provide surgical termination?

Mr WEBSTER - Not in front of me and certainly not by numbers over the last couple of years, sorry.

Ms O'BYRNE - Burnie, Launceston and Hobart?

Mr WEBSTER - Yes, exactly, the three majors do it but I haven't got the data on which ones have done which.

Dr WOODRUFF - And the second part of that was about medication terminations. Can you speak to where and how that is being made available to women in Tasmania?

Mr WEBSTER -Yes. Within the Tasmanian Health System, I can, which is through our Women's Health Service and our Sexual Health Services. It is available through the Tasmanian Health Service. Generally, it is available through the primary care sector, the general practitioners et cetera. Again, we do not have the statistics from the primary care sector. Again, because it is a pharmaceutical, maybe statistics are available through the Commonwealth Government rather than the state Government. We will see whether the Commonwealth Government have published it. I do not know whether they do or not.

Dr WOODRUFF - You were talking about data collection before and you were talking about going forward we need to be collecting these data. Is there a person tasked specifically with the job of looking at women's health needs in terms of women's data collection? My concern is if there is not, then collecting data on endometriosis, collecting data on miscarriage, collecting data on all the other things may not, in all likelihood will not, get picked up. That is the experience, unless there is someone who is specifically focused on doing that job. Do you have a person doing that work?

Mr WEBSTER - The short answer is at the moment we do not. But what we do is we have teams of people working across a number of our divisions. With the development of new systems - and I do not have to tell members here who have experienced this - we have lots of gaps in data in health. We are doing a lot of work on digital health transformation, to improve that. But we have a specific team, Monitoring, Reporting and Analysis, and their whole focus is on getting data out of our systems we need for any part of our agency. A request for data goes through them, they extract it and give it back to the area that needs that data.

Dr WOODRUFF - I suppose the point that the committee is making is, you have already identified there is data that is not collected.

Mr WEBSTER - That is right.

Dr WOODRUFF - What I am hearing is there is not anyone who is tasked specifically with looking with a gendered lens at the data collected. What this committee has found with our experience of looking through legislation is, unless we put a gender lens over legislation and the data collected by THS then we will not actually move the goalpost towards real equality in this area. Would you look at or consider the specific application of having a person with that job to look through a gendered lens at data?

Mr WEBSTER - At face value that is probably a good idea. It is specifically what we do with a whole lot of communities: try to be specific. Off the top of my head I cannot think we have appointed someone to that type of role, but it is certainly something we should

consider, given the feedback and stories we are getting. At the moment it is no surprise we have got specific people looking at child events. You are right, it is probably an area we need to improve on.

Dr WOODRUFF - Women are not a whole lot of communities, they are half of Tasmania.

Mr WEBSTER - I know.

Dr WOODRUFF - We would say elevate that.

Ms O'BYRNE - I have three little topic lines, I will be brief. Can I clarify, you are providing MTOPs in the public system?

Mr WEBSTER - Medical? Some parts of the THS are, yes.

Ms O'BYRNE - How is that accessed?

Mr WEBSTER - If they are a client of the Women's Health Service or the Sexual Health Service, then they would access it through those services.

Ms O'BYRNE - And a GP wanting to refer someone to an MTOP can do so?

Mr WEBSTER - The answer is I would need to take that on notice.

Ms O'BYRNE - That is fine. If you could take that on notice that would be great, because that is a barrier and one of the reasons women are having surgical terminations is the affordability and the support provided around medical terminations. Can I ask how many doctors in the THS are conscientious objectors for terminations?

Mr WEBSTER - We do not have that data. We do not know who are.

Ms O'BYRNE - But surely you would have to know, in terms of provision of service, what the numbers of people are in those areas who do not provide terminations.

CHAIR - We are talking about gynaecologists and anaesthetists.

Mr WEBSTER - I would have to go to each hospital and find out how many. That is not something we centrally keep a record of.

Ms O'BYRNE - That would be great if you could. I am touching on Rosalie's issues on data collection. One of the biggest issues for people, particularly with endometriosis and endometriosis-aligned complications, is your laparoscopy data does not break it down between those that are seeking it for endometriosis versus other options. Is that one of the data sets you will be collecting?

Mr WEBSTER - It is one of the gaps being identified by our Chronic Pain Network, so yes, we are looking at how we collect that.

Ms O'BYRNE - And that will also happen in terms of waitlist identification, because one of the issues for women - noting the comment made about respect and recognition is actually more in relation to the clinical care they receive - is that the waitlists for women in the public system to have endometriosis finally diagnosed, or endometriosis-related surgery, is hard to unpick because you don't collect the data separately. Would that also be a waitlist piece of data that you will be including?

Mr WEBSTER - Yes. We have a lot of breakdown to do in a lot of categories. We are bringing in and out, as part of the digital transformation of the outpatient management system that will allow doctors through the e-Referral to give us extra data about the nature of the referral, which then allows us to better triage. So, yes is the short answer.

Ms O'BYRNE - On that, are there other areas of health care specifically that women might access that would also be identified through that? How big is the scope of that project?

Mr WEBSTER - The scope of the data projects of digital health transformation - and it is a long-term project, it's not something that will be achieved overnight, it's across the next 10 years - is every area of health is being examined in terms of what data is missing so that we can break down into these areas. The short answer is that just this morning we have identified data gaps in cardio and endometriosis, miscarriage. If you've sat around the Estimates table, you know our systems are so out of date that we just don't have the data we need, so we are reinventing the wheel in a sense.

Ms O'BYRNE - My last question relates to a clinical presentation. You talked about the training you're providing, and that's fabulous, but a lot of the evidence that we've received and a lot of the evidence that exists more broadly is that it actually is to do with the way clinical assessment and clinical care is provided in emergencies. That is the first step.

Women with endometriosis presenting are overwhelmingly saying that they're being sent home because their pain is 'women's pain' and therefore not treated as seriously as 'men's pain'. We have had examples of a women giving evidence who had to go home and insert her own catheter because her urinary retention had occurred because of the pain but they weren't able to provide that sort of care for her in an ED because there weren't enough beds. She was out in the waiting area, and you can't insert a catheter in a waiting area. What are you doing about that clinical [?] in ED, which is not about respect, but is about actually understanding the differing nature of pain management for women and issues that women present with, such as endometriosis, that overwhelmingly have had poor reactions and experiences for women?

Mr WEBSTER - Again, the second part of our One Health culture goes to building capability, so when we see these capability gaps it is about identifying with colleges, with universities, changes in training, changes in education, but also bringing that training forward to make sure as part of CPD for our health professionals we are specifically targeting where we have gaps in capability. Again, you have identified these, and there are a number of them and gender diversity is another space where we believe we need to spend time working on better education, better training, to build capability so our health professionals understand the issues faced by those members of our community better.

Ms O'BYRNE - Does that lead me to an expectation that there is continuing professional development for ED staff as qualified medical practitioners in these areas, or is that still going

to be you opt into your CPD? How are you actually going to manage it rather than saying this is an area that we need to focus on?

Mr WEBSTER - In a number of areas of CPD, there is generally what doctors need to do to requalify in their college or maintain their qualifications in their college. There is what we call our mandatory tier 1 training, which is things like infection prevention. Then there is the tier 2 mandatory, which is where we target specific training for particular areas where we believe we have a gap within the health service and that training may be mandatory or targeted in areas.

Ms O'BYRNE - Is it your intention to provide that kind of training for ED staff and first presentation staff?

Mr WEBSTER - I don't lead the clinical side of the agency so I don't identify the clinical training but it's certainly that the agency identifies specific clinical training needs and then it is delivered. That is what I can say in that space.

Ms JOHNSTON - Back to terminations. I understand that medical terminations are available through our public hospitals at no cost to the patient and long may that continue to be the case. As Rosalie's questions alluded to earlier, there are barriers to accessing medical terminations in public hospitals whether it be through location, being in a regional area, the issues in terms of being able to go to a public hospital to do that. So many women rely on medical terminations but they come at a significant out-of-pocket expense to women.

How is the department ensuring that those particular barriers are addressed in terms of cost to accessing medical terminations within a person's community at an earlier stage? Obviously, there are probably more desirable medical outcomes and better health outcomes from doing that in a community but also long-term benefits to the public health system without having to put extra pressure on women having to go to the public hospital to seek such a termination.

How is the department addressing that particular issue regarding financial barriers to women accessing medical terminations?

CHAIR - I will also add to that also, as I understand it, there's no publicly funded ultrasound available to women so that cost can be a barrier right from the outset.

Ms O'BYRNE - Even the privately funded ones have a waitlist.

Mr WEBSTER - This is not meant to sound like a fob-off, but in a lot of cases this is in the primary care sector which is not the department or the state government's area of funding or responsibility. All we can really do is advocate in this space to the federal government in terms of Medicare rebates, PBS rebates - all of those sorts of things - to make sure that the primary care sector is taking up its part of the entire health system. We can use networks to grow capability but when it comes to the financial side of this, the primary care sector is funded, and directly funded in a lot of cases, through the federal government, not through state government.

Ms JOHNSTON - I appreciate that. I suppose if the Government is advocating for changes to Medicare rebates, for instance, and they don't have that data available in who is

accessing surgical terminations, who can't access surgical terminations, and are having to rely on medical terminations or, indeed, collecting data on medical terminations. How's the Government putting its best foot forward - and best case forward - in a change in rebates, for instance, or advocating for the barriers to be reduced financially if there is a lack of data?

Mr WEBSTER - It is always an issue for us in that because part of the health system and, in fact, a major part of the health system is outside of our sphere of influence, we can't dictate to GPs what data they give us and what data they collect. It's not part of our remit to do that.

All we can do is encourage the primary care sector as part of the system to collect this data, provide it to the federal government and we have access that way. It's beyond the state government's remit to dictate to GPs, 'You must collect this data and give it to us'. That is through the federal government that that occurs.

Ms JOHNSTON - I'm not sure that I heard your question correctly, Michelle. Medical terminations are available through the public system at the moment?

Mr WEBSTER - Yes, in a limited amount of cases through particular services is what I'm saying.

Ms JOHNSTON - What services would they be?

Mr WEBSTER - Mainly through the Women's Health Service and the Sexual Health Service.

Ms JOHNSTON - So, a GP is actively encouraged to refer people to that service?

Mr WEBSTER - I don't know that we actively encourage GPs to refer to that service for medical terminations. There are referral pathways from GPs to those services for a range of services. I'm not sure you can characterise that as actively going out to GPs -

CHAIR - GPs should be prescribing.

Mr WEBSTER - Exactly.

Ms JOHNSTON - If a woman accesses the service through [?inaudible 12:20:07] is that without any out-of-pocket expenses?

Mr WEBSTER - Yes, through the THS.

Ms JOHNSTON - So, there is a way people can access medical termination without-

Mr WEBSTER - I should preface that, there may be a charge through the PBS through pharmacy. The consultation service, through the THS - we don't charge.

Ms JOHNSTON - Of the consultation services, there's no out-of-pocket expenses. There is a mechanism that women can access, but perhaps it's not widely known and recognised?

Mr WEBSTER - Yes. Because it's part of the THS or the secondary part of the system, or the tertiary part in some cases, it's usually by referral; or the patients have been long-term patients of those services. It's not something that you turn up at Scottsdale, get a referral and you can get an appointment the next day through those sorts of services. It's usually much longer timelines than those.

CHAIR - A quick follow-up question, then I want to go another area if we can. We've spent a fair bit of time on this topic.

Ms O'BYRNE - Your window for a medical termination is quite small. If you can't access it efficiently and affordably, you end up with a surgical termination, which is more expensive for the state Government. What work is being done on the cost mitigation issue for your health service in allowing more public access to entops [? 12.21.30]. Because that's-

CHAIR - But that is the key question, how do we enable access to publicly funded entops? [12.21:35]

Ms O'BYRNE - Currently, you give a bucket of money to both the Youth Health Centre in Hobart and the Women's Health Centre to ameliorate costs, but it's a broader issue than just going through that one cost. You have a bigger issue with women's access, and surgical termination are of course more complex.

CHAIR - Just go to the question.

Ms O'BYRNE - What are you doing?

Mr WEBSTER - Through things like networks et cetera, we're actively trying to operate as a system. We have primary care available. The minister is constantly talking to the federal government about where we have thin markets around GPs, where we have GP shortages - those sorts of things. It's about making sure our primary care sector is sufficiently resourced through the federal government that they are able to take up their part of the system. That is the critical. Ms O'Byrne is right, you see a cost shifting of some costs from the primary care to the hospital system if you don't have a primary care system that is responsive. Ms O'Byrne is right, it's in our best interest as a funder of hospitals to get the primary care sector involved in this. But again, we have very little funding availability to the primary care sector. The major source of funding to the primary care sector is through Medicare and through the federal government. The administration of the primary care sector is through the federal government and in fact there are prohibitions in federal legislation from us accessing Medicare as a state health service.

CHAIR - Just quickly here, I have other areas I want to go to.

Ms O'BYRNE - Very quickly, and you may need to take it on notice - can you confirm whether or not the youth health services funding to provide access for people to access termination is being reduced and, if so, by how much? If not, what is the funding for both the Women's Health Service and the Youth Health Service to access those services. Thanks, Chair.

CHAIR - Okay.

Ms O'BYRNE - You will get that for us?

Mr. WEBSTER - Yes.

CHAIR - I don't know if you've had a chance to look at the Victorian Women's Trust and the Royal Women's submissions? They made a number of recommendations in their submissions. Some of them are not related to the state, they are more federal. Is there are any intention by the Government to perhaps link with Victoria where their successful 1800 My Options model for people accessing information about women's health matters?

Mr BARNETT - Thanks for the question. I am only broadly aware of that submission. I will have to pass that to the deputy secretary to respond. I am not sure if Dale is across that one?

Mr WEBSTER - Again, just from a quick read because it was a late submission, but what I would say to you is we are not averse to it. As you already know through Estimates and so on, we have a number of connections with other states on 1800 numbers. For instance, My Emergency Doctor that we use through Ambulance Tasmania is a Victorian-based service, so it is certainly something we can look at.

CHAIR - There is a lot of commentary talking about data collection, which is important. One thing the Victorian Women's Trust refers to is obstetric violence. We have seen, sadly, a lot of this raised in the north-west region more recently, but it is not unique to there. There was a recommendation that obstetric violence be recognised as a form of gendered violence in Tasmania. That would require legislative change to do that. I do not know whether that is something that has even been considered in the state in view of all the recent commentary around this matter?

Mr BARNETT - We certainly take that very seriously, not just in terms of women, but the Family Violence Action Plan which is in another portfolio area. I will pass to the deputy secretary, if you would like to add to that answer.

Mr WEBSTER - As you know, we are taking obstetric violence very seriously and making sure we are investigating every complaint of it across our system these days. This has brought us to the point where we are doing a lot of review in the obstetrics area. I read that with some interest. We would need to look at how we achieve that if we were to and how we report it and things like that. At this stage, we have not considered a policy position on it, we have simply read the submission. As you said we are very actively looking at root cause analysis of trauma to do with birthing. It's not necessarily obstetric violence, but there is a whole lot of trauma and how are we responding as a system to that trauma and the north-west -

CHAIR - Prevention would be better than cure.

Mr WEBSTER - That is right; and the north-west service and the changes we are making there, are about responding to those reports.

CHAIR - We mentioned it briefly about one in four or five pregnancies end in miscarriage. Health professionals have a higher rate of women who miscarry and always did than non-health professionals. We also heard from the Men's Health Resources submission that men are often overlooked in support during miscarriage. Not only are women not getting

that emotional and psychological support, neither are men or their partners, whether male or female. Is the Government looking at taking a much more targeted approach, this being as it is a very common complication of pregnancy? Psychological as well as physical support?

Mr BARNETT - Yes. I might pass to the deputy secretary on the second part of the question. On the first part, we have established the statewide Women's And Children's Clinical Network - people with lived experience and providing feedback to the Tasmanian Health Service on the best way forward. Certainly, my heart goes out to those that have had a traumatic birth experience, and it is clearly distressing.

CHAIR - This is more about miscarriage. Sorry. I have moved to miscarriage.

Mr BARNETT - Yes. All right. I mean, the Chief Nurse And Midwife, I would be taking advice from her. I have had a number of discussions with her about these important matters; but I will pass to the deputy secretary on the other parts of the question.

Mr WEBSTER - I've read that submission and particularly the discussion from the hearing earlier this year with some interest. Where this comes from is, and we learned this specifically through the north-west review, is having health professional staff that are really dealing only with the trauma relating to reproductive health. As you know, we put specific staff in place in the north-west when we saw that gap. I have communicated this only this week to our CEs [?12:29:33] that we need to make sure that the role of those is seen as broad as possible so we do have those connections.

The issue, I guess, is again designing services with the federal government, because most women seeking assistance with miscarriage would be going to the primary care sector.

CHAIR - Not always. A lot of them need D and Cs afterwards.

Mr WEBSTER - Exactly; but again that is the point of contact. So, we need to make sure that we are not designing a system that only contacts the ones that come to us.; we also have to make sure that we are doing that. Where they need a D and C and they're coming through the Health Service, our trauma team within reproductive health within the Health Service will be in contact with them. The missing bit is whether they are in contact with the partner. We've been talking about that, based on that submission; but the second part of it is that those who do not come to us, where do they get their support from.

CHAIR - Some of the evidence suggests that even those who come through the system requiring a D and C do not get the psychological support they need. They may get the physical support in terms of the surgical procedure and the aftercare for the surgery, but the psychological support is lacking. That is for the women and their partners.

Mr WEBSTER - And that is certainly what we have heard through those reviews, which is why we have focused on having as part of our maternity services or reproductive health services teams, people who are dealing with the trauma rather than the physical side.

CHAIR - I assume it is harder to get to those outside the hospital.

Mr WEBSTER - That's right. That's the service, but the system is probably missing it.

Dr WOODRUFF - I had a question on the action plan strategic priorities, to improve women's maternal, sexual and reproductive health. Are there targets for the improvements that are being planned, and KPIs? Could you talk to those?

Mr BARNETT - Thank you for making reference to the action plan and the gynaecological and reproductive health services plan, but in terms of the detail of that question I will pass to the deputy secretary.

Mr WEBSTER - I am going to look to Ms Badcock.

Dr WOODRUFF - There is a big plan, it has a lot of areas, but particularly starting off perhaps with sexual and reproductive health.

Ms BADCOCK - The particular action plan is a whole-of-government one, led through the Department of Premier and Cabinet. There is a series of actions that sit under that led by health, including those that relate to maternal, sexual and reproductive health. Off the top of my head I am fairly certain that we have targets, but I will have to take that on notice and provide that feedback just to be certain, and communicate what they are, and what progress has been made against those as well.

Dr WOODRUFF - Okay, if there are no targets then it needs to progress to that stage in order to get action.

CHAIR - This plan ends this year. What is the plan for that?

Ms BADCOCK - Again, because it is led through Premier and Cabinet, that is something that will need to be confirmed with them, in how that proceeds. Based on previous years this particular action plan sits under the Tasmanian Women's Strategy. It is a component of that, and there are various other action plans that also sit under the women's strategy. I would imagine that a new one would be developed, but again I would need to speak to Premier and Cabinet to get an update on that one.

Mr WEBSTER - The strategy is 2022-2027, so there is a high likelihood that we will be asked for annual action plans. It is a one-year action plan, so what I am indicating is that we would expect that we will be asked to build on it across to 2027, which is normal for these strategies.

Dr WOODRUFF - This has the Wellbeing Action Plan 2020-2023, it made it sound like a three-year action plan.

Ms BADCOCK - Yes, so this one is due to expire, the new women's strategy has just been released, so generally where the action plans that sit under it are expiring they will be redeveloped under the new strategy

Mr WEBSTER - The new action plan is 2027.

Dr WOODRUFF - Could you provide the evidence of what has been achieved, and what the targets were at the start of the action plan, and what was achieved at the end of it? Thanks.

CHAIR - Okay. Just briefly, if I might, the matters that were in the submission on pages 12 and 13 in relation to the Government's commitment to deal with issues related to intervention of people who have intersex characteristics, in response to the TLRI report and also for the commitment for the full list of arrangements to ban conversion practices. Can you give us an update on where those two matters are at and what time lines we've got for those?

Mr BARNETT - Yes, I think I can, and then I am happy to pass to the deputy secretary, certainly, with regard to the TLRI report on intersex and the variations of sex characteristics. Our Government has recently brought in legislation to update a number of acts to reflect the contemporary evidence-based terminology which is variations of sex characteristics. I am pretty sure that went through the parliament -

CHAIR - That's dealt with. What I am talking about is the non-consensual surgery on intersex babies that is not lifesaving.

Mr BARNETT - I will pass to the deputy secretary. With respect to that legislation, I think, it was passed in recent times.

CHAIR - That one. There is an outstanding piece -

Mr BARNETT - I am clarifying that. I will pass to the deputy secretary on that matter.

Mr WEBSTER - We are working with the Department of Justice on both the TRLI report that you referred to and the conversion practices report. I believe -

Mr BARNETT - I can update on that matter.

CHAIR - There are two matters.

Mr BARNETT - On the latter, maybe I can cover off on that, in regard to the gender conversion.

Mr WEBSTER - That would be great. Thank you, minister.

Dr WOODRUFF - Handy if you can put both hats on at the same time.

Mr BARNETT - Just the commitment that the Premier has given, is a commitment that I am giving, in terms of tabling legislation before the end of this year with respect to gender conversion practices. I have said that publicly a number of times. I am happy to say it again today. That's the answer to that question.

CHAIR - Thank you.

Mr BARNETT - In relation to the other part of the question -

Mr WEBSTER - In relation to the intersex, there are a number of recommendations in that TLRI report and not just the legislation, but how our clinicians, et cetera. I am leading the piece of work on this in terms of the consultation with clinicians. We are working with our clinicians, as well as with the Department of Justice, on how we respond to those recommendations. It is a fairly hefty report in terms of the background to the

recommendations. We really do need to take our clinicians on a journey through that report as well.

CHAIR - Minister, there have been some claims that those surgeries don't occur in Tasmania. Do you agree that they do occur in Tasmania?

Mr BARNETT - Thank you for the question.

Mr WEBSTER - Through you, minister, yes, we do agree they do occur in Tasmania. This goes to a definition and how we gather data based on that definition. If you like the ABS definition, we would have to say that we do. On the definition that is in our clinical set, it doesn't actually appear as data, but we would have to admit that we do.

CHAIR - Sure. We have just gone over time. Is there anything really pressing?

Thanks, minister, for your time. We will send those questions through to you, on notice and with a time line for responding. Thank you for your appearance, and that of your team today.

Mr BARNETT - Thank you and thank you to the committee members as well.

THE WITNESSES WITHDREW.

Ms MARY CROOKS, AO, EXECUTIVE DIRECTOR, AND **Ms ELEANOR LEE**, INTERN, UNIVERSITY OF MELBOURNE, VICTORIAN WOMEN'S TRUST, VIA WEBEX, WERE CALLED AND EXAMINED.

[12.49 p.m.]

CHAIR - Members around me are Dean Young, Rosalie Woodruff, Kristie Johnston, Dean Harriss and Michelle O'Byrne who is online.

Thank you for appearing before this committee. Just so you are aware, everything you say while you are appearing before the committee is covered by parliamentary privilege. That may not exist beyond this meeting. It is being broadcast, it is being recorded, and transcribed for *Hansard* and will form part of our evidence. Do you have any questions about that before we start?

Ms CROOKS - No, it is all clear.

CHAIR - We received your submission and appreciate that, thank you. If you would like to introduce yourselves and then speak to your submission, members will probably have questions following on from that.

Ms CROOKS - Okay, thank you. I am Mary Crooks, the Executive Director of the Victorian Women's Trust. I have been in that role for some 26 years. The Women's Trust started in 1985 with a gift at that time of $1 million from the Cain state government and we have been in existence ever since.

We put a great premium on being able to support interns to help us do our work and punch above our weight. I would like to introduce Eleanor Lee, who has been on internship with us from the University of Melbourne for the last couple of months and finishes up at the end of October. Mary and Eleanor, at your disposal.

CHAIR - Thank you. Would you like to add anything to your submission or is there anything else you would like to say?

Ms CROOKS - We do not automatically make submissions into invitations to inquiries. We try to be fairly selective because we are a small outfit of just 10 people, of part and full-time staff. But when we were invited to this one, it really piqued our interest. It is a terribly important inquiry you have embarked on. It so happened Eleanor had already started her internship with us and was very keen to help us build out our understanding of issues on women's' health and wellbeing. When the inquiry invitation came through, we saw it was a great opportunity to be able to bundle together a whole lot of our experiences and put it to you.

I will have Eleanor make a couple of summary comments in a minute, but I wanted to also say back in 2009, I wrote a publication called *Gender Lens for Inclusive Philanthropy*. Although it was not specifically for philanthropy, that was the hook. But it was the first time, to our knowledge, that in any public policy setting here in Australia, that the issue of a 'gender lens' was given prominence.

It really is an encouragement that this booklet, which is available on our website - I asked Eleanor this week to read it again herself, to see whether or not it had become outdated in any

sort of conceptual way - and her feeling is it hasn't, but obviously, some of the stats that I used have.

What we are trying to argue from 2009 is that we all grow up in a fairly male world. Now, this is not about being malevolent, it's not about maliciousness; it's just being able to understand the way we tend to be socialised within our worlds over decades and generations. We still largely operate within a fairly patriarchal world where the authority that has been built up over generations has largely vested with men. They've been largely the decision-makers, the heads of professions, the heads of law and business and commerce.

That is all changing, but what is slow to change is the deep-laid culture that sits below a lot of our institutions and our understandings. The importance to us is to adopt a gender lens as simply the mark of a more sophisticated understanding of how our world is nuanced, how it's layered. It's not an angry, aggressive position about male authority; it's just saying the world is very gendered in lots of ways as a result of our culture and experience. The challenge is to understand that - not be frightened of it. Because when you become more sophisticated in your understanding about the way gender does make a difference, you can end up delivering better policies and programs and everybody benefits.

I'll give you one quick example: in the book I wrote in 2009, if you take the issue for example of truanting - and this still applies - that boys when they truant from school, they truant for different reasons than girls. It's important you come to grips with, 'well, why does that happen? Why are girls truanting?' It's the same with juvenile justice. When girls commit crimes in the juvenile justice arena, they tend to be different crimes from what boys commit. When girls commit driving offences, they're different from what boys commit on the road. I'm assuming that you possibly have already fathomed in your heads how that gender difference would play out.

To me, if you're working up driver education programs, for instance, and utilising taxpayers' money to do so then it's really important that you can tailor your programs so that the messages you might be giving girls are possibly different in part from the messages you're giving boys, because they're driving differently. They're committing road offences that are different from one to the other so they're good examples of how, when you understand the way in which gender does play out, you get to a better position in responses and program delivery.

My point is there's nothing malevolent here; it's about growing much more sophisticated understandings. I think Eleanor has done this by pulling the research together, such as the way women experience a heart attack differently from men. This is crucial; like the fact that women are the ones who have babies and the quite shocking findings around obstetric violence is that this is clearly an issue that has to do with women and birthing. It becomes then a societal issue.

They are some introductory remarks about not being frightened of the fact that gender differences play out, and the challenge is to understand them, appreciate them and use that knowledge to get better policies and programs.

I'll hand over to Eleanor if she has some opening descriptors of the main research findings.

Ms LEE - The main thing I found in my research was that all of these work outcomes for women are very pattern-based. When it comes down to it, education of medical

professionals and in medical research is the key issue in a lot of these smaller health outcomes. That was something that I noticed to be prevalent regardless of whether it was an issue that only affects women, such as endometriosis, or an issue that affects all people but women have worse outcomes such as cardiovascular health.

CHAIR - I guess the question is then is how do men or women experience this - whatever this is, whether it's a health service, whether it's driving a vehicle? But, let's focus on health services. Just asking that question, is that enough? What's the next question that should follow that?

Ms CROOKS - In health services, what we haven't done for generations until more recently is start to ask questions that might help reveal the gendered differences. For example - and I know, Ruth, this is off the topic of health per se - but for generations our national census has had questions like, 'What is your occupation?', and you might say, 'Home duties', and if it said home duties, you would then have to skip the next questions which were how much income you earn and how much annual leave you get. But if you put in that category, 'I'm a nurse', the next questions will be your income, your annual leave and so on.

The way we were even asking the census questions rendered a lot of women invisible by dint of their occupation. Now the census questions are starting to build in time use and starting to build in descriptors that enable women who aren't in professional work to be understood in terms of their population characteristics. A lot of it is just having the curiosity to ask yourself, well, if we're putting forward this health program, are we sure that its responsive to gender difference. Do we understand whether this program is in fact likely to be responsive for men or are we making broad generalisations that this program will make a difference for everyone who's a consumer of it? A lot of it is about having that curiosity in the first place, that spirit of inquiry, to understand what the social realities are that you might be dealing with.

CHAIR - Is this a question for policy makers or is it a question for everyone at the coalface? I'm trying to get some guidance from you where you see the most important impact, because there are policy decisions, there are clinical decisions. There is a whole range of things related to health. Who and when should these questions be asked?

Ms CROOKS - They're wide ranging in the sense that everyone becomes implicated in a more sophisticated understanding of how gender plays its role through society. Policy makers, yes; legislators, yes; school teachers, yes; parents within families, yes. These are whole-of-society questions and it would be a real pity if the notion of appreciating gender difference was seen as something that belongs to some professional sectors and not for others. For example, the question of obstetric violence, first and foremost, that has to be a challenge thrown out to the institutions who are training our doctors.

CHAIR - And midwives, it's not just doctors.

Ms CROOKS - Yes, and midwives. The people at the coalface, there are huge opportunities for education and there is an intersection around that question of whether or not there should be some legislative outcome.

Dr WOODRUFF - Hello Mary and Eleanor. You have done fantastic research at the Women's Trust. It's really important what you've raised for us; there's lots of things I want to talk about. Let's just go to obstetric violence because it's not an area that I'm familiar with and

in your submission, you don't detail exactly what that means. I'm assuming from reading into this that it's a combination of active, as well as unintended acts in the birth process and I assume in the post-birth process and possibly in the prenatal care as well. Can you talk about that and then talk about if you have any understanding of where the colleges are at in terms of training? Is there an awareness amongst colleges of this as an issue? What is your understanding of training happening at colleges?

Through this inquiry we have an opportunity to make recommendations and findings and we've already had other people present on different issues about gaps in training of GPs and other medical professionals, including through the University of Tasmania, as well as other colleges. It's an opportunity for us to make recommendations. I'd been interested in your understanding of where things are at.

Ms CROOKS - I'll hand over to Eleanor and then I'll come in after that.

Ms LEE - With the experiences of obstetric violence in the research that I read through, the main things were related to consent. Things like penetration being done without consent when performing an examination. In some of the worst cases women were explicitly saying 'no' to certain procedures and being either forcibly restricted in their movements or having the procedure done regardless. In some of the research it even discusses how the partners and also the midwives present also experienced some forms of trauma by witnessing the clear distress and lack of consent that these women showed. I think the main things were consent, sometimes lack of education on procedures being performed and then the outcomes of those procedures and then violation of bodily autonomy. In terms of the current study for doctors during their training, it did not explicitly say to what extent obstetric violence was discussed in universities, but it did discuss that there is not enough trauma-informed care in education of especially midwives and obstetricians. I guess there is an understanding of the physical trauma women will experience during childbirth but not necessarily the emotional trauma. I think that is where the real gap lies.

Ms CROOKS - Could I just come in on two quick points there? Maybe over a decade ago, we instituted a partnership with a general practitioner, Jan Coles, at Monash University. She came to us and she was able to show us that in the medical training at Monash - and I think at that time was also pretty much generally - there was no training within an entire medical course to help doctors identify family violence; no training in the course. Her point was that there might have been one or two guest lecturers and that was it.

So, we worked with Jan on a program, Champions of Change, where she and then a number of other academics with her were able to completely turn around that situation and start helping the medical courses themselves come to this realisation that, if you have a woman who is presenting to you as a patient and she is depressed and flat and not willing to disclose her relationship at home, then she is being wrongly medicated, quite possibly. So, that whole training started to be turned around. Now, that is within a decade ago.

The other thing I want to point to is the very recent work we have done to support the journalist researcher Isy Oderberg. She has just published a book called *Hard to Bear* and this goes to the recency of issues like lifting the lid off the potential for, say, obstetric violence. What Isy showed in her book is the pain and suffering through miscarriage and the way in which the treatment of women and the lack of empathetic treatment of women in supporting them through this traumatic experience. She lifted the lid off that.

What Isy has done is now form an advisory group, of which I am part, and we are now starting to work with decision-makers and trainers and whatever. My point is that change is possible but some of it is only being recently revealed. The question of working, then, in partnerships with people within policy settings and training institutions: that is where a lot of the action has to happen.

Dr WOODRUFF - Thanks, Mary. It strikes me that doctors and midwives and other medical professionals who are working in government-funded hospitals - all hospitals have some form of state or federal funding even if they are private - ought to be required to be working within guidelines of practice around trauma-informed care and patient consent.

We have heard previously on this committee, that women or people who have suffered sexual violence may only appear essentially against their will when they are pregnant. As you say, the sort of basic procedures that women have to suffer in that situation, it is more important than ever that they have consent and especially a conversation about what is going to happen in advance of it happening; but, that is challenging. It is reversing the dominant paradigm of control of medical practitioners over the bodies of people that they are working on; but that is not happening.

It does sound as though we are not there yet, in terms of the training required for doctors and midwives in this area. Is that right?

Ms CROOKS - That is right. The medical profession is not unlike the law profession in terms of not being there, and recognising issues of harassment and sexual harassment even within the professions themselves. Just this week, the *Guardian* (Australia) ran a piece showing that the Medical Board of Australia has a survey of its workforce and it includes whether or not you are harassed; but it does not include anything to do with whether or not you have been sexually harassed. The cynic might argue that is deliberate, because there is a fair bit of evidence emerging there is a significant issue within the top levels of the medical profession around the domination, treatment and the abuse of women within the profession. To just have a survey question on harassment is inadequate, and will give you insufficient data to diagnose how your workforce is actually going.

CHAIR - We saw some time ago the College of Surgeons motioning a stand on it, but there has been more recent information that it has not really come very far in that specialty.

Ms O'BYRNE - Any conversation with the Young Women Lawyers Association would probably reveal most of that bias in harassment.

I wanted to explore the training issue particularly on menopause and endometriosis and pain management. One of the things we know is whenever we offer training where there have been identified shortfalls for GPs or in hospitals, the only people who turn up are the people who probably do not need the training as much. I wanted to talk on what your conversations may have been over time with the colleges and universities on mandating training in these areas. Also, what you then do with that huge cohort of the workforce who aren't picking up the training and are the subject of many of the concerns been raised with us on the way that people are treated when they present to their GP or whoever they see in primary care, but particularly in emergency departments, where they are often discounted. Being in this area for a while, you have effected some change from some of the policy work; what is the pathway for

colleges, universities and - not that I think continuing professional development is done properly in hospitals - but even that as a pathway?

Ms CROOKS - The most important first reaction to that is to say most commonly these issues, it is not as though you meet with resistance - although there can be backlash and resistance - but most commonly it is people who say 'Gosh, I didn't know that'. Then, what people do is they ask for practical entry points. People's better angels come to the fore here. What we have been finding is people are hungry for good information, good entry points into how they might start a process of change within their institution.

This is exactly what we have found since we launched our menstrual leave policy in 2017. Our template for menstrual leave on our website has had something like 9000 visits in that time. To me, partnership is everything and we have been working with unions, with public servants in the ATO, with commercial enterprises, and we have produced a publication called *Ourselves at Work*, which has the really simple steps you can take to start developing a positive menstrual culture in your workplaces. We find time and time again as soon as you can provide a clarity of the issue, that you're not haranguing people, but are instead saying here's the issue, and here's what you can start to do about it, that the appetite for that kind of change and constructive development is huge.

We have been watching organisations take off all over the place, nationally in Australia and globally, once they have become alerted to an issue that is unfair - it's not fair, it's not just - and your outcomes and your productivity and everything could be beneficial. There are win-wins for everyone here. The appetite is huge and it is a matter of satisfying it. We made a grant, 18 months or two years ago, to a group of women who have almost finished a whole training module that can be taken into any number of workplaces or institutions that start to take mystery out of reform in this regard. That is where we like to think that we 'grade the road' and others can then start that kind of journeying.

Ms O'BYRNE - We have been through a commission of inquiry about sexual abuse in Tasmania, and we are mandating training to safeguard families, safeguarding children. We are mandating all of that. Is there scope for mandating training on some of those issues relating to women's health, particularly in our health sector, for things such as recognising pain management, for recognising menopause as a significant health issue? One of the things is that time and time again the evidence presented to this committee and that we've heard colloquially is about women having horrific circumstances when they turn up in pain. We had one woman who was told to go home and sit with her back against the window with the sun coming through and that would fix the ridiculous pain that she had from her chronic endometriosis.

Ms CROOKS - There is a balance and a fine line, isn't there? You don't want people exercising backlash because they are sick of mandated stuff. But I do think that it's about being targeted and starting in places where the impacts and the negative impacts are really gross.

For example, I have a daughter who has endometriosis and I have been distressed by the inordinate amount of time it took for her to be diagnosed. I am not doctor. I knew there was something wrong, and I have talked to her and been a listening ear. It has now been properly diagnosed and has taken probably seven to eight years, and she's now 35. She has had so many years of pain and trauma, not properly diagnosed and it's only now that she is starting to feel more confident that maybe there is some treatment that might bring her some relief. We just shouldn't have in society that time lag for someone who -

Ms O'BYRNE - She's actively seeking -

Ms CROOKS - She has been through the mill of people, of doctors, who have been dismissive of her -

Ms O'BYRNE - My daughter had a similar thing. She was told she had migraines in her stomach.

Ms CROOKS - Yes.

Ms O'BYRNE - It is a new condition apparently.

Ms CROOKS - One of the other crucial areas where it should be mandated is in relation to the question of identifying abuse and coercive control in relationships. Again, time and time, I cannot tell you how many anecdotes we have received from women whose doctor - male and female doctors - have not been picking up the cues and have been putting women on antidepressants when, in fact, they are facing issues of going home and being beaten up. We have funded grants out of the Women's Trust, which is terribly distressing in a way. We have funded one program because there were young women presenting to have their children, to be giving birth to their child, but being too scared at the prospect of going home with the child. We have funded grants that support her in the post-birthing experience to be able to cope better with the fact that she's going home to a violent relationship. These are awful situations, but like awful situations you have to grasp the nettle of the truth and not be afraid of that in order to then try to think through, how can we do better by people?

Ms O'BYRNE - Just a quick question and I will finish, Chair. How are you funded, Mary?

Ms CROOKS - All by private donation.

Ms O'BYRNE - So, it is effectively all philanthropic,?

Ms CROOKS - It is all, because we have hundreds and thousands of women who give us $75, $100, sometimes $100 000. The Cain government started the trust with a $1 million gift to recognise the sesquicentenary of European settlement. I am proud to say that after 36 years we have managed to preserve one-third of that money in the bank; but it has been constant fundraising.

Ms O'BYRNE - Thank you so much for the submission. It was excellent. Thanks, Chair.

CHAIR - I think it encompasses a lot of what we have been talking about; it seems that the whole education piece does not need to just belong with the medical professionals and health professionals broadly but it is also with young women themselves. You have the case study there, the Menstrual and Menopause Wellbeing Policy you talked about and the publication of your book, *About Bloody Time - The Menstrual Revolution We Have to Have*. I bought a couple of copies because they are fantastic.

I was horrified to be reminded again that 34 per cent of young women had no idea what was happening to them when they had their first period. How is that possible in this day and age? There you go. If more than a third of young women do not know what is happening it means at that point that they probably have a lack of knowledge about how they might get pregnant, what a normal relationship might look like, what consent looks like, all those things, if they are completely oblivious to what a period is.

In order to deal with this and perhaps empower young women in this area of their lives, what do we need to do for them and how can governments - particularly a state government - assist in that?

Ms CROOKS - Great question; and when we started our research which led to *About Bloody Time*, we had 22 discussion groups across Victoria of all age cohorts and we had a survey of 3500 women. One of the things that really shocked me, as somebody who was then in my early 60s, was the relative state of ignorance that I entered into when I started menstruating. I thought that might have all gone by the wayside but it had not. As you rightly say, a lot of young women still, in 2023, start menstruating with a lot of disinformation, a lack of confidence and not a lot of support, understanding and information.

We had situations, for example, which I have found incredibly sad, of girls who would go onto the contraceptive pill when they were 13 or 14 - not necessarily as a contraceptive but to make their periods disappear. As you quite rightly say, that goes to questions of how self-confident you feel about presenting for childbirth, to become pregnant, to nurture a child, if you have this negative body image that is working deeply in your system.

We have started some discussions with people in Victoria to look at the whole way that a positive menstrual culture can be opened up within school communities, with school nurses, with having emergency sanitary, menstrual products in schools because girls are getting caught short, feeling embarrassed and going home. It is interesting: one of the main reasons girls do truant in 2023 is because they are worried and embarrassed that the evidence of their menstruation might be on display at school.

Again, it is about targeting and tailoring the change, whether it is within families, in schools, in workplaces, or the removal of the GST on the contraceptive pill, for example. These are whole of society reforms.

CHAIR - I will go back to the point on endometriosis. I am a former nurse, midwife and sex educator so I do my best to help these young women understand what was going to happen. They were a mixed class, they were not gendered classes, but you want the boys to know about it too. I remember back in the day when the advice on endometriosis, which was known to be a condition, was just, 'Get pregnant, that will fix it' - completely ignoring the fact that often you can't get pregnant, because you have got endometriosis. That is a long time ago, when that advice was being given, but we are still at a point now where it is still so under-recognised, taking years for diagnosis. There is still a lack of clarity around potential treatment. So, there is some research that may suggest that there is a glimmer of hope here. What do we need to do to make sure that conditions that we have known about for years, that we have been given really poor advice on in the past, don't continue on this slow, meandering journey of truth?

Ms LEE - I think one of the key things is the normalisation of menstrual pain. I have a number of friends who have been diagnosed with either endometriosis or polycystic ovary

syndrome, both of which have pain in periods. Until very recently, they were just told to go on the pill and that it is normal to be in pain, and that is the end of that. Period pain - to an extent - is normal. But vomiting, missing days from school, not being able to function at work or at school, is not normal. I think that is a key thing in women being more likely to advocate for themselves, and for healthcare practitioners being more aware of what is or is not normal period pain, and when it should be further investigated.

Ms CROOKS - In our argument in our book, the key to it is to bring menstruation out from the shadows; get it out of the stigmatised realm where women soldier on, where it's not talked about, it's not good to talk about it, and where it is a source of shame and embarrassment to women. Bring it out of the shadows, and have women and their male partners, doctors and so on start to deal with it in a much more open and engaging way.

Everyone is going to benefit from it. We have seen here even in our small office that the men who work with us will tell us that their own understanding of the menstrual cycle of their partners has now been altered for the better by being in our office and coming to terms with all of this, and they are reporting that they are feeling much more positive and encouraged, and empowered, to see what this means with their ongoing productive relationship with one another.

It's a good example of people being able to bring these things out of the shadows, and part of it is what Eleanor was saying. My daughter and Eleanor's friends and other women have to get used to calling out that, 'Hey, this is my lived experience, and we need to be working on this rather than being pushed aside'. I guess that is part of the challenge - not to continue in oppressive silences of these things, but to break it open, to bring it out.

Dr WOODRUFF - Thank you, May and Eleanor, I have a question in relation to cardiovascular health and the research that you point to. I am staggered at the number in that research from 2018. The Australian research is extremely concerning, and I was not aware of the reality that found that women admitted to Australian hospitals with serious heart attacks are half as likely as men to get correct treatment, and twice as likely to die six months after discharge. That is very concerning Australian research that was in the Medical Journal of Australia. What, if anything, are you aware of has happened in response to that? I suppose it's something for our public hospitals, in terms of when women are admitted, and the treatment that they get. There is obviously a need to have an update in training in terms of responding to the different symptoms that women present with. It is clearly something for GPs; but do you have any knowledge about training that is being undertaken or the response of colleges to that research?

Ms LEE - The main thing that I found was public information campaigns. The Heart Foundation and organisations like that are trying to publicise the difference in symptoms women experience. But beyond that it didn't seem as though much was done in the way of educating healthcare practitioners in understanding the different ways in which women present with cardiovascular disease or heart attacks. It is often still discussed as being an atypical presentation when in reality it is just the way in which women present - which is 50 per cent of the population.

Dr WOODRUFF - It is very disturbing. We might become more educated about the symptoms that women present with heart attack but if you get to the hospital and are half as

likely to get the right treatment, and twice as likely to die within six months afterwards - they are extreme figures ,especially-

CHAIR - Worse if you are an aboriginal woman.

Dr WOODRUFF - That's right; worse if you are an aboriginal woman. This is the leading cause of death in Australia of women. It is something that is critical to get action on, which could achieve big differences in the death rate for women.

Ms CROOKS - Rosalie, it comes back to those initial comments I made about being prepared to look at what is happening and ask questions around how does this play out for women? How does this play out for men? Being curious in these settings.

If I was working, for example, in a health area with men around prostate cancer I would want to know and understand the lived experience of men with that cancer. I would want to know as much as I can about it in order to do a good job, in order to tailor treatment and supports. So, what we are saying with this notion of a gender lens is do not just assume that the world is constructed within the lived experience of men. The world is constructed in the lived experience of men and women, girls, boys, women, indigenous women - and I want to come back to that in a minute.

It's really about getting much more nuanced and sophisticated in our understanding of how these things play out, and then being prepared to research them and then being prepared to try and change things.

Dr WOODRUFF - I suppose we are at the change end; we have already done the gender lens. The research has been done and now here we are looking at the sort of interventions that need to make change in institutions. I suppose we're slightly at the pointier end here, potentially, with being able to make recommendations to the Tasmanian Health Service and to training colleges about the sort of advice and expertise or guidelines that they would provide for medical practitioners in institutions.

You are probably not aware - and we can do our own work in this area - but I wondered if you knew of any follow up response to that glaring research in 2018; because it is five years ago now.

Ms CROOKS - We are not; and you are at the pointy end from your point of view and change and recommendations. We have been working in the health and economic sector and other areas for a long time, but Eleanor's work itself is now giving us some campaign directions that we will be taking up in 2024. But I would just say, I've seen so much change occur because well-intentioned people are prepared to accept that maybe we didn't know enough about that; now that we do, let's make the change.

I've seen a lot of things change because people brought the right attitudes to it; and the opportunities for investing in training and education. It should be seen as an opportunity to do better, rather than some oppressive mandate.

For example, a long time ago we funded a program with what was then the Country Fire Authority (CFA) in Victoria, called Women and Fire. What was happening was that women weren't seeing the CFA volunteer program as something that they could do - because the social

conditioning was that firefighting was men's business, and it needed strength and great physical capacity. Through that program, we were able to show that no, it doesn't. To pull a hose off a truck is not a question of physical strength, it is about skill and the right application of skill. That program changed things for all time, and now we've seen a huge number of women enter the CFA volunteer fighting brigades because they have got over the barrier - you do not need to be a big, burly bloke to be able to fight a fire. So, these changes are occurring, and it is exciting in a way.

CHAIR - Can I just go back to the point on education and training. I think you touched on it, Mary, around the use of language. You talk about a woman who presents with a heart attack and is seen as having atypical symptoms where she is not; she is having symptoms typical of a woman, for example. Does that matter go back to medical colleges and to guidelines, or is this a broader conversation? How do we change the language to ensure that we are not creating the idea that women are different because they are not typical of men?

Ms LEE - I think it comes from the colleges and the education of medical professionals, in which the male body is seen as the standard, and the female body is seen as the 'other'. Even the representation of sex in anatomical textbooks, even now in Australia, the presentation of a body is the male body, except for sex-specific sections. We have extra organs in there. We have a uterus, and fallopian tubes, and all of that stuff, and it is not even put into the normal human body, it is the 'othered' body. If you begin at that point in your education, then women's bodies are going to be 'othered' all the way through your profession.

Ms CROOKS - In a mature social democracy like ours, we should be able to talk about gendered difference, and differences in the female body, without people thinking, 'Here come the Feminazis'. This is about having a much more open and sophisticated understanding of the realities of our social world, and then being able to do better by people. You talk about the language. We have to cultivate circumstances where people, and men in particular, do not feel fearful because we're starting to talk about women's bodies in a way that shows gendered difference. We have to get away from all of that, because it holds us back.

In terms of our work in menstrual reform, and I am not sure whether you have predicted this, but the backlash we have received in our works with unions - and there are unions we have been working with where it is the male leadership of the union that has been most active in trying to get menstrual leave into enterprise bargaining agreements - but the backlash most commonly has been coming from older women. And part of it is, 'Oh, for God's sake, in our time we had to soldier on, so suck it up princesses', type of thing. I will gently push back with that and say that that is part of the stigma at work too, in the past, of just suffering in silence. And I sort of understand where older women are coming from that they had suffer in silence and why should anybody now be coming along saying - what was good for her should be changed. The backlash coming from older women is something that can be explained, understood and respected, but it's not an argument for not changing things now.

CHAIR - The point you wanted to come back to on the impact on Aboriginal women - can you talk more broadly about intersectionality, including Aboriginal women. I think it's a broader issue and would like to hear your thoughts in this area.

Ms CROOKS - Yes. We wanted to raise the question because we didn't make it a big focus in our submission. Intersectionality is a pretty awkward, clunky term, but we have tried to demystify it wherever we can. It is really to try and convey the notion of compounded

disadvantage. For example, if, in our world - whether it's in Melbourne or in Hobart - there is a woman presenting to, say, a male doctor about being depressed and worried about things, if that woman is indigenous, Vietnamese or less educated formally, or if she has a disability of sorts - it may be a mild intellectual disability or whatever - then she is much more likely to experience a more fraught outcome, because of the overlapping of all of those layers of disadvantage all at work at the same time.

I saw a coded reference to this recently with Tanya Hosch who is in the AFL and recently had a leg amputated because she is diabetic. She made a speech in Elizabeth in August just after she had come out of hospital and referred to the fact she realised in her medical treatment over the last couple of years she was experiencing aspects of that treatment that were worse because of her indigeneity. That is probably a gentle coded reference to the fact if you are an Aboriginal woman presenting in a hospital in Melbourne today chances are, sadly, through a whole lot of ingrained, barely noticeable ways, she would be treated attitudinally differently from a more polished, articulate non-indigenous woman presenting in the same hospital that day - that notion of deeply ingrained prejudice.

I have said for a long time, we are all fuelled with prejudices but the trick is to dredge them out and deal with them. This kind of casual racism or casual gender bias is there to be unearthed and dealt with, but intersectionality is critical. We have to find really smart ways of conveying more nuanced way in which disadvantage becomes compounded because of those overlapping views.

CHAIR - We're just about out of time, Mary. Are there any pressing questions?

Is there anything you wish you had said you haven't - some little gem you'd like to impart to the committee?

Ms LEE - Yes; with the indigenous women's health, I'm partly doing a research project on it at the moment. It is really important to investigate that further, especially Aboriginal community-controlled health organisations. They have a lot of information and resources about these issues and the way indigenous people generally - especially indigenous women - face further barriers in receiving health care, especially on stereotypes that may result in them being turned away because of different perceptions of them. It is important that is investigated further and specifically looked into, reaching out to indigenous organisations that specialise in that.

Ms CROOKS - Being prepared to invest in the knowledge, wisdom of indigenous communities and indigenous leadership in health services to engage with their own people on their own terms.

The example of COVID-19 has been stunning to me. Like you, I suspect when COVID-19 hit and when it looked like a threat to rip through remote communities, I felt very fearful. It is only through my friendship with Fiona Stanley in the last year that I have come to understand the reason Indigenous Australians did not suffer deaths and did not suffer high hospitalisations at all is because governments were prepared to invest the communications challenge and the vaccine response to indigenous leadership. They knew how to deal with their people on these messages and how to set them up to stay safe and secure.

That follows on from Eleanor's point that instead of treating indigenous people or migrant women or women who might be unemployed or might be victims of abuse that we have to try and exercise the deep listening and the wisdom and work with the agencies who are best placed to produce good outcomes with people who are behind the eight ball.

CHAIR - Hearing the lived experience of those and applying the learnings from that; we previously heard from our state Government, the minister and senior officials from the Department of Health. The words are there; we need to see the action that sits behind that to see it change.

Ms CROOKS - One of my favourite sayings is that listening is an attitude, not a methodology.

CHAIR - That's good. Thank you so much, both of you, for your time and the submission and the work you are doing in this area. I feel very grateful you have chosen to engage with this committee. We are the only stand-alone Gender and Equality Committee in the nation and we are pretty proud of that. We appreciate your input into that and the expertise you are bringing. Thank you very much for your time.

Ms CROOKS - It was great to have the opportunity and we thank you for giving us the opportunity. Good luck in your deliberations.

THE WITNESSES WITHDREW.