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THE PARLIAMENTARY JOINT SESSIONAL COMMITTEE ON GENDER AND EQUALITY MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON MONDAY, 16 OCTOBER 2023

TASMANIAN EXPERIENCES OF GENDERED BIAS IN HEALTH CARE

PROFESSOR SUE MATTHEWS, ROYAL WOMEN'S HOSPITAL, MELBOURNE WAS CALLED AND EXAMINED VIA WebEx.

CHAIR - Welcome, Sue, to this hearing for the Gender & Equality Committee into gendered bias in healthcare. Thank you also for the submission on behalf of Royal Women's. We appreciate that. Everything you say is covered by parliamentary privilege while you appear in front of the committee, but that may not extend beyond the committee. Do you have any questions about anything to do with that?

Prof. MATTHEWS - No, I am fine, thank you.

CHAIR - Also, the committee is being broadcast and the hearing will be transcribed so that it will be made part of our public record and inform our report. If you would like to introduce yourself, and then speak to your submission further if you would like to add anything or clarify any points in it. Then the committee members will have questions. Thank you.

Prof. MATTHEWS - I am Sue Matthews and I am the Chief Executive of the Royal Women's Hospital in Melbourne. We are the largest women's hospital in Victoria and we focus on the health of women and newborns so we put the submission in on that regard. I know that this committee is focused on the experiences of people living in Tasmania but I hope that I can offer some insights based on our experiences in Victoria. I note that others have spoken eloquently about the impacts of sex and gender discrimination on the LGBTIQ+ community. While I think there are very important considerations and I urge you to include them, I am going to try to be succinct, so I am going to focus on access inequities that impact women and the ways in which our hospital has attempted to address some of them.

I will also use the term 'women', but also what I am saying applies to people assigned female at birth. For many reasons, women are disproportionally advantaged or disadvantaged. They struggle to have their health issues recognised as legitimate. Their health issues are often stigmatised and kept in secret. Despite all the scientific progress of the last century, women still face discrimination in every aspect of healthcare, whether consciously or unconsciously, from clinical trials to diagnosis and through to care management.

Women have a complex and wonderful biology which means we frequently interact with the health system and are at risk for specific health issues, complications and conditions that only affect females. Many of these have been over medicalised, under-researched, misunderstood and sometimes trivialised and ignored. I am thinking about natural life course events that happen only to women and persons born with a uterus such as menstruation, pregnancy and childbirth, endometriosis, et cetera. Then there are ways in which our sex impacts the presentation and outcomes of non-gendered health conditions, such as stroke, heart disease and dementia.

It stands to reason that women have specific and specialised healthcare needs and I stress this because many people argue that this is not the case. Living in a wealthy country like Australia, all women and girls have a right to expect access to high quality, timely and appropriate healthcare throughout their lifetime. However, many experience family violence, sexual assault and incest; they have high rates of complex mental health issues; many are homeless; suffered economic disadvantage; and are unemployed or underemployed. For these and other reasons, women struggle to access specialised medical care and treatment that is affordable, that supports their health and wellbeing across their lifespan, that takes into account their specific life situation and health needs and that is effective, evidence-based and compassionate.

At the Women's Hospital, we still have a lot of work to do to address sex and gender bias, but we have a number of initiatives that we believe are helping. These include but are not limited to:

- Improving access to abortion and contraception services by providing expanded surgical abortion services at our own hospital, specifically for pregnant people experiencing very complex challenges and disadvantage.
- Working with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to develop and deliver advanced abortion training for gynaecologists and obstetricians.
- Delivering our state-wide Clinical Champions Program that trains nurses, doctors and other health professionals working in primary care and public hospitals to deliver early medical abortion and contraception care in rural and regional areas.

We are providing pregnant women living with physical and intellectual disability with specialist midwifery, antenatal care, postnatal care and social work support through our Australian - the only one - Women with Individual Needs Clinic. We provide menopause clinics virtually, to allow rural and regional women to access them without travelling to Melbourne. We are advocating to address the inherent bias in the way that the Pharmaceutical Benefits Scheme and the Therapeutic Goods Administration create access barriers to some women-specific medications and devices to ensure that more Victorian public hospitals provide surgical abortion services; to increased research and funding for menopause services to support women to continue to live active and fulfilling lives as they age; to expand dedicated women's health services across the state and to increase research in women's health, and in the sex-specific impacts on diseases and ill health.

CHAIR - Thank you very much. I will just introduce the members of the committee to Sue, I forgot to do that. I am Ruth Forrest, the chair. We also have Dean Young, Josh Willie, Dean Harriss, and Kristie Johnston is on screen there. A couple more members will be joining us, but have just been held up. They will come in at some point.

I have a background as a nurse and midwife, so I come with a degree of knowledge. To pick up on the points you made on over-medicalisation, I would like you to expand on that a bit: how it has occurred historically, perhaps, but also currently; what that means; and how you see that can be addressed. I saw it in my practice all the time.

Prof. MATTHEWS - The first thing is we have a preoccupation with acute care in health. We were built around hospitals; and while I am the CEO of an acute care hospital, there are so many things that can be done in primary care and need to be shifted to that. For example, abortion services. In Australia we have a high proportion of abortion services provided in hospitals, much higher than others. America and Canada in particular have higher rates of medical abortion done at home with supports, with your GP, with someone who knows you; as opposed to needing to have a surgical abortion by waiting longer. That is an example of medicalising it. You can probably talk a lot about how birth has been medicalised. Healthcare was founded around the military and that makes it very rigid. Hospitals in particular were designed around medical staff, so we run clinics around times the doctors are available or the nurses are available, not necessarily at the time the person is available who wants to have that care and treatment and how they want to have it. It has become a very medicalised process.

Healthcare professionals are educated to believe they are the experts. I would say we are shifting that. Medical and healthcare professionals have expertise and they should share that expertise with the patient and person and family, but it is the person who has the expertise in their own life and they know the impact. I cannot tell you the number of times I hear from mothers who say their child was ill, they took them to see the doctor, and the doctor did not believe them. I guarantee you, when a mum says her child is ill, her child is ill in some way, shape, or form. It is not unlike a woman with endometriosis, which takes up to an average of seven years to be diagnosed. That woman knows what she is going through is not normal. In fact we have normalised it, because those women are told, 'Oh you know, it's just painful periods, it's just part of puberty, you're just growing up and you'll be fine, it's just the way that things are', as opposed to really listening to and hearing those individuals about their experience of pain, of whatever it is that they are going through. We have to believe them and we have to care for them in a different way.

CHAIR - We have some evidence received on obstetric violence and the incidence of that. Again, it comes back to that over-medicalisation of birth in some situations; probably quite a lot in some areas. From a women's health perspective, and particularly being the largest birthing unit in Melbourne - are you or?

Prof. MATTHEWS - The largest women's hospital. We share the largest with Monash Health.

CHAIR - Sure, so, how do you see putting women more at the centre of the decision-making on their whole childbirth experience and moving away from that very medicalised model that, sadly, we still see?

Prof. MATTHEWS - We have a program called the COSMOS program. We have done a fair amount of research into that, which is an individual midwife assigned to a woman. That midwife cares for that woman throughout their birthing process, their whole antenatal period, the birth and postnatal period. We know that provides better outcomes, there are less complications, less caesarean sections and much higher satisfaction for women. We would advocate that model be everywhere, as much as possible. There are high-risk women that it might not be appropriate for. We are running a program now to trial it with higher-risk women so we can do some research and understand when and how we bring in an obstetrician into that model. It is absolutely the number one best outcome model and number one best patient satisfaction model.

CHAIR - On the comments on the high-risk women situation, one could argue high-risk women need continuity of care and a known carer possibly more than the low-risk women. Do you want to comment on that?

Prof. MATTHEWS - That is one of the things we are researching, to show that is probably the case. There will be times when it is outside the scope of practice of a midwife or a nurse or whatever that is, but the continuity of carer is absolutely critical. Most of the time, that would be with the midwife. The higher-risk depends on what they are higher-risk for. If they are higher-risk because they are experiencing family violence or because they are from culturally, linguistically diverse population, or lower socio-economic, et cetera - absolutely, the midwifery model would be clear. We believe it will be clear that would be better. If it is something genetic or clinical, such as women with disabilities who may have a structural difficulty within their body and they would need an obstetrician to care for that structural deficit.

CHAIR - Yes. Are you able to send us some information about the COSMOS program? That would be great. You can send it through the committee secretary.

How do you consider reducing the risk of obstetric violence? There is less satisfaction from a woman and her family in the birthing process. Is that the key to it all or do you think there are other things also?

Prof. MATTHEWS - And by obstetric violence, are you thinking about obstetrical trauma?

CHAIR - Yes, it is called obstetric violence in some of the submissions we have, but obstetric trauma could be the same sort of experience, yes.

Prof. MATTHEWS - Yes. A midwife will have less episiotomies, less perineal tears; those are things that would be considered obstetrical trauma and traumatic deliveries, et cetera. But there is also the side of that psychosocial support those women might need. It depends on what their background is. I think the difference is that, when you have an individual carer, you can focus on the journey, not the event. When you come into an event as it is happening - a woman is in labour and you come in - you do not have that whole picture of all those things, the intersectionality, of all the things impacting their birth experience. The trauma is both physical and sometimes psychological.

We have just implemented midwives who do trauma debriefs with the women who have had a difficult or traumatic birth of some sort or an experience that could be seen as traumatic. It is very new, just a few months old, but we're seeing great satisfaction from those women that they're able to debrief, have those conversations, ask the questions about what happened, why did that happen, et cetera. That's obviously a post-event, but the pre-event is having those midwives who have much better outcomes in that regard.

CHAIR - When does that particular counselling occur? Is that within the first couple of days?

Prof. MATTHEWS - It's up to the woman. The midwife will approach them and ask them; but sometimes they will want to wait to have that debrief and sometimes they want to do it right away.

CHAIR - Sure. I'll just go to other members in case there's other questions. Rosalie Woodruff has just arrived.

Dr WOODRUFF - Sorry I missed the start of this, Sue. Very nice to meet you and hear what you're doing. You mentioned before about the patient-centered model - in this case, the woman-centered model - for birth and also for all care. This is not news. It has been something that has been going in - particularly in delivery - since the 1500s when the medical guilds formed and took that away from women who were always midwives. I'm wondering what you think today, in 2023 Melbourne and Tasmania, are the impediments to taking an approach that all the research has continued to show repeatedly is better for mother outcomes, better for baby outcomes, better for family outcomes, better for father and child development outcomes and better for social cost outcomes. Why is it still not happening?

Prof. MATTHEWS - It's a big question. I think it is in the over 100 years of a system that was designed around healthcare professionals, not around - for me, it's women and babies - but really the system is designed to make us less patient-centred. It is really hard to undo those many decades of design that have to be changed. We have to change the education system for anyone who's going into healthcare to learn about the differences and why it should be different. We have to provide care and services that are not popular for healthcare professionals.

I'll give you an example. Not that long ago, I was in our fertility area - we provide fertility services for women - and I was talking to one of our women and said, 'How has your care been?' et cetera and she said:

> It's great - but one of the things that is a challenge is all of the care is provided between 8 a.m. and 6 p.m. You ring me during the day to ask about something that's very personal and private, and I may be in a meeting or I may be somewhere that I can't have that conversation and so I say, 'I have to ring you back', because I have to find a time when I can have a conversation that's more personal and private. And then when I ring you back, it's either after hours and nobody's available; or when I ring you back, the person who rang me that needed to talk to me is in with another patient.

So, we've designed the system around us, not around them. Hospitals, primary care providers, healthcare in general, need to shift that whole system; and the reason it hasn't happened is because it's easier for healthcare professionals.

Dr WOODRUFF - Right. Okay. That's in terms of the prenatal and postnatal care space, isn't it? What about in the hospital space; is that still about colleges and the timeframe of colleges - like the College of Obstetricians and Gynaecologists, I don't know what it's called but that's the college, I think. Is that about their timelines for when they come around and they do visits and they go through hospitals? Is that something that is a problem or is that adjusted over time?

Prof. MATTHEWS - Look, I don't know that it's the colleges. I think it's that we see people based on the time that is appropriate for that individual medical profession, et cetera. We set up our clinics to make better use of time. But if I said to an obstetrician, 'I now need you to do your rounds every day at whatever time - 7 a.m. or 8 p.m. - they may choose to not

do that. And in Australia, where we have a public and a private system, many of them work in private and as well as public. And in private, it's within your parameters - you drive when you see people and when you don't. In a public hospital that's much more difficult. It is something that we need to talk about. At the Women's, we have a program that's called Creating Exceptional Experiences. It's a program that healthcare professionals and others who work in the hospital go through to remind them why they went into health care. We go into health care not because of the rigid, strict time commitments, et cetera; we go into health care to make a difference. I'm a nurse by background, so we go into health care to make a difference in people's lives; and our program reminds them of that and reminds them of the impact that what they are doing has an impact on our women.

One example is in the first week of that, everyone reaches into a basket and they pull out a piece of paper and on that piece of paper is a patient experience that they have to do themselves, to understand and feel what it is like to be a patient. I remember our Chief Financial Officer pulled one out where he had to go into one of our clinic rooms and ask them to put him into stirrups for 20 minutes. That was one of the experiences and it absolutely changes -

Ms O'BYRNE - Why are none of the men laughing?

Prof. MATTHEWS - Exactly.

CHAIR - He probably was allowed to leave his clothes on though, wasn't he? I bet.

Prof. MATTHEWS - Yes, he was. Anyone could have drawn that piece of paper randomly, because we have about 20 different scenarios. They go into our emergency departments and they listen to all the noises, and what can they hear about other patients; is it private enough, and do they hear things that they shouldn't have been able to hear. Getting from the car park to one of our clinics that isn't well signed - and how do you get to it if you don't know where it is? Those are the sorts of things. It's a program that runs for six weeks and people do different experiences and they have conversations about the impact. We have videotaped and recorded some of our patients and they've shared their experiences. Some of them are phenomenal, exceptional experiences and some of them are not as great; and people say, 'Gee, I didn't realise that that was something that might happen in our hospital, because we're the Royal Women's Hospital. We're supposed to be wonderful and great and fabulous'. As CEO, I would love to think that 100 per cent of people have an exceptional experience, but there's always room for improvements and learning. Reminding people why we went into it has really created the environment where that is much better, I think.

Dr WOODRUFF - That's interesting.

CHAIR - Just on that, if I might, Rosalie - all the staff are invited to that, obviously, even the Chief Financial Officer; so everyone gets to understand the patient experience?

Prof. MATTHEWS - Correct, yes. What I always say is - if you are not supporting a patient, you're supporting someone who is. All of our staff understand the ethos of the Women's and the vision for us as caring for very disadvantaged women in particular. But, they recognise their role is as important as anyone who is providing direct patient care.

Dr WOODRUFF - Thanks, Sue. I have another question and it's in your recommended actions in relation to abortion and contraception. You suggest that state governments work with federal governments to establish a national approach to collecting, monitoring and analysing abortion data across public and private providers. I think that's a great idea. I didn't realise that there wasn't any collection of statistics but now that you say it, it's very obvious that wouldn't be the case.

Do you know whether any progress is happening in that area? Is it something that you have spoken to your Victorian minister about? Is there something that Tasmania can or could be doing in that space?

Prof MATTHEWS - Yes, I've spoken at a number of tables. I am on both the National Women's Health Advisory Council and the Victorian Women's Health Advisory Council, so I raise it at every opportunity where it's appropriate.

South Australia is the only state right now that captures this kind of data in any meaningful way. We're working on it in Victoria so, again, trying to advocate at every turn. There's 88 000, we think, abortions in Australia every year. Where are they done? Who's doing them? What are they done for?

So, an example is terminations for medical reasons are not differentiated. We think about 4 per cent of terminations are done for medical reasons, meaning that infant/foetus would not be able to survive either to term or would not survive more than a day or two after that they were born. The earlier we find those things out the easier it is - although, easy is not the right term - but for a woman and her family to make a decision about terminating earlier so that they do not have to go through a full pregnancy and delivery sometimes of an infant that they know will not survive. We do not have that data. We have a good estimate of those things but we really need to have it. I would suggest, what could Tasmania do? Do it yourselves, in Tasmania. Every state should be doing it themselves, but also having those conversations at the national level.

Dr WOODRUFF - Would you be able to recommend or provide some information to the committee about what you think a minimum dataset would look like?

Prof. MATTHEWS - I will take that on notice. We probably can, yes.

Dr WOODRUFF - You just rattled off a list of things; I wonder if you have developed a list of 'asks', if you like, of things that you want to have information about. It sounds like you have expertise that would be very valuable. We asked the Minister for Health some questions about this recently but you are probably more informed than we were in what we were asking.

Prof. MATTHEWS - We will send something along.

Dr WOODRUFF - Thank you.

CHAIR - We will write to you, Sue, to confirm that as well.

Ms O'BYRNE - With the data collection, when we did the decriminalisation bill here - because terminations were included in the Criminal Code then - not collecting data was seen

as a protective measurement for hospitals and doctors. Is the failure to do it a hangover from that? Is there any other justification that you ever hear?

Prof. MATTHEWS - That is often the justification. As we get to more and more electronic health records, we have a screen that protects the privacy of women, whether they are experiencing family violence, whether they are experiencing termination of pregnancy, all kinds of things. I think that is helping but there is also resistance because it is going to cost dollars. It is going to create challenges to report, yet again, something else. There is a lot of reporting in health care, as I am sure you are aware. It is often one of those things that people say is just an additional thing to report. It is a critical additional thing to report.

Ms O'BYRNE - That would be the same for laparoscopies for endometriosis. They are listed broadly as laparoscopies, so it is impossible to determine the number when we are tracking whether or not women are accessing appropriate care.

My next question was about endometriosis, because as I walked in the room - and I apologise for my delay - you were talking about that lack of diagnosis. But, one of the main concerns that we get from women is not only are they presenting to their GP and do not get a diagnosis but they present to their hospital and they are sent home with minor pain relief or quite dismissive behaviours. I am wondering whether or not Victoria has a different set of data for that, given the work that the Royal Women's has done.

Correct me if I am wrong, but to get to the Royal Women's emergency you have to have been referred for an identified gynaecological issue or can any women walk in? How does that work? How does that then play out in the experience women have in emergency departments across Victoria?

Prof. MATTHEWS - Our hospital has an emergency department, an emergency centre, but we care for sexual and reproductive health concerns for women, whether it is gynaecological et cetera. Women know to come here for those things if they choose. We have a catchment area that we provide the general care and then we do care for a number of high risk and tertiary cautionary issues. Women will come here and an ambulance would come here but an ambulance would not bring a woman here who broke her leg or who is having a heart attack. They would go next door to Royal Melbourne Hospital. We have a partnership with Royal Melbourne Hospital where, if there is a woman who is in a car accident and pregnant, we send staff over there to care for pregnancy related issues. And vice versa - they would send someone over here if we have a pregnant woman who needed care for something else that they can provide care for here. We have a great partnership.

If a woman goes to Royal Melbourne Hospital who has a gynaecological issue, our gynaecologist will go there and care for them in their emergency department and sometimes they would then come and be admitted here if they needed to be admitted.

Ms O'BYRNE - Men who present with acute abdominal pain are often referred immediately for tests. If a woman presents with acute abdominal pain they are sent home. Would they make it to you? What is the difference in the experience that they would have? I imagine that the Melbourne ED must have a greater understanding now. Are we seeing a better level of treatment of women presenting in a hospital that has a more informed response, or are we seeing the same kind of emergency department experience?

Prof. MATTHEWS - Between Melbourne Health and ourselves, we have a really strong partnership and a greater experience for those women, but if you go to another emergency department you may not have the same. We are educating other hospitals as best we can for other things and to primary care as well, but we just do not have the funds and resources to do it across the state. We do have resources to train healthcare professionals to do medical abortion and contraception throughout the state, but for endometriosis we are not there yet.

Ms O'BYRNE - Would you be a supporter of mandatory training for those sorts of things? What is your view on that?

Prof. MATTHEWS - Yes. Part of the challenge is normal women's health issues need to be normalised. They need to be seen as part of a healthcare professional's education and training as opposed to a special thing that they go to on endometriosis et cetera. Once people have been educated and come out and work in the real world, it is a challenge to get to them after they have had all that education. I would love to see something that is mandatory particularly for primary care professionals and those who work in emergency departments. Those who work in women's health get this, but it is those who are not specialists in women's health who need to have the education and training.

Ms O'BYRNE - I have a question on terminations, Chair, if that is okay? One of the things that your paper talks about are the barriers, other than cost, to accessing medical terminations. It talks about the increase in the time. Speaking to Family Planning here, one of their concerns is that offering women a choice between a surgical termination where you are sedated and you are in a caring environment and everything is supported and structured and pain free versus a hit-and-miss relationship with your pharmacist and then a day at home, which may be quite traumatic, that they are opting for surgical terminations which is probably not preferable.

Do you have a view on whether or not hospitals should provide an outpatient service for medical terminations, to provide a level of support for women that does not require them to take that step of having surgery? Is that something that you looked at or have any view on?

Prof. MATTHEWS - We have proposed a national research and training centre for contraception and abortion services and that would be able to educate across the country for primary care professionals as the first and foremost provider of medical abortion. Now that nurse practitioners will be able to do it, that is something we have been advocating for and that was announced recently. We will also be advocating that they are purposely trained to do that.

Having it afterwards again is a challenge. I do not know that an acute care service is the right place, at the right cost, to be providing this education and support for women. We believe we should have a phone-a-friend line where we would be able to help a general practitioner or a nurse practitioner who might be challenged in how to support a woman to go through this at home, even how to present the option to her, because the option is much preferred for women overall. The research has shown that. Once they understand it and they understand the experience that they will go through, but their general practitioner and now nurse practitioner need to have the skills and training to be able to support them to do that.

Ms O'BYRNE - Actually, our Family Planning Service has a couple of conscientious objectors working in it, which makes it challenging. My only other thing then was about the

provision of contraception in hospitals- implants, intra-uterine devices. That is something that states can determine as an obligation or is it the responsibility of the health services?

Prof. MATTHEWS - Again, I think it would be, it is general women's health. It is not something that we need to be demanding and saying, 'You must do this'. I had a conversation with an unnamed CEO in Victoria who said, 'We have never been told we have to do abortion'. My response was, 'Have you been told specifically you have to do total hip replacements?'. So, why do we have to specifically tell people that they have to in organisations? We may have to go through that, in order to transition to 'it is just general health and wellbeing for women'. That is one of our biggest challenges, when a major hospital CEO says, 'Well, I've never been told'.

Ms O'BYRNE - What they have never been told is probably quite large.

Mr WILLIE - Thanks, Sue. Tasmania is a very decentralised state and healthcare in rural and regional areas is a real challenge in Tasmania, let alone unbiased care. You have spoken about less medicalising and putting things back into primary care and training. You also mentioned in your opening statement a virtual menopause clinic. What practical steps is your system over there is doing to produce equity across the system, particularly in rural and regional areas?

Prof. MATTHEWS - A couple of things. We have a program called the Clinical Champions Program, where we provide education and support to rural and regional facilities and general practitioners, on medical abortion, contraception et cetera. We have a roadshow. It stalled during COVID-19 as we did it virtually, but we have a program that supports them and is partly - because it is getting bigger - 'phone a friend' if you have a challenge. We think we will have to slow down a bit because we are getting more calls than we can handle. The other program which is not at the Women's is called 1800 My Options. That is a phone service where women can ring up to find out where their closest practitioner is to provide abortion termination services and contraception services. They can also tell them where the next closest one is, because often they do not want to go to the closest one because they are known to the person; they do not have a confidence level that someone will not see them going into the office et cetera. There is that program - 1800 My Option -, which is run by Women's Health Victoria.

Mr WILLIE - Very good. Are you experiencing similar challenges as we are in Tasmania, in terms of rural and regional healthcare? We are having centres close and all sorts of things here.

Prof. MATTHEWS - It is a challenge, and a lack of GPs is becoming more and more of a challenge than it had been. Nurse practitioners are an area that, in particular Australia had, coming from Canada many years ago, but Australia does not use nurse practitioners anywhere near the amount that other jurisdictions do. It is something that should really be looked at, because those are people who live and work in that community.

Mr WILLIE - Will that help free people up to do training and things like that? I can imagine in these sorts of locations it is difficult to get time to go and do training.

Prof. MATTHEWS - Which is why our program goes to them, because then they do not have to come to Melbourne. It takes a couple of days out of their time at least, for some of them, and that is just not acceptable. For many of them, because they may be the only provider,

it means them being away for two days. If we are doing a four-hour program and we go to them, it means we take them for four hours as opposed to two or three days away from patient care. That is important we are able to do it where they are, not everybody coming to Melbourne. I would guess that Hobart or Launceston would probably be too far and take time away instead of having people go to them, for sure.

We have also learned, through COVID-19, to do things virtually. Prior to that, we had to be face-to-face. We trialled a program called the Maternity Services Education Program, again, where we go out to rural and regional hospitals and provide education to them. Sometimes on obstetric emergencies, for example, but sometimes it is on teamwork and how to build a team together. We take actors with us, we take video equipment to record and then we show them and we talk to them about how we could have done that differently. Those are things that need to be face-to-face, but over COVID-19 we did some of it virtually. There is some that can be done and some you have to do face-to-face.

CHAIR - Tasmania is a small state with obviously limited capacity, health professional numbers and everything. Does the Royal Women's have the capacity to have those services purchased to assist Tasmania? If the Government is willing to fund it, whether there is that option?

Prof. MATTHEWS - If it were funded appropriately we could scale it up. We have people here who are training others to come up as well so that we've got more than one or two people to do it and as we see, that's why we presented the option of a national training and research centre. But yes, we do have that capacity and certainly could build it if we needed to.

Mr WILLIE - Is it expensive to operate that kind of model?

Prof. MATTHEWS - We don't just do it at a profit. We provide the care and that education and support is at cost with a slight overarching fee for human resources and things that we have to provide as well. The more staff we have the more payroll and jobs that we have to do so I don't know the cost for the whole state of Tasmania. I would have to understand more about the state and what the needs would be.

Mr YOUNG - You've spoken about changing the model to be more patient-focused. In that case, how have you dealt with issues involving staffing, training, reallocating resources, productivity? How much resistance to that change have you found yourself and how have you dealt with it?

Prof. MATTHEWS - That's a big question. Once they've taken the Creating Exceptional Experiences course, the resistance goes down significantly because they recognise and acknowledge again, they went into health care to make a difference - and reminding them how they are making a difference is really helpful. To look at it as a big picture, there will always be people who don't meet those values that we have as women, but we're very good at encouraging them to work in another organisation. We're pretty good at that.

There are some very difficult situations and very difficult decisions we've had to make, or they've had to make, but that's okay, because that allows us and ensures that we keep that culture, and are we perfect? Absolutely not, I will be the first one to put up my hand and say we're not. But, I believe, and our patient satisfaction results and staff satisfaction results, our

'Are staff safe to speak up??' are quite strong. We look to those to make sure that we're hitting the mark with them.

Yes, it costs to take them away and give them education because somebody's backfilling their time, potentially - depending on what the education is; but we firmly believe that that is well spent because it does lead to less turnover, higher satisfaction. The research shows that for one nurse in a hospital to turnover, costs $40 000. If I can save five nurses from turning over in a year that saves me the money. It's difficult to pinpoint and say that was exactly the saving but because of it, because you don't always know that people are staying because of certain things, but we get anecdotal evidence that shows that they stay because they are given those supports to do education and training. They're given support to speak up when they want to speak up and say something is not right, or doesn't feel right. Those are tough conversations and we are giving people the skills to do that and the empowerment to do that.

Mr YOUNG - That's something that has to be led from the very top.

Prof. MATTHEWS - Definitely, but it also speaks to the board having the values of this. They understand the ethos. They're very clear that sometimes you have to spend money to save money and sometimes it's cost avoidance rather than saving money. You have to have a board that understands that, because hospitals are very challenging, difficult to understand, complex organisations, particularly healthcare finances. They are very difficult; but again, they see that and we're very clear in sharing with them our thoughts.

I also think it's not only led from the top; it's led from all levels of the organisation. Just last week, I had a volunteer who said to me, 'We want to have this in our NICU and I was wondering could we look at that?' My answer was, absolutely let's look at it. It is led from them not from me, because I did not know it was an issue or a concern for the volunteers, but they equally lead those things and bring forward patient care ideas and examples.

We have a program here called the Ideas Tank. It is a bit like Shark Tank. We have funds from a bank and funds from super and different pots of money, and our staff present options and ideas for things that would improve patient experience and/or improve staff experience. Once a year we allocate those funds. We have a group that look at them, then come and present to us and share their thoughts. That empowers them to know their ideas are heard and are really important to us.

CHAIR - You talked earlier about research and women not being included in research and we have heard that also from other witnesses. On page seven of your submission, that final dot point before your recommended action, you talk about systemic failure to include pregnant women in therapeutic clinical trials. This has always been a very difficult, ethical balance. If we do not do it, we are missing out on a whole body of research that could be really beneficial to women and their babies. Can you talk a little bit about how you see that particular research for women who are pregnant being included?

Prof MATTHEWS - I look at it as: if not, why not? There is an ethical issue in not including them, in that they could potentially have things that could help them and/or their baby and we would not find them. The COVID-19 vaccine is a really good example of that, where, initially pregnant women were excluded. We found before that pregnant women had severe outcomes from COVID-19 and had huge issues and challenges, once they were able to get the

vaccine and included in that trial, those went down. Women were saved, babies were saved because they were able to participate in that research.

However, there is a confidence for them to be able to consent to doing that. They need to understand the risks and benefits and potentials. It is their choice; it should not be my choice. If I know that is going to cause harm to the woman or the baby, that is a different thing and it is unethical, but if the woman is given the choice, it is their choice, it is not ours to automatically disregard them and say they should not be included. They should be given the option, it is unethical to not give it to them.

CHAIR - Like any other person, then. If I want to sign up to a research project that UTAS might be running, that is my choice. If I was a pregnant woman wanting and was given the opportunity, it becomes my choice.

Prof MATTHEWS - Correct.

CHAIR - Why are we not seeing that approach being taken, rather than this most blanket exclusion?

Prof MATTHEWS - Women are excluded and have been excluded forever. It was just in the last two decades that women themselves have been included, let alone pregnant women. I think it became that we have to exclude them because they are complicated; because they have hormonal swings; they get periods. What we finally come to is that is why they need to be included. Rather than excluding them, we need to include them, so we understand the differences. It is the same with pregnant women. I will use an example - not of pregnant women.

There was a sleeping pill in America that was tested on men and given to women. What they found is that women were having car accidents at a much greater rate the following day. When they finally looked into it, they found that women metabolised that sleeping pill in a different way and they still had more in their system in the morning and were having car accidents because they were sleepy at the wheel. They were never included in those trials. It was just an assumption - women were smaller than men and that based on their weight they were given the same dosage a man might be given.

Because women's biology is different - whether it is the hormonal biology or just our biology, then that is the difference and needs to be studied and understood that way. Pregnant women are no different because they will have, again, different biology that is happening at the time of their pregnancy. They need to be included in trials and given the choice.

CHAIR - You touched on the normalising of normal women's experiences like menstruation, menopause and childbirth. We've done a lot on the childbirth side of things. In terms of menstruation and menopause, what are your views about the most important aspects of normalising both of those and how we make that the modus operandi, if you like?

Prof. MATTHEWS - It starts in medical schools. I'm not going to change a 60 or 70-year-old healthcare professional's understanding of it, necessarily; not that I can't change any of them. But the focus should be on the medical and nursing schools and midwifery schools because that's the future of where we're going. Right now - and I don't know the specific data

- but if you talk to someone in the medical schools they tell you they get one hour of menopause, or a day of women's health.

It needs to be something that is focussed throughout. It needs to be differentiated when they talk about anything. So, when you have your session on cardiac care then you should be talking about, 'And here's how women present differently than men', because they have very different experiences. They are less likely to be admitted to intensive care and more likely to die of a heart attack because the way they present is different. The expectations of women's pain and their ability to tolerate pain is different than men's. All of those things, if you do them in the schools, will set us up to move forward. And then we focus on those that are in the system. Regardless of the stage in their career, you need them to understand it.

One of the things we haven't done and we've been advocating a lot - the evidence is there for example in cardiac care, the evidence is very clear, and we need to understand why it hasn't been taken up to the extent that it needs to be, and what is the barrier to that. We've advocated for research into that area and we're looking at a business case for a Women's Health Research Institute in Victoria right now, and it's one of the things we are putting forward in that for sure.

CHAIR - The Women's Health Institute, is that a standalone?

Prof. MATTHEWS - We don't know yet; we're doing the business case, so we're working with Government on it.

CHAIR - I see - you're trying to establish the Women's Health Institute.

Prof. MATTHEWS - Correct.

Ms O'BYRNE - May I ask where the funding from that would come from? Internally, state or federal?

CHAIR - Anyone who would give you money!

Prof. MATTHEWS - The state has announced that they've given us the funding to do the business case. We're working with them on developing that, and then the question will be how will it be funded ongoing. I would assume the business case would go to the state government but obviously we would be looking to national; and, like you say, anyone who would give us money for it. We have a very keen philanthropist who is interested as well, and we'll be working with them, and our university partners.

The way we're looking at it is that it's an ecosystem of research; so, it wouldn't all be done at the research institute. There are lots of people doing research in women's health that wouldn't necessarily be housed in it, but we would be partnering with them and how would we support them and provide an eco-system that would be beneficial to everyone.

CHAIR - Who are your university partners that you're working with currently?

Prof. MATTHEWS - Currently the University of Melbourne and LaTrobe University.

CHAIR - What you were talking about when you said the training and education of all health professionals - and it should be all health professionals because they all deal with

everybody - it's basically by putting a gendered lens across every aspect of the training and education. If they are able to implement that, is that what we're talking about here? Am I right?

Prof. MATTHEWS - Yes, definitely; and understanding the differences through every aspect so that gendered lens of sex and gender, we understand that the sex is the biological piece of that and how does that differ. The other piece that we need to think about more is the intersectionality, and how are things beyond sex, including gender and other things, how do they impact women differently than men. Poverty impacts women differently than men. There's all kinds of things - homelessness, those sorts of things.

CHAIR - Any other questions?

Ms O'BYRNE - Yes, I was thinking that the research institute, whether or not anyone else is doing anything in Australia. Is there any other research of women's health? Not at all? Because Melbourne was the first one with a women's hospital as well, which is an amazing story in itself.

Prof. MATTHEWS - Correct.

Ms O'BYRNE - It would be great to see you having the first research facility, too.

CHAIR - We are just about out of time anyway. Is there anything you would like to leave us with that you perhaps have not mentioned, or something like, 'I meant to say that and I haven't'?

Prof. MATTHEWS - I don't think so. I think it's about shifting from being the experts to having expertise, and understanding that it is the woman's choice in everything. But, it's also about making sure that we thread that education, gender, sex and gendered lens throughout all of the education and everything that we do.

CHAIR - Great. Thank you. That's a very good summary of the whole lot, really. We do appreciate you taking the time out to not only prepare the submission but also to speak to us. We appreciate that it's a busy place that you are running there, and a very important facility. It's good to hear from some of the bigger facilities to understand what is perhaps possible when you have a greater capacity. Tasmania, being a small state, needs to look to how do we perhaps link in to some of those things rather than try and be all things to all people and share some of those resources. Thank you for your time.

Prof. MATTHEWS - It's all part of our capacity-building, so thank you. We appreciate it.

CHAIR - Thank you.

THE WITNESS WITHDREW.