2024 (No. 13)

PARLIAMENT OF TASMANIA

Joint Sessional Committee on Gender and Equality

Inquiry into

EXPERIENCES OF GENDERED BIAS IN HEALTHCARE IN TASMANIA

MEMBERS OF THE COMMITTEE

Legislative Council

Hon. Mr *Duigan* (until 17 October 2023 to 14 February 2024)
Hon. Mr *Edmunds* (from 18 June 2024)
Hon. Ms *Forrest* (Chair)
Hon. Mr *Harriss*
Hon. Ms *Howlett* (from 17 October 2023 to 14 February 2024)
Hon. Ms *Thomas* (from 18 June 2024)
Hon. Mr *Willie* (until 14 February 2024)

House of Assembly

Mrs *Alexander* (until 30 May 2023)
Mrs *Beswick* (from 18 June 2024)
Ms *Brown* (from 18 June 2024)
Ms *Johnston* (from 30 May 2023 to 14 February 2024)
Ms *O'Byrne* (Deputy Chair until 14 February 2024)
Hon. Mrs *Petrusma* (from 18 June 2024)
Ms *Rosol* (from 18 June 2024)
Dr *Woodruff* (until 14 February 2024)
Mr *Young* (until 14 February 2024)

CONTENTS

CHAIR'S FOREWORD

On behalf of the Joint Sessional Committee on Gender and Equality, I am pleased to present this report into gendered bias in healthcare. This report confirms the lived experiences of gendered bias of many Tasmanians who access primary and acute healthcare. Gendered bias in healthcare is real and negatively impacts members of our community, particularly members of the LGBTIQA+ community and women.

Gendered bias is evident across many areas of healthcare including access, affordability, safety, inclusivity, timely and accurate diagnosis and increases the risk of misdiagnosis and poorer health outcomes. Discrimination towards members of the LGBTIQA+ community can compound the negative impacts of gendered bias.

The Committee has made 34 findings and 17 recommendations. These finding and recommendations draw attention to evidence of gendered bias and highlights actions needed to mitigate and address the negative impacts on Tasmanians' health, particularly for women and members of the LGBTIQA+ community.

Recommendations include improved training and education for healthcare trainees and professionals, consistent and contemporary clinical guidelines particularly in areas of women's and reproductive health; dedicated services for members of the LGBTIQA+ community; improved data collection and adequate funding for dedicated women's and reproductive healthcare.

The Committee also recommends the introduction of a Human Rights Act to support and enhance the other recommendations to address gendered bias in healthcare.

Intersectionality (the impact of gender in addition to other factors) can amplify the gender-related bias some members of the Tasmanian community experience when accessing healthcare, particularly for those who are culturally and linguistically diverse, Aboriginal or Torres Strait Islander, live with disability, are members of the LGBTIQA+ community and/or are of a particular age.

For members of the LGBTIQA+ community, a lack of information regarding the location of inclusive and safe care often leads to delays to seeking care and a heightened risk of an adverse experience accessing services that may not be inclusive. Evidence shows dedicated LGBTIQA+ clinics and outreach services are needed.

The Committee recommends the government publish, and regularly update on the Department of Health website, a list of healthcare providers that indicate they

provide safe and inclusive care and establish regionally accessible health services or clinics that are safe and inclusive.

There are many gaps in health data particularly with regard to female-specific health conditions and reproductive health. Current data collection and record keeping within the Tasmanian Health Service is also inadequate. This is recognised by the government and investment in digital data management and data collection is underway.

Many people accessing the health system experience a level of disempowerment when navigating this system. Women regularly experience gender bias in primary and acute healthcare settings. This is evidenced by women's experiences of being more likely to have the severity of their physical pain and symptoms dismissed by treating medical professionals. This can, and does, delay timely treatment and provision of adequate pain relief and can contribute to misdiagnosis.

Women presenting with atypical cardio-vascular disease symptoms or abdominal pain often experience delays to care, pain relief and accurate diagnosis. The lack of a clear and consistent care pathway for female abdominal pain in emergency departments, contributes to these adverse impacts and can delay admission.

The Committee recommends the Tasmanian Health Service establish contemporary and consistent clinical practice guidelines for the assessment, treatment and admission of women presenting to Tasmanian emergency departments with abdominal pain, women presenting with atypical cardiovascular symptoms, birth trauma and miscarriage.

Women's reproductive health services are inadequately funded to ensure equitable, timely, safe, effective and accessible care can be provided both for contraceptive care and termination of pregnancy care throughout Tasmania. Many women are unable to afford the costs or access in a timely way, a medical termination of pregnancy. These circumstances have led to an increase in the number of women accessing a surgical termination in the Tasmanian Health Service. This adds to the pressures acute health services are under as surgical terminations of pregnancy are time sensitive and cannot be delayed. In some cases, women continue an unwanted and unplanned pregnancy.

The Medicare rebate for many reproductive health-related care and investigation is completely inadequate to cover the costs of providing this care. This leaves GPs facing financial barriers for the provision of timely care. The rebates expose unacceptable and inexplicable gender bias, demonstrated by rebates for male-related procedures and investigations being significantly higher than comparative female-related procedures and investigations.

The Committee recommends the State Government actively seek the support of the Federal Government to remove gender bias in Medicare rebates.

Underlying the lived experience of gendered bias in healthcare for women is an historical legacy of research and research funding that has focused on the male body. Adding to this, this body of research has been predominately undertaken by men. In medical literature and textbooks men's bodies are seen as the norm and women's bodies a variation of the norm.

The Committee heard of significant gaps in the education and training of healthcare professionals in both undergraduate and postgraduate programs particularly in the areas of LGBTIQA+ patient care, women-specific conditions (such as endometriosis, menopause and miscarriage), gender and unconscious bias, empathy and bystander intervention. The Committee recommends improvements to training and education to address key areas of gender bias.

Gendered bias is also evident in the health workforce with negative impacts on the gender pay gap with women GPs whom are more likely to spend a longer time with their patients thus seeing fewer patients per day than some male colleagues. Due to inadequate Medicare rebates some GPs do not offer specific reproductive healthcare or women-specific care, such as antenatal, endometriosis and menopause care due to the time such care requires.

The highly feminised health workforce, particularly in lower paid roles, can also mean men presenting for care are less likely to be cared for by other men. Stereotypes of masculinity, the nature of healthcare settings and sometimes the lack of availability of a male healthcare professional, can create barriers to men seeking healthcare. Increased diversity in the healthcare workforce and policies to address stereotypes of masculinity, can assist to address these matters.

Maternity services need to recognise non-birthing parents throughout the childbirth experience. These services require appropriate policies, education and training to ensure inclusive care.

The Committee further noted parental leave in Australia does not fully consider the needs of the non-birthing parent. The Committee recommends the State Government encourage the Federal Government to consider further changes to the structure of parental leave, responding to the economic and socio-cultural needs of non-birthing parents. The State Government has a role to play by being a model employer.

On behalf of the Committee, I sincerely thank all those who took the time to make submissions or provide evidence to the Inquiry and for sharing their invaluable experience and knowledge.

In particular, I thank those who were willing to share their own lived experiences of gendered bias when receiving healthcare. Members of the Committee note it is often challenging and difficult to relive such experiences and this evidence is so valuable to the Committee's work.

Hon. Ruth Forrest MLC
CHAIR

15 August 2024

FINDINGS

The Committee finds:

1. Gendered bias in healthcare is particularly prevalent for the LGBTIQA+ community.

2. Members of the LGBTIQA+ community have experienced discrimination in healthcare settings.

3. Delayed diagnosis as a result of gendered bias or discrimination can have a negative impact on health outcomes for members of the LGBTIQA+ community.

4. There is a lack of information available and communication to members of the LGBTIQA+ community regarding providers from whom they can be guaranteed safe and inclusive care.

5. There is a deficiency in knowledge in the wider medical community about LGBTIQA+ specific health related matters.

6. Dedicated LBGTIQA+ clinics would provide great benefit in Tasmania by allowing patients a safe and inclusive space.

7. The Department of Health is working with a Reference Group to produce inclusive healthcare learning resources.

8. The current medical records' systems are inadequate and do not allow correct identification of pronouns or prefix markers.

9. Many women experience gender-based bias when presenting for healthcare, particularly related to cardiovascular disease, abdominal pain and/or reproductive healthcare. This can, and does result in delays to diagnosis, misdiagnosis and poorer health outcomes.

10. Women are more likely to have the severity of their physical pain and symptoms dismissed by treating medical professionals, delaying timely treatment and pain relief.

11. There is not a clear and consistent care pathway for female abdominal pain, in emergency departments.

12. Organisations providing Medical Termination of Pregnancy (MTOP) services are inadequately funded to provide equitable, accessible and affordable care across regions.

13. Lack of access and affordability of Medical Termination of Pregnancy (MTOP) often results in women seeking Surgical Termination of Pregnancy (STOP), which adds to the burden on acute health services.

14. There is a lack of clinical guidelines or formal trauma informed briefings to support women following traumatic birth experiences and miscarriages.

15. There is a historical legacy of research, and funding for research, focussed on the male body which has had negative implications for women and women centred healthcare.

16. Pay inequity occurs for women in the healthcare profession, including as a result of female GP's being more likely to spend longer periods with patients, resulting in seeing less patients per day.

17. There is an inherent gender related bias in Medicare rebates resulting in cost inequity and disadvantage for women specific investigations and care.

18. Health data collection has current gaps, particularly in regard to reproductive health, and is acknowledged by the Department of Health.

19. Primary and outpatient healthcare is predominantly a 9am to 5pm service, creating limitations to provide patient centred care accommodating work, caring and personal commitments.

20. There is a significant gap in training for medical, nursing and allied health professionals in the areas of:

    a. LGBTIQA+ patient care;
    b. Women-specific conditions (such as endometriosis, menopause and miscarriage);
    c. Gender bias;
    d. Unconscious bias;
    e. Empathy; and
    f. Bystander intervention.

21. Anatomy books currently used in Australian medical schools and training of medical professionals, utilise the male body as standard and the female body as 'other', which influences diagnosis and treatment of women's health issues.

22. Menopause is excluded from Australian undergraduate and post-graduate medical and allied health training.

23. The Australian College of Rural and Remote Medicine (ACRRM) has provided educational resources to improve ACRRM doctors' understanding of key gender issues in practice.

24. Some medical reception staff lack training in the areas of:

    a. Patient confidentiality;
    b. Gender bias;
    c. Unconscious bias;
    d. Empathy; and
    e. Bystander intervention.

25. A level of disempowerment for people navigating the health system.

26. Non-birthing parents can also experience ante- and post-natal anxiety and depression.

27. Parental leave in Australia does not fully consider the needs of the non-birthing parent, including their economic and socio-cultural needs.

28. Stereotypes of masculinity, the nature of healthcare settings and sometimes the lack of availability of a male healthcare professional, can create barriers to men seeking healthcare.

29. There continues to be a delineation with caring roles in society.

30. There is a need for increased diversity in the healthcare workforce.

31. Intersectionality (intersection of gender and other factors) can amplify the gender related bias some members of the Tasmanian community experience when accessing healthcare particularly for those:

    a. Who are culturally and linguistically diverse;
    b. Who are Aboriginal or Torres Strait Islander;
    c. with disability;
    d. who are members of the LGBTIQA+ community; and
    e. who are of a particular age.

The extent to which this is experienced is not yet fully understood.

32. There is a need for greater utilisation of interpreter services and additional training, including cultural awareness and inclusion training to assist medical professionals in treating those from diverse backgrounds;

33. Gendered bias can impact the timely diagnosis of conditions such as Attention-Deficit Hyperactivity Disorder (ADHD) and autism.

34. A Human Rights Act in Tasmania may improve the experiences of Tasmanians seeking healthcare, particularly those from marginalised groups.

RECOMMENDATIONS

The Committee recommends:

1. **In relation to the LGBTIQA+ community, the Committee recommends the Government, as a matter of priority, update Tasmanian Health Service medical records and data collection for patients who change their prefix, pronoun and gender markers so changes are made in a timely manner.**
2. **In relation to the LGBTIQA+ community, the Committee recommends the Government publish, and regularly update, on the Department of Health website a list of healthcare providers that indicate they provide safe and inclusive care.**
3. **In relation to the LGBTIQA+ community, the Committee recommends the Government establish regionally accessible health services or clinics that are safe and inclusive.**
4. **The Tasmanian Health Service establish contemporary and consistent clinical practice guidelines for:**
    a. **the assessment, treatment and admission of women presenting to Tasmanian Emergency Departments with abdominal pain;**
    b. **women presenting with atypical cardiovascular symptoms;**
    c. **birth trauma; and**
    d. **miscarriage.**
5. **The Government increase funding to Family Planning Tasmania to ensure equitable and accessible reproductive healthcare across the state.**
6. **The Government provide additional funding to relevant organisations to provide specialised services in endometriosis and pelvic pain.**
7. **The Government actively seek the support of the Federal Government to remove gender bias in Medicare rebates.**
8. **The Government ensure relevant women's health related data is collected and appropriately reported.**
9. **The Government:**
    a. **establish benchmark training for all Tasmanian Health Service employees with regard to gender-inclusive care for women and LGBTIQA+ people;**
    b. **liaise with UTAS and TasTafe to embed gender-inclusive training for women and LGBTIQA+ people in all health-related education programs; and**
    c. **liaise with non-government healthcare providers to embed gender-inclusive practices for women and LGBTIQA+ people in their services.**

10. **Medical reception staff be provided with training in the areas of:**
    a. **Patient confidentiality;**
    b. **Gender bias;**
    c. **Unconscious bias;**
    d. **Empathy; and**
    e. **Bystander intervention.**
11. **The Government promote and actively support medical research into the health of women.**
12. **The Government incorporate more support services to facilitate engagement during ante- and post-natal care to consider the welfare of non-birthing parents.**
13. **The Government responds to the negative stereotypes of masculinity that may influence men's interaction with healthcare, by developing appropriate policies, education and training.**
14. **The Government recommend the Federal Government, in considering further changes to the structure of parental leave in Australia, acknowledges and responds to the economic, socio-cultural context needs of non-birthing parents.**
15. **The Government introduce a Human Rights Act.**
16. **The Government support and, where appropriate, provide additional training for health professionals to meet the needs of patients from culturally and linguistically diverse backgrounds.**
17. **The Government ensure all staff are aware of their obligations in regard to accessing interpreter services.**

1 BACKGROUND, TERMS OF REFERENCE AND CONDUCT OF THE INQUIRY

Background

1.1 Gendered bias in healthcare is a recognised issue, with such biases affecting a wide range of individuals. Gendered bias can lead to poorer health outcomes including from delayed diagnosis or refusal of treatment. Bias has been particularly of note for women and can result in having their health concerns ignored or dismissed, due to an increased likelihood of failures to investigate symptoms. There is also a growing trend of bias towards the LGBTIQA+ community. Patients who identify with this community are likely to experience discrimination in healthcare, as well as barriers to accessing healthcare in the first instance.

1.2 In a submission provided to the Committee for this Inquiry, Working It Out provided a useful explanation of gendered bias in healthcare:

> *Gender bias in healthcare relates to systems and individuals who hold biased views (conscious or unconscious) that affect the quality and outcome for patients, workforce, and other people and leads to negative service impacts and health outcomes. These prejudices lead to favouring a particular gender to another.*[1]

1.3 A similar definition was provided by TasCOSS:

> *Gender bias is a term that describes practices or beliefs which may favour or preference the experience of one gender over others. In relation to gender bias in healthcare and/or medicine, this term has been interpreted to mean, "an unintended, but systematic neglect of [a particular gender], stereotyped preconceptions about the health, behaviour, experiences, needs, wishes and so on, of [people of a particular gender], or neglect of gender issues relevant to the topic of interest." (Hamberg, K 2008, 'Gender bias in medicine,' Women's Health, vol. 4, no. 3, pp. 237-243.) Gender bias therefore "has implications in treatment… and it is important to take into consideration in most fields of medical research, clinical practice and education." (Hamberg, K 2008, 'Gender bias in medicine,' Women's Health, vol. 4, no. 3, pp. 237-243.)*[2]

1.4 The negative impacts from gendered bias in healthcare can be profound. As such, the area of gendered bias in healthcare should be an important consideration for the healthcare profession in order to provide people with a more equitable and safe system of care.

[1] Submission No. 3, Working It Out, p. 1.

[2] Submission No. 8, TasCOSS, p. 4.

Terms of Reference

1.5 On 16 November 2022, the Joint Sessional Committee on Gender and Equality resolved to undertake an Inquiry into *Tasmanian experiences of gendered bias in healthcare.*

1.6 The Committee resolved to inquire into and report upon the following terms of reference: -

(1) Examples of Tasmanian's lived experience of gender bias in healthcare;

(2) Areas of healthcare in which gendered bias is particularly prevalent;

(3) The impacts of gender bias in healthcare on overall health outcomes;

(4) Systemic behaviours that cause gender bias in healthcare;

(5) Work in other jurisdictions to limit gender bias in healthcare;

(6) Best practice for addressing gender bias in healthcare;

(7) Gender bias in research grant allocation and health related research; and

(8) Any other matter incidental thereto.

1.7 This Report should be read in conjunction with the attached documents.

1.8 The minutes of the Committee are attached as Appendix B.

Conduct of the Inquiry

1.9 The Committee resolved to invite, by way of advertisement on the Parliament of Tasmania website and in the three major Tasmanian newspapers, interested persons and organisations to make a submission to the Committee in relation to the Terms of Reference. In addition to such general invitation, the Committee directly invited a number of persons and organisations to provide the Committee with any information they deemed to be relevant to the Inquiry.

1.10 The Committee received 16 submissions and held four public hearings in Hobart, with twenty-five witnesses. Initial hearings were held at Parliament House in Hobart on 13 and 14 June 2023. Additional hearings were also held at Parliament House in Hobart on 12 and 16 October 2023.

1.11 The Committee had not yet reported when the House of Assembly was dissolved on 14 February 2024. On 22 May 2024 the Legislative Council sent a message to the House of Assembly to appoint a new Joint Sessional Gender and

Equality Committee for the 51st Parliament. This message was agreed to by the House of Assembly on 13 June, with an amendment stating that "That the Committee be authorised to receive all evidence and papers received by the Joint Sessional Committee on this subject in the previous Parliament".

1.12 Both Houses agreed to a new Committee of the Joint Sessional Committee on Gender and Equality on 18 June 2024. The new Membership consists of the Honourable *Ruth Forrest* MLC, the Honourable *Dean Harriss* MLC, the Honourable *Luke Edmunds* MLC, and Honourable *Bec Thomas* MLC, Mrs *Miriam Beswick* MP, Ms *Meg Brown* MP, the Honourable *Jacquie Petrusma* MP and Ms *Cecily Rosol* MP.

1.13 The new Committee met on 20 June 2024 and resolved to adopt and table this report on the *Experiences of Gender Bias in Healthcare in Tasmania* of the previous Committee. Members who contributed to this report include the Honourable *Nick Duigan* MLC, the Honourable *Ruth Forrest* MLC, the Honourable *Dean Harriss* MLC, the Honourable *Jane Howlett* MLC, the Honourable *Josh Willie* MLC, Mrs *Lara Alexander* MP, Ms *Kristie Johnston* MP, Ms *Michelle O'Byrne* MP, Dr *Rosalie Woodruff* MP and Mr *Dean Young* MP.

Structure of this Report

1.14 This report consists of the following Chapters:

- Chapter 1 provides a brief overview and administrative details of the Inquiry.

- Chapter 2 looks at the issues of gendered bias in healthcare that are affecting the LGBTIQA+ community including delayed diagnosis due to lack of care or difficulty receiving proper care, a lack of specialised providers who understand LGBTIQA+ issues, a lack of readily available accessible lists detailing inclusive providers and medical records' systems that are not adaptive to appropriate gender identity markers.

- Chapter 3 examines the evidence gathered around gendered bias in healthcare for women. Gendered bias was described in a number of areas including the gendered costs of healthcare, a lack of training in female specific conditions, and a tendency of medical professionals to dismiss female pain. Evidence also explored an aspect of gendered bias for female workers within the health profession, with many female general practitioners earning less. This inequality in pay arises in a multitude of contexts, including due to the likelihood of female general practitioners often seeing patients with more complex needs and therefore having longer consultations and seeing fewer patients per day.

- Chapter 4 considers the need for more training in the healthcare profession to help reduce gendered biases experienced by consumers. Training in areas such as LGBTIQA+ care, recognition of personal biases, bystander training, trauma

informed care and additional training for healthcare support staff are all areas that could be improved to reduce gendered bias.

- Chapter 5 talks about the gendered bias that is experienced in the area of men's health. Evidence of bias was heard in relation to non-birthing parents, male employment in the healthcare industry, gendered norms impacting the care men receive and parental leave.

- Chapter 6 considers other areas in which gendered bias in healthcare is occurring, such as within the culturally and linguistically diverse community and for people living with a disability. Evidence also demonstrates the intersectionality of gendered bias, as well as the consideration a Tasmanian Human Rights Act to recognise and protect people's rights as well as to encourage cultural change in a number of areas in society.

2 GENDERED BIAS FOR THE LGBTIQA+ COMMUNITY

2.1 This Chapter discusses the various areas of gendered bias in healthcare experienced by those in the Lesbian, Gay, Bisexual, Transgender, Gender Non – Binary and Gender Diverse, Intersex, Queer and Questioning and Asexual (LGBTIQA+) community. The Committee heard evidence from a number of witnesses indicating that gendered bias is particularly prevalent for these people. Evidence to the Committee described experiences including:

- delayed diagnosis;
- a lack of inclusive providers lists;
- an absence of specialised LGBTIQA+ services;
- systems not adapted to the needs of the LGBTIQA+ community; and
- inadequate training for healthcare professionals.

2.2 In her opening statement, Dr Miranda Hann outlined some of the issues faced with access to care by those in the LGBTIQA+ community:

> ***Dr HANN*** *- … I'm a GP and I work at Ochre Medical Centre in Hobart. I largely work with the LGBTIQ community in Tasmania and probably anywhere from about 30 per cent to 50 per cent of my patients are trans or gender-diverse identifying. I don't have a good way to calculate that with the way best practice is set up but it's a large proportion of the patients that I see. That means I have a high exposure to the stories of poor access to health care that the community shares with me and have perhaps a bit of a different insight to other health providers in this space.*
>
> *There are pretty horrific stats in terms of the access to health care for trans and gender-diverse people. One of the papers I'm happy to share with you records that one in five have been refused care by a medical professional and that's just outright refused, and 50 per cent of trans and gender-diverse people have to teach their doctor about transgender care. I would argue that that stat is probably under-representative of the number of people I experience who have had to teach their doctors and certainly I've had patients teach me things. A total of 28 per cent have faced harassment in a medical setting and 48 per cent have postponed medical care because they couldn't afford it. All of those stats are very much within the realm, if not under-representative, of the community that I see in Tasmania. Because of this, there's a huge healthcare disparity in this patient population and huge healthcare needs that aren't being well addressed at the moment in most of our health care settings that we have in Tasmania.*[3]

[3] Transcript of Evidence, 13 June 2023, pp. 1-2.

2.3 In their submission, Working It Out referred to a study of LGBTIQA+ Tasmanians by Dwyer et al., 2021,[4] which explored gender bias experiences in healthcare settings and found:

- *Healthcare practitioners widely lack knowledge, understanding, and training about LGBTIQ+ specific issues.*
- *Discrimination and harassment from healthcare providers. Accounts include a psychiatrist refusing to see a patient again after finding out the patient was gay; a doctor referring to sexual orientation as a lifestyle; false information on file and given to other healthcare providers; stereotypical remarks regarding sexual orientation; a nurse telling a lesbian to go on birth control because they still might have sexual intercourse with a man; and deadnaming of female patients who are transgender.*
- *14% reported needing to educate the healthcare provider because of a lack of knowledge.*
- *9% identified being asked inappropriate questions.*
- *7% identified specific needs of the person were ignored.*
- *14% of intersex people reported a negative impact on their healthcare compared to 4% [of]people who talked about their sexual orientation.*[5]

2.4 TasCOSS, in their submission, also discussed the significant impacts of gendered bias in healthcare for the LGBTIQA+ community:

> *Research shows us health outcomes are poorer for members of the LGBTQIA+ community, both for physical and mental health. National studies have shown the comparatively high rates of health issues within the LGBTQIA+ community, particularly mental health, with 57.2% of LGBTQIA+ participants in a 2020 national survey reporting either high or very high psychological distress (compared to 13% of the general Australian population).*[6]

2.5 TasCOSS, expressed their concern around the impact such bias is having on the LGBTIQA+ community:

> *TasCOSS is particularly concerned about the impact bias in healthcare, or fears of experiencing bias in healthcare, is having on the LGBTQIA+ community. Recent reports, which include data from surveys within the community, show that many LGBTQIA+ Tasmanians are avoiding accessing*

[4] Cited in submission No. 2, p. 2: Dwyer, A., Grant, R., Mason, R., and Barnes, A. 2021. 'Just listen properly, like with intent': LGBTIQ+ Tasmanians: Telling us the story - Final Report, December 2021.
[5] Submission No. 2, Working It Out, pp. 2-3.
[6] Submission No. 8, TasCOSS, p. 6.

> *health services due to fears of experiencing stigma or discrimination, (*Dwyer, A et al. 2021, *'LGBTIQ+ Tasmanians: Telling us the Story — Final Report,'* pp. 37-38*) and that this issue is particularly acute for the trans and gender diverse community. (*Dwyer, A et al. 2021, *'LGBTIQ+ Tasmanians: Telling us the Story — Final Report,'* pp. 39-41*).*[7]

2.6 In the submission from Equal Opportunity Tasmania, it was noted that the treatment of transgender people in the community was one of increasing concern:

> *Equal Opportunity Tasmania has received a number of complaints relating to the provision of healthcare to transgender patients.*
> *…*
> *In S. v H [2017] TASADT 49 the Respondent operated a hospital. The Complainant, a transgender woman, who was a patient at the hospital, relevantly alleged that staff of the Respondent referred to her in the masculine, despite repeated requests by her that they stop doing so and refer to her by her preferred name and pronoun.*
> *The Tribunal made a finding of discrimination and offensive, humiliating, intimidating, insulting or ridiculing conduct…* [8]

2.7 Equal Opportunity Tasmania also noted that a better understanding of the impact of gendered bias on transgender individuals is an important step to improving healthcare:

> *I note that the provision of healthcare to transgender people is a complex issue and subject to high levels of disinformation. Transgender people are continuously discussed without consultation, where statements are made in a flippant way, rendering harm to an already vulnerable community. While Equal Opportunity Tasmania has not received reports of young transgender people and their experiences of transition in a healthcare setting, in particular how that experience has been impacted by gendered biases, I encourage the development of an understanding of this area. Discussions in the community will continue to be had and it is important that policy responses are informed following meaningful and targeted consultation with the community, including specific demographics of that community.*[9]

Delayed Diagnosis

2.8 Gendered bias in healthcare can lead to issues of delayed diagnosis, which in turn results in more significant health issues and increased costs for patients.

[7] Submission No. 8, TasCOSS, p. 7.
[8] Submission No 14, Equal Opportunity Tasmania, p. 11.
[9] Submission No. 14, Equal Opportunity Tasmania, p. 12.

The impacts of costs due to delayed diagnosis on those in the LGBTIQA+ community was discussed in verbal evidence:

> ***Mr WILLIE*** *- I read your opinion piece. I saw the delayed diagnosis issue, particularly for women, but also for the LGBTIQ+ community. Do you have any understanding of the cost to the system? There's obviously a very real human cost, but there's a disproportionate cost to people and the system too if people are not going to appointments and there's all these barriers that we're talking about.*
>
> ***Dr HANN -*** *I can't give you numbers specifically, but I know it's about 10 times more expensive for a trip to the emergency department than it is for a trip to the GP to address the same issue. That is certainly something both female patients and trans and gender-diverse patients are going to have to experience more often, because if you are not heard within a GP clinic setting, your symptoms get worse and your next step is the emergency department.*
>
> *Had those symptoms been investigated or the merit had been taken seriously a bit earlier, that may have been prevented. Certainly, from a cost perspective, avoidance of primary care means your next step is going through the emergency department. The cost of health care for each of those presentations is substantially higher than if we just did the preventative health for that person. Typically, people with complex medical needs presenting via emergency departments are not presenting just once, they are going to be presenting multiples times and thus, increasing their costs to the healthcare system significantly.*
>
> *I cannot give you exact numbers, but from the general practitioner's conference, the difference between assessing and managing something in primary care venues the emergency department is about a 10-fold difference.*[10]

Inclusive Provider Lists

2.9 Evidence was presented to the Committee indicating there are limited formalised lists of inclusive practices available to those in the LGBTIQA+ community:

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

[10] Transcript of Evidence, 13 June 2023, Dr Hann, p. 5.

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

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

Informally I have done that, but unlike a lot of other states that have a website you can go to and can click through and try to find providers within your area for specific things, we do not have a resource like that in Tasmania.[11]

2.10 This issue was also discussed with Mr Rodney Croome and Dr Ruby Grant in their evidence to the Committee:

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

***Dr GRANT** - Yes, lists such as that are a really great example. This is a community who in their mind, even though we have faced many barriers to health care, many LGBTIQA+ people are incredibly health literate because they have to be. They are very well connected, so this kind of word of mouth for unofficial lists happens everywhere. There are lots of different Facebook groups where people have collated this kind of information and share. The point in your question is it is not good enough for these things to be informally collated by individuals in the community and what does that mean for a young queer person coming out who does not have those connections to community[?] There have certainly been more formalised versions of these kinds of lists of inclusive services and businesses and Working it Out's Signpost app is something that was trying to do that more broadly on health services, other community services,*

[11] Transcript of Evidence, 13 June 2023, Dr Hann, p. 5-6.

businesses and places. I do not believe that is currently being resourced anymore and something that has fallen by the wayside. It probably was not able to reach as many people and would have been great if it could. We would certainly encourage such lists being more formally provided and maintained. Lots of other state governments have official sites on their health department page that have lists like this, or there are other such resources available. Having the resources maintained and updated and also promoted within communities so it can actually reach people who need it most would be really beneficial.[12]

Specialised LGBTIQA+ Services

2.11 Specialised services for the LGBTIQA+ community would be a way to minimise potential biases impacting healthcare of this community. Dr Hann suggested that a dedicated LGBTIQA+ health clinic would be of great benefit to the Tasmanian community:

> ***CHAIR*** *- … In terms of a closing comment, what do you think would make the most difference? … If there was one or a couple things you could say that really would make the biggest difference, what would they be?*
>
> ***Dr HANN -*** *Ruby Grant, who is a researcher here, just did a study on transgender and gender-diverse people's access to healthcare services in Tasmania, and the number one thing that was requested was a dedicated LGBTIQ+ health clinic and service, which we do not have in Tasmania.*
>
> *…*
>
> ***Dr HANN - …*** *It is the first thing I looked for when I moved here and could not find it and then had to figure out what GP to go to. It is the way that I know, as a service user, it is how I would pick my GPs, it was how I would pick my health service, it is how I would understand things that work within the state I was living in. Not having that here has been floundering for me - and I am a very privileged and educated individual in the community. It just means that the service that you are walking into is safe, you are not going to be mis-gendered, you are not going to be made to feel 'other', you are not going to be put in situations that are going to make you feel more vulnerable than you already do in a healthcare setting, which is vulnerable for any person. If you can make some of those access barriers feel less scary then people are going to use the service more. It means there will be adjustments made for neuro-diverse patients, who are a much higher proportion [within the] gender[diverse] community.*
>
> *It means you are part of your community as you're getting your healthcare treatment. You're walking in and the people around you are people who*

[12] Transcript of Evidence, 13 June 2023, Mr Croome & Dr Grant, pp. 9-10.

> *you know and make you feel safe. It's sort of like our Aboriginal Health Service. Our Aboriginal community accesses the Tasmanian Aboriginal Centre (TAC) and the Aboriginal Health Service preferentially because you're walking into community and community's going to use a different language. Community's going to treat you differently and community's going to understand your needs more effectively than perhaps those who aren't part of the community or aren't exposed to the community as regularly.*[13]

2.12 In their submission, TasCOSS noted the importance of specialist services designed to work for particular groups in producing the best health outcomes for the community. They supported this position by pointing to a national survey on the health and wellbeing of LGBTIQA+ people:

> *Recent national surveys and reports have highlighted the positive impact of specialist health services designed to work with particular groups. For example, the results of Private Lives 3, a national survey about the health and wellbeing of LGBTIQ people, revealed that participants felt most comfortable accessing specialist LGBTIQ medical services or mainstream services that were known to be inclusive (*Hill, A 2020, *'Private Lives 3: The health and wellbeing of LGBTIQ people in Australia,'* Latrobe University, pp. 55-60.) *The report made a number of recommendations which included:*
>
> - *the importance of targeted services, such as the expansion of funded services for the LGBTIQ community;*
> - *increased funding for LGBTIQ community-controlled organisations to develop and deliver inclusive services and service development; and*
> - *government support to engage in ongoing evaluation of existing LGBTIQ-inclusive care to review current services and shape future improvements (*Hill, A 2020, *'Private Lives 3: The health and wellbeing of LGBTIQ people in Australia,'* Latrobe University, pp. 119-120).[14]

2.13 TasCOSS further noted:

> *… A recent report outlining the experiences and views of the LGBTQIA+ community in Tasmania highlighted the need for a dedicated Gender Clinic in Tasmania in order to ensure access to appropriate and effective gender-affirming treatment and care (Dwyer, A et al. 2021, 'LGBTIQ+ Tasmanians: Telling us the Story — Final Report,' pp. 39-41.).*[15]

[13] Transcript of Evidence, 13 June 2023, Dr Hann, p. 9.
[14] Submission No. 8, TasCOSS, p. 8.
[15] Submission No. 8, TasCOSS, p. 9.

2.14 In its submission, the Department of Health acknowledged the prevalence of negative health experiences for those in the LGBTIQA+ community, highlighting the work it is doing to improve outcomes:

> *Research indicates that experiences with health services can be negative for many LGBTIQ+ people. Since 1999, DoH has had an LGBTIQ+ Reference Group to help consider ways to improve access and opportunities for LGBTIQ+ people. The Reference Group is co-chaired by the Secretary, DoH and a nominated community representative. Membership organisations include Equal Opportunity Tasmania, Primary Health Tasmania, TasCAHRD, Rainbow Tasmania, FPLAG, [PFLAG]Equality Tasmania, Working it Out, Women's Health Tasmania and Health Consumers Tasmania. The Reference Group also provides oversight of DoH's Sex and Gender Reform activities.*
>
> *With the support of the Reference Group DoH launched its LGBTIQ+ inclusive healthcare learning resources for Tasmanian health sector staff in December 2021, to train, inform and reorient the public health workforce. The learning resources aim to ensure our health system is inclusive, welcoming, safe, and respectful for LGBTIQ+ Tasmanians.*
>
> *DoH staff are expected to treat patients, clients and colleagues with respect – regardless of their sex, sexual orientation and gender identify. This includes not assuming a person's sex or gender based on things such as name, voice or appearance.* [16]

2.15 Both Women's Health Tasmania and TasCOSS, in their written submissions, made recommendations around the use of specialist health services for certain populations. TasCOSS recommended:

> *Increase[d] funding for the expansion of specialist health services to work with priority populations experiencing, or at risk of experiencing, gender bias in healthcare.*[17]

2.16 Further, Women's Health Tasmania recommended:

> *RECOMMENDATION 5 - Tasmanian health workforce training on inclusive practice, including specific education on transgender health.*
> *…*
>
> *RECOMMENDATION 8 - Support for health services that traditionally service cisgender populations to provide inclusive care for trans and non-binary people.*[18]

[16] Submission No. 11, Department of Health, p. 10.
[17] Submission No. 8, TasCOSS, p. 11.
[18] Submission No.5, Women's Health Tasmania, p. 18.

2.17 In its submission, Working It Out noted a Tasmanian Government survey into the needs of LGBTIQA+ Tasmanians. This survey identified a number of key priorities, which if implemented, could assist in addressing gender bias for the LGBTIQA+ community:

> *The Tasmanian state government conducted a 2021 survey into the needs of LGBTIQ+ Tasmanians (Dwyer et al., 2021).*[19] *The following elements were identified as key priorities which would also assist in addressing gender bias in healthcare settings:*
>
> - *Funded mental health and suicide prevention strategy and services.*
> - *LGBTIQ+ specific services.*
> - *Measures to ensure safety and inclusivity in mainstream service provision.*
> - *LGBTIQ+ inclusive practice training for all healthcare providers. Priority workforce training included, medical and nursing staff and students, then specialists, then professional staff and aged care staff.*[20]

Systems not adaptive for the LBGTIQA+ Community

2.18 One issue raised was that there are problems with the current electronic medical records systems used across Tasmania, as they do not feature or identify appropriate gender markers. In her submission, Dr Hann noted:

> *The systems aren't built for trans people - this starts at the IT. Our systems don't have good options for pronouns, gender identity, and then fail further when the Medicare marker (M or F) doesn't match someone's identity. We then often loose [sic] medical records if someone's Medicare marker changes - their old records don't get automatically linked (at RHH anyway). And it creates challenges if we put someone's identified gender marker down, but Medicare hasn't been updated, then billing/uploading health records/finding health records becomes incredibly challenging.*[21]

2.19 This was expanded upon in verbal evidence to the Committee:

> ***Dr WOODRUFF** - Miranda, you talked about pronouns and them being out of sync, and the systems we have as being incapable of dealing with*

[19] Dwyer, A., Grant, R., Mason, R., and Barnes, A. 2021. 'Just listen properly, like with intent': LGBTIQ+ Tasmanians: Telling us the story - Final Report, December 2021.
[20] Submission No. 2, Working It Out, p. 3.
[21] Submission No. 1, Dr Hann, p. 2.

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

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

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

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

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

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

change that, those prefix markers are another element that provides areas of confusing misgendering for people on referrals.[22]

2.20 Further, the issues with electronic systems across different medical areas and providers was discussed:

> ***Dr WOODRUFF*** *- That's an electronic system issue that is different by private practices and even with public hospitals within Tasmania? They have different electronic record systems?*
>
> ***Dr HANN*** *- Yes, those electronic records issues are going to be different for every health system you are in, whether it's primary care, hospital or private hospital. None use the same record system. Quite a few GP practices use Best Practice, but medical specialists do not and surgeons do not and the hospitals do not. They all have their own sections and the ones that the surgeons use are different than the ones that our endocrinologists use, which are different than the ones that the hospitals use. None of those electronic records talk, so if you are going to be sending information between different providers or services, you are essentially faxing a new document each time that you are sharing information between services.*[23]

2.21 This issue relating to pronouns and electronic systems was also discussed with Equality Tasmania:

> ***Dr WOODRUFF*** *... It has been mentioned to us that there is so much variation within Tasmania in different electronic systems held within the public and private specialties and the mismatch with Medicare. Do you have any comment on the best way forward to fast-track some appropriate move towards consistency in the use of options for people to identify their own pronoun by which they'd like to be referred? It's a small thing but it can be a big thing and it can stand in the way of people feeling like they are heard and included. Has this come up as an issue?*
>
> *...*
>
> ***Mr CROOME*** *- The LGBTIQ+ reference group in the Department of Health that I mentioned before has been looking at this issue since the passage of the gender reforms in 2019. I'm not in a position now to give an update on where that's up to but I'm sure if you were to ask the department to provide a submission on that they would, to give you an idea of how far they've got. It is, as you've said, a very complicated issue. There's a number of different data-gathering systems that the department uses and sometimes the department doesn't gather data at all, when it should do.*[24]

[22] Transcript of Evidence, 13 June 2023, Dr Hann, p. 7.
[23] Transcript of Evidence, 13 June 2023, Dr Hann, pp. 7-8.
[24] Transcript of Evidence, 13 June, Equality Tasmania, p. 7.

2.22 The Hon. Guy *Barnett*, Minister for Health, did note in evidence to the Committee, that there was work being done on how sex and gender information is recorded, collected and managed:

> ***Mr BARNETT*** *- 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.*[25]

2.23 The Hon. Guy *Barnett*, Minister for Health, provided additional information to the Committee regarding the current nature of records management in relation to preferred pronouns, prefix and gender markers:

> *Due to current system constraints, there is no capture of pronoun; only sex and not gender information can be captured.*
>
> *Department of Health Information, Communication and Technology (ICT) is in the planning phase for a system upgrade to enable the capturing and downstream communication of sex and gender information. The sex information must be maintained to ensure appropriate clinical care.*[26]

2.24 Furthermore, the additional information provided by the Hon. Guy *Barnett*, Minister for Health stated:

> *Patients can request the altering of their prefix whenever they present to any Acute/Rural Hospital or Community health facility. However, there is a link between sex and prefix in place. Department of Health ICT is currently undertaking work to break that link to allow patients to choose their prefix freely.*[27]

2.25 Evidence relating to the need for specific training for the care of those in the LBGTIQA+ community was also received by the Committee. This will be discussed in more detail in the next Chapter of the report.

[25] Transcript of Evidence, 12 October 2023, Hon. Guy Barnett MP, p. 2.
[26] Additional information, Reply to letter dated 10 November 2023, 1 December 2023, Hon. Guy Barnett MP. p.1.
[27] Additional information, Reply to letter dated 10 November 2023, 1 December 2023, Hon. Guy Barnett MP. p.1.

Findings

The Committee finds:

2.26 Gendered bias in healthcare is particularly prevalent for the LGBTIQA+ community;

2.27 Members of the LGBTIQA+ community have experienced discrimination in healthcare settings;

2.28 Delayed diagnosis as a result of gendered bias or discrimination can have a negative impact on health outcomes for members of the LGBTIQA+ community;

2.29 There is a lack of information available and communication to members of the LGBTIQA+ community regarding providers from whom they can be guaranteed safe and inclusive care;

2.30 There is a deficiency in knowledge in the wider medical community about LGBTIQA+ specific health related matters;

2.31 Dedicated LBGTIQA+ clinics would provide great benefit in Tasmania by allowing patients a safe and inclusive space;

2.32 The Department of Health is working with a Reference Group to produce inclusive healthcare learning resources; and

2.33 The current medical records' systems are inadequate and do not allow correct identification of pronouns or prefix markers.

Recommendations

In relation to the LGBTIQA+ community, the Committee recommends the Government:

1. **as a matter of priority, update Tasmanian Health Service medical records and data collection for patients who change their prefix, pronoun and gender markers so changes are made in a timely manner.**
2. **publish, and regularly update, on the Department of Health website a list of healthcare providers that indicate they provide safe and inclusive care.**
3. **establish regionally accessible health services or clinics that are safe and inclusive.**

3. WOMEN'S HEALTH

3.1 This Chapter considers bias that is experienced by women in healthcare settings. The Committee received evidence which discussed the following areas of gendered bias in relation to women's health:

- bias in research and grant allocation;
- gendered bias in the medical profession;
- experiences of gendered bias in the healthcare profession;
- the potential role of trauma informed and empathetic care;
- stereotypes regarding femininity;
- denial of healthcare;
- leave entitlements for health conditions or instances of ill health; and
- insufficiencies in the provision of women's health services.

Bias in Research and Grant Allocations

3.2 In response to the Committee's term of reference addressing grant allocation and health related research, Ms Amanda Duncan noted the historical legacy of research and funding related to women and women centred healthcare:

> *In 1977 the US Food and Drug Administration recommended women of childbearing age be excluded from clinical research studies due to a variation of hormones during the menstrual cycle. Hormonal changes were deemed as a "complication" when undertaking clinical research as sample sizes would need to be larger, thus incurring additional cost to fund the research. Therefore, male-only studies were justified by the belief that what would work for men, would also work for women. This assumption has had catastrophic results for many women.*[28]

3.3 In their submission to the Committee, Men's Resources Tasmania (MRT) detailed aspects of the modern context of medical research and funding in relation to gendered bias:

> *Gendered approaches to research funding tends to focus on the gender of the researcher and the gender of research subjects in medical trials. A review of the allocation of research funding clearly shows a bias towards researching women's health over men's health. For example, in 2021 the NHMRC*[29] *allocated more than six times more funding to women's health ($81m), than men's health ($13m), or ten times more funding when research in women's health and maternal health is combined ($131m).While the NHMRC has a gender equity strategy to increase the number of women and non-binary researchers receiving grants, it has no strategy in place to increase research funding into men's health.*

[28] Submission No. 3a, Ms Duncan, p. 1.

[29] National Health and Medical Research Council

While men may have traditionally made up a greater proportion of researchers, they have not necessarily all been focused on understanding men's health.[30]

3.4 Professor Sue Matthews, of the Royal Women's Hospital Victoria, discussed the lack of research conducted on pregnant women:

> ***CHAIR*** *- …On page seven of your submission… 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.*[31]

3.5 The Chair questioned Professor Matthews further in relation to why she thought women were excluded from research:

> ***CHAIR*** *- Why are we not seeing that approach being taken, rather than this [al]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*

[30] Submission No. 9, Men's Resources Tasmania, pp. 9-10.
[31] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, pp. 12-13.

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.[32]

3.6 The Victorian Women's Trust, in its submission, provided comment on gendered bias in medical research:

Medical research bias against female inclusion has occurred due to concerns of studies negatively impacting the female reproductive system, and that female hormonal changes may impact the reliability of results. This exclusion of women was enforced by the United States Food and Drug Administration (FDA), which prohibited researchers from including women of childbearing age in drug trails. This effectively blocked all women internationally from participating in clinical trials, reinforcing within the medical profession that the male body is the norm, and the female body is a variation of the male body which data can be generalised to.

*Although recent studies of Australian research shows that there is now equal sex representation in studies, only 8.9% of research analysed data by sex, preventing identification of differences in results between females and males, which may impact diagnosis and treatment. (*Merone, L., Tsey, K., Russell, D., & Nagle, C. (2022). Mind The Gap: Reporting and Analysis of Sex and Gender in Health Research in Australia, a Cross-Sectional Study. *Women's Health Reports, 3*(1), 759-767.*) There are known sex differences in the ways drugs are processed by the body, and in the ways the body reacts to a drug once it is in the bloodstream, therefore research which does not analyse data by sex, will not be able to analyse or observe these differences.*

[32] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 13.

This can result in negative outcomes for female patients, including adverse reactions to drugs, lower effectiveness of interventions, and delayed or misdiagnosis. With women twice as likely to experience adverse drug reactions than men, partially due to dosing recommendations being based on the average male body. Further, despite general sex parity in research, some areas of research still lack female representation in studies, due to incorrect assumptions that women are less affected by a disease, such as in cardiovascular research.[33]

3.7 The Victorian Women's Trust submission went on to describe the areas in which gendered bias in research is particularly of note, the first being cardiovascular health:

Cardiovascular disease (CVD) is the leading cause of death for Australian women and is one of the clearest examples of gender bias in medical research. CVD has traditionally been seen as a disease which primarily affects men, resulting in gender bias at the research, policy, and clinical levels.

Clinical trials have primarily recruited male patients, which has resulted in drugs being less effective for women who have CVD. Even despite recent gains in understanding of sex differences in CVD, research shows that since 2008, women account for only 40% of participants of cardiovascular clinical trials, with only 36% of these studies reporting results by sex (Carcel, C., Woodward, M., Balicki, G., Koroneos, G. L., Sousa, D. A. d., Cordonnier, C., Lukaszyk, C., Thompson, K., Wang, X., Davies, L., Bassi, M., Anderson, C., Peyers, S. A., & Sandset, E. C. (2019). Trends in Recruitment of Women and Reporting of Sex Differences in Large-Scale Published Randomised Controlled Trials in Stroke. *International Journal of Stroke, 14*(9), 931-938)*.*

*Female patients often present differently to male patients when experiencing a heart attack, with 40% of women not experiencing what has been considered to be the 'typical' (male) symptoms. Women are therefore more likely to have their heart attack symptoms missed by doctors, with a UK study finding women were up to 37% more likely to be misdiagnosed when experiencing a heart attack (*Wu, J., Gale, C., Hall, M., Dondo, T., Metcalfe, E., Oliver, G., Batin, P., Hemingway, H., Timmis, A., & West, R. (2018). Impact of Initial Hospital Diagnosis on Mortality for Acute Myocardial Infarction: A National Cohort Study. *European Heart Journal, 7*(2), 139-148)*. Women are less likely to be assessed, tested, and prescribed medications for CVD.*

*A study conducted by the University of Sydney found that women admitted to Australian hospitals with serious heart attacks, are half as likely as men to get correct treatment and are twice as likely to die six months after discharge (*Khan, E., Brieger, D., Amerena, J., Atherton, J.,

[33] Submission No. 17, Victorian Women's Trust, p. 3.

> Chew, D., Farshid, A., Ilton, M., Juergens, C., Kangaharan, N., Rajaratnam, R., Sweeny, A., Walters, D., & Chow, C. (2018). Differences in Management and Outcomes for Men and Women with ST-elevation Myocardial Infarction. *Medical Journal of Australia, 209*(3), 118-123).
>
> *Another study conducted in Australia, found that women were 12% less likely to be screened for CVD risk than men (*Hyun, K., Redfern, J., Patel, A., Peiris, D., Brieger, D., Sullivan, D., Harris, M., Usherwood, T., Macmahon, S., Lynford, M., & Woodward, M. (2017). Gender Inequalities in Cardiovascular Risk Factor Assessment and Management in Primary Healthcare. *Heart, 103*(7), 492-498). *This gap is even larger for Indigenous women, who are twice as likely to be diagnosed with, and die from CVD.*
>
> *Disparities in medical research create a clear flow on effect in the treatment, diagnosis, and outcomes for female patients.*[34]

3.8 The gendered nature of cardiovascular health was also discussed in the Australian Medical Association (AMA) submission:

> *In terms of mortality, the biggest issue is women with cardiovascular disease being taken seriously when they present to emergency departments with chest pain. There are multiple articles looking at acute coronary syndrome/heart attacks that show women are less likely to have an angiogram, less likely to be treated with a stent or preventive medications, and more likely to die after a heart attack. Interesting to note is that women without risk factors have a higher mortality as medicine tends to ignore people without risk factors. (ref. https://doi.org/10.1016/S0140-6736(21)00272-5).*[35]

3.9 The Victorian Women's Trust also noted that chronic pain was an area in which gendered bias occurs in research:

> *Women report more chronic pain in Australia than men, with women's pain often being normalised by healthcare professionals, and less likely to be taken seriously. Approximately 80% of all patients diagnosed with an autoimmune condition are women, many of whom present with chronic pain. Importantly, a number of chronic pain conditions can only occur in women, such as endometriosis, but this does not explain the sex disparity.*
>
> *There are many proposed causes for the sex disparity in prevalence of chronic pain, some of these include: gender roles resulting in men presenting a higher threshold for pain, likely due to it being less socially acceptable for men to show pain, psychological differences in the experience and reception of pain, and genetic differences. The causes are*

[34] Submission No. 17, Victorian Women's Trust, pp. 3-4.
[35] Submission No. 10, Australian Medical Association, p. 3.

highly debated, but what is certain, is that there is a large sex bias in the research of pain.

*Even with reduced sex disparities in recent research, the majority of pain research was prior to these improvements, and undertaken in male humans and male rodents. Pain is also an area of research where sex disparities are continuing, as seen in a recent study of research articles published in the journal, Pain, which found that only 12% of articles contained studies which tested on only females, or both sexes (*Mogil, J. (2016). Equality Need Not be Painful. *Nature, 535*(7)).

Recent research that is being conducted on pain continues to have sex disparities, with conditions that have a disproportionate effect on women, such as migraines and endometriosis, receiving far less funding than conditions which predominately affect men, even when they are less prevalent population wide.[36]

3.10 The last example given of gendered bias in research and funding by the Victorian Women's Trust submission was endometriosis. It was noted that:

Across Australia, there are currently over 830,000 people with endometriosis, of which almost 16,000 reside in Tasmania. It can be a debilitating disease with common symptoms including pain, bloating, fatigue, nausea, and heavy bleeding, leading to reduced participation in school, work, and other commitments, and can impact fertility.

Endometriosis is estimated to cost the Australian economy almost $10 billion annually, at a cost of $30,000 per patient, mostly due to productivity loss. Despite affecting the same number of women as diabetes, it receives only 5% of the funding. Current treatments include prescription painkillers, hormonal treatments, removal of lesions via surgery, and hysterectomy, all of which are either invasive, have major side effects, or both. There is no cure.

Endometriosis faces more difficulties than other conditions in receiving funding, sitting at the intersection of chronic pain, and being a condition which only affects people with female anatomy. This results in less funding, research, and awareness from medical professionals.
There have been recent breakthroughs in endometriosis research, including in Australia, with growing understanding of possible causes and cures. Increased funding is needed to ensure that this continues.[37]

3.11 Finally, the Victorian Women's Trust gave a number of recommendations around research:

[36] Submission No. 17, Victorian Women's Trust, p. 4.
[37] Submission No. 17, Victorian Women's Trust, p. 5.

1. Encourage research institutions that receive state funding to ensure equal sex representation in studies and analysis of data by sex.

2. Prioritise sex specific research for conditions such as cardiovascular disease and chronic pain, to better understand these conditions in women and improve outcomes.

3. Increase funding for research which reflects the prevalence of conditions that disproportionately impact women such as endometriosis, migraines, and autoimmune conditions.[38]

Gendered Bias in the Medical Profession

3.12 Gendered bias was raised in evidence to the Committee in relation to costs and pay inequity. The Family Planning Tasmania (FPT) submission noted:

> *[T]he Australian Medicare Benefits Scheme (MBS) incentivises short consultations, effectively penalising doctors for spending more time with patients. Short consultations are incompatible with the often complex needs of women's healthcare, particularly relating to contraception, pregnancy and termination. Complex consultations are one reason why female doctors are more likely to spend more time with patients than male doctors, resulting in women in healthcare earning less than men (20% gender pay gap) as well as what amounts to a "tax" on women's health as either the patients or doctors themselves cover the additional cost of providing longer consultations. In Tasmania, out of pocket fees for appointments with GPs specialising in women's health (outside of Family Planning Tasmania) are between 50% - 100% higher than a standard GP appointment. This additional cost is on top of the Australian gender pay gap of 13.4% that means women are less able than men to afford their medical and healthcare costs to begin with.*[39]

3.13 The issue of female doctors spending more time with patients was also highlighted in verbal evidence from the AMA:

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

[38] Submission No. 17. Victorian Women's Trust, p. 9.

[39] Submission No. 12, Family Planning Tasmania, p. 2.

> ***Dr BENDALL*** *- And regularly run an hour late because someone actually tried and had just been at the same time.*[40]

3.14 These comments were supported in the written submission of the AMA:

> *Female GPs are usually part-time contractors in small private businesses which do not offer maternity leave, job security, long service leave, employee assistance programs, employer contributed superannuation or Work cover in the long run. Those who may suffer from vicarious trauma through their chronic mental health work have to fund their own care and sick leave. This may lead to the loss of health professionals through burnout.*
>
> *…*
>
> *Female health professionals earn less than their male counterparts for a multitude of reasons (ref. https://www1.racgp.org.au/newsgp/professional/does-medicare-discriminate-against-women?feed=RACGPnewsGPArticles). It is a common experience in general practice for patients to present to male doctors for straightforward issues, but then electing to see female GPs for complex, challenging and [ti]me consuming presentations. As well as impacting income, a heavy caseload of medically complex patients can be exhausting for female GPs.*[41]

3.15 Dr Hann also noted, in her submission to the Committee, the wider issue of a lack of diversity in those training and able to train in the healthcare system:

> *In theory, best practice revolves around top down change of practice and attitude. This is being attempted by starting to teach a different narrative in medical school - but I don't think this is being done aggressively enough and certainly isn't challenging that basis of a heteronormative cis white male perspective to create long standing change. Changing the way we choose who is admitted to medical school is a start - which requires better education/access to linguistically and culturally diverse students to higher education (and thus primary and secondary education). I challenge this by calling out behaviour when I see it in health systems (of other doctors, health providers, or even patients - I'm assumed to be a nurse constantly).*[42]

3.16 Ms *O'Byrne* questioned Dr Annette Barratt, from the AMA, about what could be done to improve employment conditions for healthcare professionals, particularly females:

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[40] Transcript of Evidence, 14 June 2023, Australian Medical Association Tasmania, p. 45.
[41] Submission No. 10, Australian Medical Association Tasmania, p. 8.
[42] Submission No. 1, Dr Hann, pp. 1-2.

Ms O'BYRNE *- Appreciating that absolutely, the other thing then goes to general practice being under the pump and women working part-time and when they are returning from work after having children, and the entire employment framework that operates around that. … what needs to be done to make sure that you have a better ability to not be discriminated against in your employment?*

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

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

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

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

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

Dr AHMED *- There is an alternative model of having a percentage of billings, so a lower percentage. You still get a percentage of what you are billing but some of it gets taken away to be reserved for your super, holiday, annual leave, that sort of thing.*[43]

3.17 The Australian College of Rural and Remote Medicine (ACRRM) also noted the explicit increased existence of the gender pay gap for healthcare workers compared to the national average:

> *Despite being an industry dominated by women, the national gender pay gap for healthcare workers is 20.7% compared to the national average of*

[43] Transcript of Evidence, 14 June 2023, Australian Medical Association Tasmania, pp. 49-50.

14.2%.8 While representation in general practice and Rural Generalist practice is broadly in population parity there remain structural barriers for women within medicine in general. For example, in areas such as surgery, women are under-represented and leave training in higher proportions than men.[44]

Experiences of Gendered Bias in the Healthcare Profession

3.18 Equal Opportunity Tasmania noted in their written submission to the Inquiry, that the context of gendered bias for healthcare professionals within the system should also be acknowledged:

> *While highlighting gendered bias in the course of employment in healthcare settings may seem outside the scope of the Inquiry, it is essential that there is an understanding of the industry and the experiences of female staff who have encountered gender discrimination while working within it.*
>
> *Medicine has historically been a male-dominated profession. Research has been usually undertaken by male medical practitioners, the gender pay gap and experiences of sexual harassment within the profession have been widely reported, and women who do progress to senior levels continue to experience discrimination on the basis of attributes such as family responsibilities, pregnancy and breastfeeding.*
>
> *In order to combat gendered bias in the administration of healthcare, female staff must be able to be retained through ensuring safety in the workplace. The industry must be attractive to women choosing to study STEM and progress careers in the medical profession.*
>
> *Lived experience of gender bias is helpful in the performance of duties, however more important is having adequate female staffing at more senior levels, which will assist to provide better care to female patients. Women's careers must be supported as their careers are arguably linked with the provision of care where gender is a relevant factor in the treatment. Workplaces which are safe for women will be better able to provide women with appropriate healthcare.*[45]

3.19 The AMA raised the lack of women in leadership roles in the healthcare industry as an issue:

> *For some decades now, the Tasmania State Government has tried to lead by example and promote women into leadership roles within the public service and onto government boards (ref. https://www.stategrowth.tas.gov.au/about/boards_and_committees/wo*

[44] Submission No. 4, Australian College of Rural and Remote Medicine, p. 3.
[45] Submission No. 14, Equal Opportunity Tasmania, p. 9.

men_on_boards). However, the lived experience of those within the system is that discrimination against women is alive and well. As one member put it: "Tasmania has increasing numbers of women in leadership roles within the health sector, which is a significant change from my youth, but in some areas, it is still harder for women to achieve than men."

In discussing this further with another member, her experience has been that men are still appointed to the positions of power, whether it be within the Department of Health or within the colleges. While there are some women within leadership roles, they are few and far between at the middle to upper management levels, and for those who have made it into such a role, they often experience bullying behaviour which can lead to them leaving the service. It would be worth the committee seeking information from the Department of Health as to how many women are in Clinical Director roles, Regional Director roles and Director roles across the agency. Until more women are appointed into leadership roles, at best the perception of and at worst the reality of a 'boys club' will prevail.[46]

3.20 The Committee wrote to the Minister for Health requesting data related to the gender breakdown of those in Clinical Director roles, Regional Director roles and Director roles across the Department of Health and Tasmanian Health Service, including their medical qualifications where applicable. The response is included in Appendix C, v.

3.21 This was further discussed in verbal evidence by Dr Barratt of the AMA, who noted the effort the organisation has made to try and achieve gender balance on its committees:

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

The health sector in Tasmania has guidelines for gender balance, but has not yet managed to reach those in all areas. It has certainly improved since the day I started in health politics. Very early in my career, I was often the

[46] Submission No. 3, Australian Medical Association Tasmania, pp. 2-3.

token female who turned up to committees. I'd be the only person under 30, and I'd certainly be the only one who wasn't a male in a suit wearing a college tie. Things, thankfully, have changed in those years.[47]

Trauma Informed and Empathetic Care

3.22 The Committee also heard in public hearings that there was a need for trauma informed care for medical professionals:

> ***Ms O'BYRNE*** *- … If you were looking to this committee to recommend things that would substantially make differences, what would you hope to see?*
>
> ***Ms BOLT -*** *Definitely trauma-informed training. Everyone is time-poor, but training needs to be from the top down. Typically departments send staff to get training, but rarely do senior executives attend those training sessions.*
>
> *Empathetic thinking. I have been around the medical profession for some time, but there is something unique about the absence of empathy in a lot of practitioners. I'm not sure why that is. Some are fantastic, then there are others, typically people would say surgeons, who do the job and then visit the patient after they have done the surgery as if the person were just another sausage in the sausage factory. Regardless of who the patient is, there has been a physical assault on your body, they've usually had some form of emotional trauma, yet they don't get the dialogue or interaction often.*[48]

3.23 Trauma informed care was also discussed with Ms Dimitria Papavassiliou, a witness from Health Consumers Tasmania (HCT):

> ***CHAIR*** *- … From your perspective as a consumer, what does trauma-informed care look like during the antenatal period and during the labour and birth and postnatal period? They're three different points, obviously. What does it look like?*
>
> *…*
>
> ***Ms PAPAVASSILIOU -*** *I feel for me it's relational, so having a really good relationship with all your health professionals. It's not just your GP, it's not just your midwife, it's a collection of people and they all need to have a good relationship. That was something I felt I lacked in some spaces and I wish I had the feeling of safety that, because it's relational, they know me. They make me feel safe in the way that they interact with me, the way that*

[47] Transcript of Evidence, 14 June 2023, Australian Medical Association Tasmania, p. 35.
[48] Transcript of Evidence, 14 June 2023, Equal Opportunity Tasmania, p. 8.

they might talk or the space that they give me through my whole experience, but also… the principles of trauma-informed care, empowering me to make decisions, giving me information that's evidence-based. There's so much bullshit within the birthing space around what's evidence and what isn't. I think that's something that's really lacking, so that we can make informed decisions, not for the health professional to make a decision for me. That would have been amazing in terms of having that.

***Dr WOODRUFF** - Giving you agency.*

***Ms PAPAVASSILIOU -** Yes, being informed enough to make decisions that I'm confident with. I feel like sometimes health professionals think that we're going to make stupid decisions. We don't know everything.*[49]

3.24 Professor Matthews discussed with the Committee the way the Royal Women's Hospital Victoria is dealing with women post-birth:

***Prof. MATTHEWS - …** 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.*[50]

3.25 Dr Woodruff questioned Professor Matthews regarding why she thought, despite research, there has been no significant change in how healthcare is delivered:

***Dr WOODRUFF** - … 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?*

[49] Transcript of Evidence, 13 June 2023, Health Consumers Tasmania, pp. 15-16.
[50] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 4.

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.[51]

Stereotypes regarding femininity

3.26 A number of submissions to the Committee expressed concerns about the way female patients are treated by medical professionals, particularly in relation to pain. Dr Hann noted:

> *As a GP, I get regular examples of female bodied and identifying patient not feeling heard or listened to, especially in relationship to pain. Female pain is often assumed to be not as bad as it's reported, is under-medicated, and under-investigated. There is significant research in this area to support this. Despite this research, it continues to happen in clinical practice. I'm often told stories of medical professionals not believing my patients when they disclose their symptoms, leaving them feeling "gas-lit" by health professionals.*

[51] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 5.

This is particularly prevalent in the emergency departments (frequently under-investigated and given less pain relief than male counterparts) and in GP/pain specialities when pain is the presenting factor.[52]

3.27 This 'gaslighting' by medical professionals was echoed in verbal evidence given by Ms Ellen MacDonald from HCT, who described her experience of seeking assistance for pain:

> ***Ms MacDONALD*** *- The other area I wanted to talk about in barriers to accessing diagnosis was from my own lived experience of bowel cancer. What I know from other women who have experienced bowel cancer is that sometimes quite obvious and very debilitating symptoms are perceived as women's issues and are dismissed.*
>
> *I was diagnosed early in 2020 and was experiencing abdominal pain, iron deficiency, fatigue, changes in my bowel function. I saw three GPs before it was investigated as cancer. So, it took a lot.*
>
> *…*
>
> ***Ms MacDONALD*** *- I think there's multiple things at play. There's obviously my age as well because young onset bowel cancer isn't very common, and also the fact that I have a higher weight. It is very intersectional. One GP I saw just thought I had a poor diet and recommended oregano oil capsules. She told me I could get these tests done but it wasn't urgent. She was looking at my liver and not anything to do with my bowels. She did a blood test and that sort of thing, and recommended that I have a scan of my liver. She thought I had pain from my liver. Perhaps that was an assumption because of my weight, that maybe I had some fatty liver condition or something like that.*
>
> ***Ms O'BYRNE*** *- Something that has been raised a bit is the assumptions about people depending on how they physically present, like 'you're very thin, therefore you must be healthy' or 'you're overweight, therefore you must be unhealthy', and neither of those two statements are true.*
>
> ***Ms MacDONALD*** *- No, and you can't tell just by looking at someone.*
>
> ***Ms O'BYRNE*** *- But you think it impacts on the way they do investigative work?*
>
> ***Ms MacDONALD*** *- Yes, absolutely and for me it was compounding in some ways because of the dismissal that I had for concerns about my health in the past, and the 'lose weight' line. You start to doubt yourself and gaslight yourself in a lot of ways as well.*

[52] Submission No. 1, Dr Hann, p. 1.

They found low iron and there was all of these things. The second GP that I saw because I was still concerned said it's pretty normal to have low iron when you've got young kids and you've had babies, and all of this sort of stuff… [53]

3.28 The Chair questioned Ms MacDonald as to whether she, or someone with the same symptoms, would have been treated differently if they were a male presenting for care:

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

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

The third GP I saw, who I saw for severe anxiety - in the back of my mind I was quite concerned about my health at this point, I had not even brought up any of the other things - but she saw the notes from before. The way I perceive it is she saw me for the person who was sitting in front of her and she said, 'What about these things?', then immediately did the standard bowel cancer screening test, an inflammation test, more blood tests. Within a week I was going for a colonoscopy and they found bowel cancer. I didn't expect to find that at all. But that is definitely the way I saw that situation, that she didn't just make assumptions. She has never dismissed me in concerns that I've brought to her.[54]

3.29 Ms Papavassilious also spoke about feeling 'gaslit' by doctors in her experience giving birth:

Ms PAPAVASSILIOU *- … They gaslight you into believing that you're crazy. I had things thrown at me like, 'Your baby could die', all sorts of nonsense to be coerced into doing things I didn't want to do. I felt very disempowered during the whole birth.*[55]

3.30 In her submission, Ms Duncan noted the inadequacies that exist in the medical profession in dealing with women's pain:

Healthcare has been built on hierarchical and patriarchal culture – meaning, "doctor and institution knows best". Insidiously ingrained

[53] Transcript of Evidence, 13 June 2023, Health Consumers Tasmania, p. 7.
[54] Transcript of Evidence, 13 June 2023, Health Consumers Tasmania, p. 7.
[55] Transcript of Evidence, 13 June 2023, Health Consumers Tasmania, p. 12.

cultures are perpetuating gender biases in healthcare which are affecting women's health.

Sadly, many women are still being treated as "hysterical" when presenting to health care facilities with an array of different medical conditions. I have witnessed this as a nurse and also as a patient who suffers from endometriosis, adenomyosis and interstitial cystitis myself.[56]

3.31 Ms Duncan went on to outline her own experience:

I presented to a GP's clinic during extreme menstrual pain. I couldn't book in to see my regular GP due to extensive waiting periods, so I had to attend a different clinic. I sat in the waiting room pale, vomiting into a bag, and I was feeling extremely dizzy, all because I had my period. I had a heat bottle strapped to my abdomen and another heat bottle tucked into the back of my pants, providing some, but minimal comfort. In the waiting room, I received scornful looks as I rocked back and forth appearing like I was in labour. I sat there under people's watchful eyes feeling vulnerable, exposed and critisised. Finally, I was called into the GP's office. I sat down feeling relieved. Help was on its way. I was wrong. The doctor told me I was "clearly drug seeking" and using my period as 'an excuse'. I had no words because I was shocked someone could suggest such a thing. He said that because I was asking for Panadeine Forte from a doctor that wasn't my regular GP, it looked "suspicious". When I explained I was unable to make an appointment with my regular GP, he told me that "excuses" like that were a part of "drug seeking behaviours". He threatened that if I tried to "seek opioids again", he would report me to AHPRA [Ms Duncan is a registered nurse].[57]

3.32 Ms Duncan discussed these experiences with healthcare professionals in verbal evidence to the Committee, especially exploring her role of self-advocacy in seeking treatment due to inadequate care:

***Ms DUNCAN** - … In January, when I was in hospital, the staff and nurses were amazing but whenever the catheter was removed, I would go back into urinary retention as a result of the pain. I do not know how much you may or may not know about endometriosis, but the pelvic floor is heavily affected and all those functions can be affected. When I went into what my version of retention is, which is a much lower capacity of urine volumes than most average people's, I was told by some junior medical doctors that if the nurses made me wait long enough, I eventually would go on my own. I was in extreme pain and when I did go, I was peeing blood. I was told, when I requested an indwelling catheter to stay in, that I didn't need one and I was given the only option to do in-out catheters. I don't know if*

[56] Submission No. 3a, Ms Duncan, p. 2.
[57] Submission No. 3a, Ms Duncan, p. 2.

anyone has seen what they look like but they are very sharp and it was excruciating.

***CHAIR** - They are not flexible.*

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

***CHAIR** - They also carry risk of infection.*

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

***Ms DUNCAN** - For me, this is where I get frustrated because I have clinical knowledge and I was dealing with in-out catheters four or five times an hour, screaming in the bathroom in pain and I was told I didn't need a catheter because the catheter that I had had a greater risk of infection than doing one to four or five catheters an hour every hour. I kept saying, 'I think I have an infection', and I wasn't believed about that either. It got to the point where two female junior doctors and some female nurses went against medical advice and inserted one for me at my request, after six hours of being acopic because I was left in pain. It was really traumatic, I had no autonomy over my body. I kept saying that I wanted something and I wasn't receiving it.*[58]

3.33 The AMA's submission, discussed gender bias impacting women's healthcare, including medical professionals delaying the admission of female patients to their care unless there is a diagnostic certainty:

> *What I have observed in my field of practice is a more dismissive approach by the medical and legal systems to females with "unseen" injuries, particularly occupational overuse disorders (which are more common in women in any case due to more frequent involvement in repetitive factory and office-based tasks). I have no hard evidence, just my impression over the years.*
>
> *On a weekly basis I am disappointed at how poorly women are treated by the health system. This specifically relates to the issue of abdominal pain in women versus men. It is very common that it is apparent a woman will require admission to hospital with abdominal pain. However, the models of care we have in place mandate that the patient be admitted under a specific team – either gynaecology or general surgery. The diagnosis may not be apparent, but all clinicians involved in the care of the patient agree she needs admission. But in the absence of diagnostic certainty, neither team wants to run the risk of having the patient admitted under their care when the diagnosis is eventually reached.*

[58] Transcript of Evidence, 14 June 2023, Ms Duncan, pp. 2-3.

I have seen women be pushed back and forth between three different teams for over 20 hours, with multiple rounds of imaging and investigations, before admission was finally arranged. This has included angry words between teams in front of the patient, guaranteed to make her feel like a burden. This would never happen to a man.

There are solutions if our structures allow it. The simplest would be to have a "female abdominal pain" admission unit, with shared care by both gynae and surgery, until such time as the diagnosis became clear. There should also be removal of administrative barriers for movement of patient care from one team's bed card to another.

Better structural reform would be at the level of colleges, with both teams having the requisite training to provide care to whatever pathology came their way.[59]

3.34 Ms Duncan told the Committee of her experiences regarding inadequate care in the emergency department for health concerns relating to numerous conditions which often result in intense pelvic pain:

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

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

***Ms O'BYRNE** - Just being hysterical.*

***Ms DUNCAN** - We are hysterical and I think that's just what being a woman is. You go through childbirth and you must be able to tolerate pain and it is a very different kind of pain. I feel like you are stuck between a rock and a hard place because if you have education and understanding around your condition, you are almost gaslit for being too controlling, and too this and that about your own healthcare choices. But then, if you are not informed, you get brushed off.*

I was in the ED once and was diagnosed with adenomyosis, and the male senior doctor was telling me that it is not a painful condition. Thankfully a junior RMO (registered medical officer) advocated for me, saying it is an

[59] Submission No. 10, Australian Medical Association, pp. 9-10.

incredibly painful condition. As a junior, it took a lot for her to say that to a consultant. I admired her for that and it was really validating.

As someone who has worked in the emergency department, I have been in handovers where someone just said, 'Oh, she is just here for her period, she just needs some pain relief'. There is no care in that in a lot of situations, because it is not a priority in terms of emergency medicine, it is just pain management.[60]

3.35 Following discussions on the difficulties of women getting pelvic pain to be taken seriously by some doctors, the Chair asked the representatives from the AMA what the correct treatment pathway should look like:

CHAIR *- So what should the treatment pathway look like?*

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

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

Dr AHMAD *- With some of the surgicals being outsourced to the private facilities, if that could be done with the public processes that will be amazing. So that is something that could be considered.*[61]

3.36 Equal Opportunity Tasmania noted in their submission to the Inquiry that, while stereotypes regarding the forms of pain endured by women is beginning to shift, the transition is and will continue to be slow while gendered perceptions remain to exist in the healthcare setting:

The stereotypical perception of women as being dramatic, sensitive and emotional may impact the seriousness with which their reported symptoms are considered and addressed. With increasing awareness, these stereotypes are being challenged, however there is still substantial work needed to change existing views.[62]

3.37 This idea that females' pain is treated as under-rated was also reflected upon by FPT in their submission:

Stereotypes about gender*: these affect how doctors treat illness and approach their patients. Women's pain is more likely to be treated as a*

[60] Transcript of Evidence, 14 June 2023, Ms Duncan, pp. 3-4.
[61] Transcript of Evidence, 14 June 2023, Australian Medical Association, p. 53.
[62] Submission No.14, Equal Opportunity Tasmania, p. 15

product of a mental health condition than a physical condition. The same study shows that women with chronic pain are seen as emotional or hysterical compared with men, who are seen as brave or stoic. When doctors don't take patient's symptoms seriously, it can lead to later diagnosis. This study found that in 72% of cases, women wait for longer for a diagnosis than men.[63]

3.38 In verbal evidence, Ms *O'Byrne* questioned Ms Duncan on her experience with the understanding and treatment of her pain:

> ***Ms O'BYRNE*** *- … A number of things that you might present to ED with don't require hospital admission, but they do require an emergency response that can be managed within the ED. That understanding seems to be where the challenge is. People say, all these people present to hospital and they don't need to go into hospital, so they must have been okay. Broadly, of the emergency treatments that don't require admission, pain management is a significant one.*
>
> *From your experience, how well is that resolved?*
>
> *…*
>
> *I am interested in your perspective as a user of this health service, but also somebody who works in the health service. I notice that in all of your comments you have talked about how good and kind the staff have been. You have been very sympathetic to the stresses they are under. I am particularly interested in pain management, because that seems to be where we first dismiss a number of concerns.*
>
> ***Ms DUNCAN*** *- … I think there was a research paper the other week with evidence that supported what you just said - that men who have pain will receive greater pain relief and faster pain relief than a woman who presents with even worse pain, who will get much less, and often the waiting time is much longer. That has been provided in research.*
>
> *Pain management I think is not well managed in the community. A lot of GPs are quite hesitant to prescribe schedule 8 and schedule 4 opioids like Endone and Targin because of the potential risk of addiction. I am fortunate to have a really great GP, but I haven't always had great GPs. There is that hesitation - just have some Panadol or Nurofen.*
>
> *For that cohort of people who do not receive adequate pain relief prescriptions from their GP, there are no other options but to go to the emergency department. I think if there was better management in the*

[63] Submission No. 12, Family Planning Tasmania, p. 2.

community, it would hopefully prevent, in some circumstances, people needing to go to the ED.[64]

3.39 In their submission to the Committee, the AMA consulted with its members to collect comment on gendered bias. Responses were vast and included those such as the following:

> *"It is my experience that women are rarely regarded as experts, even of their own experiences. How do we know if someone has not been offered an appropriate investigation or referral? It is usually when a measurable harm occurs. A patient who was in late pregnancy presented with visual changes, headaches and leg swelling to their obstetrician. There was also evidence of a rising blood pressure. She was told she was anxious and that her symptoms were due to the heat. It turned out to be early pre-eclampsia and because she wasn't diagnosed early, she ended up being very unwell with a severe form of pre-eclampsia called HELLP*[65] *syndrome.*
>
> *I only have suspicions that women with chest pain or shortness of breath are not receiving the same investigations that other patients with similar symptoms would receive like a cardiac stress test or a D dimer test (which can evaluate the risk of a pulmonary embolus). Gender bias can be invisible but can cause real harms by the disbelief of women's experiences."*[66]

3.40 In her submission, Dr Hann noted negative experiences with health professionals in connection to gendered bias can result in missed or delayed diagnosis:

> *This leads to worse health outcomes, missed or delayed diagnoses (see recent ABC article about ovarian cancer missed in a 25 year old female because her pain was ignored), and resulting lack of trust in health systems. The lack of trust results in less interaction with preventative health services, thus presenting with end stage disease rather than preventing complications early.*[67]

3.41 Negative impacts on patient outcomes due to gender bias was also discussed with Dr Colin Smith from ACRRM:

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

[64] Transcript of Evidence, 14 June 2023, Ms Duncan, p. 5.
[65] Hemolysis, Elevated Liver enzymes and Low Platelets
[66] Submission No. 10, Australian Medical Association Tasmania, p. 7.
[67] Submission No.1, Dr Hann, p. 1.

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

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

If you have someone who has transitioned from male to female, part of the job of a GP is risk stratification; that becomes quite difficult because then you are putting hormonal treatments and a whole bunch of overlays of psychological stuff on top of things. That's an area we're just starting to think about.[68]

3.42 The ACRRM again noted this nature in their written submission to the Committee:

The gender and other diversity of patients and their communities has important implications for the way that healthcare practitioners and services should provide best practice care.

Studies demonstrate that gender sensitive care leads to better patient outcomes and recovery from mental and physical conditions. Conversely, gender bias can have a significant negative impact on medical diagnosis and the quality of healthcare people receive. It can lead to substantial delays in diagnosis, misdiagnosis and even death. For example, a study of transgender people demonstrated that 28% had postponed necessary medical care when sick and 33% had delayed accessing preventative care due to discrimination by healthcare providers.[69]

3.43 Such distrust of medical professionals was also discussed by Mr Bruce Levett from HCT, highlighting the breadth of community concerns:

Ms O'BYRNE *- … within your frame of people that you support, are there other non-cisgendered women who are having that kind of ignoring of their treatment?*

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

[68] Transcript of Evidence, 14 June 2023, Australian College of Rural and Remote Medicine, pp. 12-13.
[69] Submission No.4, Australian College of Rural and Remote Medicine, p. 2.

Dr WOODRUFF *- Because of an experience like this?*

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

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

Mr LEVETT - *Yes, that's why I won't mention the location. I understand that for at least one, maybe two, the only interaction they had with the health system was with a home birth that went wrong, so they ended up in hospital. They would push and push and push to not engage with the system because they didn't trust it.*[70]

3.44 Dr Hann noted that there continues to be a perception of female pain that is perpetuated by senior medical professionals:

> *The heteronormative cis white male gaze that perpetrates health systems, health education, and current health hierarchies means that these gaps continue to be reinforced. Current medical school education focuses on white male bodies and systems, with minimal focus on culturally diverse bodies/presentations or female presentations of disease (unless presented in racialised and stigmatised manners). Practices are reinforced by comments made by supervisors to junior doctors/nurses, such as "ah, it's probably just her period cramps that she can't handle" or "women are so whiney" or "she's probably just making it up" (all are comments I've heard as a junior doctor).*[71]

3.45 Professor Matthews, of the Royal Women's Hospital Victoria also noted the need for healthcare professionals to be more open to the concerns of patients when considering avenues of treatment:

> ***Prof. MATTHEWS -…*** *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,*

[70] Transcript of Evidence, 13 June 2023, Health Consumers Tasmania, p. 14.
[71] Submission No. 1, Dr Hann, p. 1.

'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.[72]

3.46 Mr *Willie* questioned Professor Matthews on what Victoria is doing to address equity in healthcare:

> ***Mr WILLIE*** *- … 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.*[73]

3.47 Professor Matthews also discussed with the Committee the Hospital led COSMOS program which aims to provide exceptional care for expectant mothers:

> ***CHAIR*** *- …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*

[72] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 3.
[73] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 10.

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.[74]

3.48 The Committee requested further information from the Royal Women's Hospital Victoria regarding the nature of the COSMOS program:

COSMOS is a program that delivers a 'caseload midwifery' model of maternity care and has been operating in Australia for many years.

Considered the "gold standard" of maternal care, caseload midwifery sees a woman assigned to an individual midwife (with back up midwives) throughout their pregnancy, birth and early postnatal period. It has been shown to reduce caesarean births, epidural pain relief during labour, length of hospital stay, episiotomies, low birth weight babies and newborn admissions to special and intensive care.

The midwives refer women to other health professionals as appropriate, and work collaboratively with obstetricians but women stay under the care of their known midwife, even if their particular pregnancy needs more specialised input.

…

In 2023-24, the Women's is employing 12.6 FTE for the COSMOS program and expects to care for 549 women within those resources.[75]

3.49 The additional information provided to the Committee further detailed information other programs offered by the Royal Women's Hospital Victoria. This includes Baggarrook Yurrongi (Women's Journey), a midwifery program which specialise in the care of Aboriginal and Torres Strait islander women and babies:

The goal of the program is to improve the health of Aboriginal mothers and their babies, close the health gap in outcomes and deliver services which are culturally sensitive, and responsive to the needs of First Nation communities.

In 2023-24, the Women's is employing 4.6 FTE for the Baggarrook program and expects to care for 161 women.[76]

[74] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 3.
[75] Additional information, 27 November 2023, The Royal Women's Hospital Victoria, pp. 1-2.
[76] Additional information, 27 November 2023, The Royal Women's Hospital Victoria, p. 2.

3.50 Finally, the Royal Women's Hospital Victoria also detailed the Magnolia Program, which offers aid to vulnerable and socio-economically disadvantaged women to reduce the occurrence of preterm birth:

> *Currently established as a randomised research trial, led by La Trobe University, the Magnolia program is being delivered at the Women's, the Northern Hospital and Bendigo Health and will last three years.*
>
> *In 2023-24, the Women's is employing 4.0 FTE for the Magnolia program and expects to care for 190 women.*[77]

Denial of Healthcare due to Bias

3.51 Some evidence presented to the Committee demonstrated instances of patients been denied care by health professionals. In her submission Dr Hann noted:

> *Many of my patients have been declined medical care by a health professional, told their identity wasn't real, or told to go elsewhere to have their medical needs met (even if those medical needs were completely unrelated to their gender - aka headache).*[78]

3.52 This was further discussed in verbal evidence:

> ***CHAIR** - I would have thought it would be completely unethical for a doctor to refuse to treat someone purely because they're trans.*
>
> ***Dr HANN** - The rule around the ethics of that in medicine is if you refuse to provide care to somebody, you have to refer them on to someone who can. For instance, like with abortion, if you don't provide abortions you have to be able to refer that patient to another space that will provide them. That doesn't mean these people are referred onwards and it doesn't mean that's an ethical pattern that's followed. In order for that to be enforced, the patient would have to report the clinician and I doubt most patients know that that's a requirement within our ethical framework in medicine.*[79]

3.53 Refusal of care was also raised in the area of pregnancy terminations, with FPT noting in its submission that staff often hear information regarding negative experiences from patients:

> *"I often hear about women seeking termination either being outright denied a referral for a termination, or being sent for repeated investigations without any referral or acknowledgement of their request*

[77] Additional information, 27 November 2023, The Royal Women's Hospital Victoria, p. 3.
[78] Submission No. 1, Dr Hann, p. 2.
[79] Transcript of Evidence, 13 June 2023, Dr Hann, pp. 2-3.

for a termination. A terrible example recently was a young person being told that she was in the prime age group to have a healthy pregnancy and would regret having a termination."[80]

3.54 The above comment was further discussed in verbal evidence with Ms Jessica Willis from FPT:

> ***Ms O'BYRNE*** *-… it says in the submission:*
>
> > *I often hear about women seeking termination either being outright denied a referral for a termination or being sent for repeated investigations without referral.*
>
> *And the line about someone being told they were in the prime age group to have a healthy pregnancy and they would regret having a termination.*
>
> ***Ms WILLIS*** *- That's something our doctors have come across, hence the inclusion in the submission. I think for Family Planning Tasmania, from an organisational perspective, the bigger problem is actually simply that it's acceptable for so many doctors just not to engage in the topic of abortion, for example. It's too easy for them to be able to say, I just don't do women's health care, go find someone that does. For me, that's a much bigger problem.*
>
> ***Ms O'BYRNE*** *- The legislation says that they're supposed to find you someone who does. That doesn't seem to be the lived experience that we're hearing.*
>
> ***Ms WILLIS*** *- I would say that definitely happens, although most GPs would at least know a colleague who is happy to provide women's healthcare services, and so they can send everyone in that direction.*
>
> *For me, that feels like a bigger problem. Again, that doctor who is then not engaging with women's health care because it's not financially very rewarding, and because you need to have additional skills and training, for me it's sort of outrageous that the doctor probably then goes on to earn more money by choosing not to engage with this whole complex area of health care.*[81]

3.55 In evidence to the Committee, Professor Matthews discussed the many issues women face with having their healthcare issues addressed:

> ***Prof. MATTHEWS*** *-… I will also use the term 'women', but also what I am saying applies to people assigned female at birth. For many reasons,*

[80] Submission No. 12, Family Planning Tasmania, p. 3.
[81] Transcript of Evidence, 14 June 2023, Family Planning Tasmania, pp. 26-27.

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.[82]

3.56 Professor Matthews continued, noting the work the Royal Women's Hospital Victoria is doing to address these issues:

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*

[82] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, pp. 1-2.

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.[83]

Gendered Cost of Healthcare

3.57 A number of submissions discussed the gendered nature of healthcare costs. In their submission, FPT discussed the high costs for a number of women's healthcare services:

Medication termination: a high quality Medication Termination of Pregnancy (MTOP) service such as that provided at Family Planning Tasmania takes over 180 minutes of medical practitioner time to provide. Medicare (via MBS) will cover 40 minutes of this - and at a rate that is not sufficient to cover a GP's salary. The nurse time spent on MTOP (75 minutes) is not rebated by Medicare at all.

Antenatal care: the Medicare rebate for an Antenatal appointment is just $42.40, despite the fact these appointments overwhelmingly require a 30 minute consultation. This rebate is less than a regular consult for over 30 minutes ($76.95), effectively penalising pregnant women (or the doctors that treat them).

Lack of rebate for nurse services: at FPT nurses provide most cervical screening tests but are unable to claim Medicare rebates for their time (item numbers for nurses previously existed but were withdrawn by

[83] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 2.

MBS). This is effectively a financial penalty for women to undertake what is an essential preventative health/screening service. [84]

3.58 The AMA, in their submission, gave the example of ultrasound costings to highlight this point:

> *These are the full rebates (not benefits) that radiologists receive for performing certain procedures:*
>
> *Ultrasound scrotum: $113.95*
> *Ultrasound pelvis: $102.20*
> *Ultrasound breast: $102.20*
>
> *Arguably a pelvic scan is more complex than a scrotal scan and also involves a vaginal probe in addition to the standard probe (more equipment). Considering organisations like the AMA, are consulted on the fees list, it shows how bias prevails across the medical organisations and government departments to the detriment of women and their health.*[85]

3.59 The AMA also discussed in their submission the costs incurred by pregnant women for scans:

> *The 20-week scan is imperative in determining foetal health. The first trimester screen is another important test which can help a woman calculate the chances her child has one of three foetal chromosomal disorders in addition to other abnormalities. An early assessment allows her more choices with regards to further testing.*
>
> *An example from IMED radiology (Southern Tas) of the costs of a 20-week morphology scan that is ordered by an obstetrician:*

	Initial outlay	Rebate	Out of pocket cost
Health care card (HCC) holders	$196	$101.75	$95
Full fee paying	$326	$101.75	$225

> *An example from IMED radiology (Southern Tas) for the costs of the first trimester screen scan:*

	Initial outlay	Rebate	Out of pocket costs
HCC holders	$156	$61.95	$95
Full fee paying	$287	$61.95	$225

[84] Submission No. 12, Family Planning Tasmania, p. 3.
[85] Submission No. 10, Australian Medical Association Tasmania, p.5.

Understandably these costs may serve as a barrier to pregnant women getting equitable health opportunities that may have long term ramifications. With the poorest families in Australia scraping by on $150 a week after housing costs it is just not possible to pay the initial outlay required for these tests, even as health care card holders.[86]

3.60 In its written submission, the AMA discussed the discrepancies in funding for women specific medications:

There are several medications specifically used by females, such as those for contraception and menopausal hormone replacement. Some are funded, but many of the newer and widely recommended options are not. It is routine in general practice to have discussions about the best medications to manage contraception, menstrual bleeding difficulties and in particular mental health but one also must consider the affordability of and therefore access to the prescribed medication. Often, the agent most likely to have the most favourable treatment and side effect profile is unaffordable. The agents that come to mind here are Estrogel - a topical estrogen replacement (lower risk of blood clots than funded oral agents), several other topical agents, and contraceptives like Zoely (an oral contraceptive pill touted for its minimal mental health side effects -$87/3 months), and Slinda (non-oestrogen oral contraceptive which has a 24-hour window to take it – an ideal pill for women who can't take oestrogen e.g. women with migraines with aura. $33/month for a 3-month box, or $76/3 months). These medications are not on the Pharmaceutical Benefits Scheme. These have implications for Health care card holders and Aboriginal and Torres Strait Islander patients who can access the Close the Gap pharmaceutical benefits.[87]

3.61 The Royal Women's Hospital Victoria also discussed issues with the supply of women specific medications:

Recent supply constraints for a number of medications used to treat and care for women in Australia have highlighted the vulnerability of women to supply disruptions. This includes Nifedipine (an angina and hypertension drug used 'off-label' to prevent pre-term labour) and Misoprostol (a gastric ulcer medication used off-label to assist labour, and for miscarriage and abortion).

Supply disruption to vital medications used to manage women's health has been an issue in Australia for some time due to:

- *Pharmaceutical companies not maintaining TGA registration and market supply because newer and more commercially successful*

[86] Submission No. 10, Australian Medical Association Tasmania, pp. 5-6.
[87] Submission No. 10, Australian Medical Association Tasmania, pp. 3-4.

medications are available for the officially registered 'on-label' use.

- *The commercial unattractiveness of these older, off-patent medications used for off-label purposes means they are generally only imported by a single sponsor. When that sponsor elects to discontinue importation, there is no other alternative, forcing pharmacies and health services to import agents directly under the TGA SAS scheme.*[88]
- *The structural disadvantage faced by women more broadly as a result of poor sex-specific research with the default focus being on white men.*
- *The systemic failure to include pregnant women in therapeutic clinical trials (which represents a broader gender bias resulting in a lack of much-needed research in women's health conditions and risks) has resulted in a dearth of newer, potentially more effective medications used commonly in women's health.*[89]

3.62 MRT also argued that there is a level of inconsistency of funding between genders for healthcare services:

> *Governments at all levels consistently direct more funding to improve the lives and health of women and girls through research grants, health screening programs, women's budgets and women's health strategies.*
>
> *Even when a health issue predominantly impacts men we find that funding is repeatedly directed towards initiatives that are more effective at reaching women.*[90]

3.63 The conjunction of impacts of the cost of healthcare with potential financial disadvantage of women was highlighted as a further barrier to potential involvement with the healthcare system. Ms Willis, from FPT, explored this at a hearing of the Committee:

> ***Ms WILLIS*** *-… 96 per cent of our patients are either female or assigned female at birth, and all of our doctors - 25 doctors and eight nurses - are also female. We were motivated to submit to this inquiry because we really do witness, day to day, the disadvantages women experience in our healthcare system - that is, both female patients and female doctors.*
>
> *I have tried to outline in my submission the areas we see and think women face the most disadvantage. I would probably summarise by saying it is largely a financial disadvantage in the sense of the complex needs that women have throughout their reproductive life and beyond, and the fact*

[88] Therapeutic Goods Association Special Access Scheme
[89] Submission No. 16, The Royal Women's Hospital Victoria, pp. 6-7.
[90] Submission No. 9, Men's Resources Tasmania, p. 4.

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

The Medicare rebates for these services are grossly insufficient for the amount of time it takes, which effectively results in what I fear is a women's health tax that's either paid by the patient or borne by the GPs, who are also overwhelmingly female.[91]

Leave Entitlements Available for Women

3.64 The Committee received evidence regarding a disjointed relationship between women's health concerns and their positions of paid employment. In her submission, Ms Duncan noted that leave entitlements are often limited, including sick leave. Such limits further complicate the management and treatment of health conditions for some women, if inadequate leave is available or if alternate forms of leave have to be taken, such as annual leave:

The majority of women have 10 sick days per year. There are 12 months in the year. How many menstrual cycles does that cover? As a result of frequent sick leave due to Endometriosis and pain, women often face unnecessary and detrimental comments in their workplace regarding their 'professionalism'. I too have also experienced this. Female senior colleagues (who are nurses) have contacted me via social media or spoken with colleagues who I associate with outside of work, to question the validity of my sick leave. Women as well as men are perpetuating a hierarchical and patriarchal cultures which discriminates against female employees with endometriosis.

Women who miscarry are often only afforded two days paid leave… two. 1 in 4 women miscarry and 1 in 4 women have an abortion. Women with endometriosis rarely have sick leave accrued. This is a facet of the gender pay gap. A female nurse in Launceston recently shared with me she miscarried whilst at work and continued to work due to fear to professional repercussions if she asked to go home. There are many women among us who have continued to work in the depths of grief to maintain financial stability, and there are also women who have taken time to grieve, but are not being financially supported to mentally, emotionally and physically heal from a pregnancy loss.[92]

3.65 The impact of caring stereotypes of femininity also arises in the context of leave entitlement. The AMA, in its submission, noted that the process of seeking carer's leave has become increasingly complex:

[91] Transcript of Evidence, 14 June 2023, Family Planning Tasmania, p. 23.
[92] Submission No. 3a, Ms Duncan, p. 6.

Women are disproportionately burdened by the care of children, especially single mothers. Some workplaces require a doctor's medical certificate for carers to take carer's leave. This requires time, money and takes up unnecessary General Practice appointments as most children, with a simple respiratory illness, do not need any medical intervention. An examination can also be distressing to a sick child.[93]

Insufficiencies in the Provision of Women's Health Services

3.66 Evidence to the Committee suggested there were several particular areas of women's health in which the provision of adequate services is an issue. These areas include the availability of abortion services, treatment for menopause, access to contraception and access to gynaecological services. The FPT submission discussed the insufficient numbers of general practitioners available to provide women's health services:

> *Many patients come to FPT because they are unable to access quality women's health care in General Practice. In particular, typically only female GPs provide cervical screening tests, Implanon inserts/removals and Intrauterine Device (IUD) inserts. Very few GPs (male or female) provide medication termination of pregnancy (MTOP), in part because it is time consuming and financially unsustainable to deliver and these GPs have not undertaken additional training and qualifications to understand the complexity in women's health.*
>
> *This problem is particularly bad in rural and remote parts of Tasmania. Family Planning Tasmania is contacted frequently by medical services in rural and remote regions requesting women's health outreach. While FPT has doctors who are keen and willing to provide outreach (and have in the last 6 months carried out successful outreach to St Helen's, which was funded by the requesting organisation), FPT is not funded to provide this and cannot cover the costs through the Medicare rebate. The lack of GPs providing women's health services results in women forgoing essential screening services such as cervical screening.*[94]

3.67 The submission from Women's Health Tasmania also discussed issues with reproductive health literacy in the healthcare workforce:

> *Doctors, particularly general practitioners, need to be encouraged to do extra training in women's health. We are aware of a patient whose menopausal symptoms were disregarded by her long-term male general*

[93] Submission No. 10, Australian Medical Association Tasmania, p. 7.
[94] Submission No. 12, Family Planning Tasmania, p. 3.

practitioner (GP) – he told her it doesn't tend to last very long. She says she felt her symptoms were invalidated, minimised, and brushed aside. It is important to note that menopause can have serious psychosocial effects on women including loss of income.

When this same patient saw a female GP she got a comprehensive assessment and was offered hormone replacement therapy. Women in rural or remote areas may not have the benefit of choice, and their care may be even more disrupted by the use of locums.[95]

3.68 Problems accessing maternal healthcare were discussed in verbal evidence by Ms Jo Flanagan from Women's Health Tasmania:

> ***Ms FLANAGAN*** *- … We are concerned about the state of maternal health care in Tasmania, and our concerns are based on anecdotal information we have received from clients over the last five years. They include problems finding GPs who are knowledgeable about pregnancy and pregnancy care pathways; problems gaining access to specialist midwifery programs; service responses during the COVID-19 pandemic, specifically with the withdrawal of services during the pandemic; what appears to be premature discharge of new mothers and infants from the hospital to a lack of support in appropriate housing; lack of support for women experiencing maternal exhaustion and difficulties with breastfeeding; poor access to GPs post-birth for new mothers and infants who cannot get appointments and are referred to emergency departments after the birth; limited access to CHaPS [Child Health and Parenting Service] services, lack of access to allied health supports - for example pelvic floor physiotherapists and psychologists who work with women experiencing birth trauma - and we're also concerned about the very high rate of birth trauma that we are seeing in our counselling services - that's trauma associated with child-birth complications, interventions and outcomes.*[96]

3.69 The Royal Women's Hospital Victoria raised in its submission the need for women to have access to safe and effective contraception and, if necessary, terminations:

> *Access to safe, effective and appropriate contraception and abortion is basic healthcare, fundamental to women's self-determination and key to addressing gender inequality. However, in Australia, we are yet to widely recognise and accept this, and we are well behind many similar countries.*[97]

3.70 The Royal Women's Hospital Victoria went on to discuss difficulties that could be faced by women seeking terminations across Australia:

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[95] Submission No. 10, Australian Medical Association Tasmania, p. 3.
[96] Transcript of Evidence, 14 June 2023, Women's Health Tasmania, p. 58.
[97] Submission No. 16, The Royal Women's Hospital Victoria, p. 3.

> *Early medical abortion (using the medications mifepristone and misoprostol) is a well-established alternative to surgical abortion for early pregnancy. These routinely used medications are widely recognised as safe and effective, including by the World Health Organization. Early medical abortion is non-invasive and should be the first option for unwanted pregnancy. However, in Australia, its use is still comparatively low to that of other countries where it is considered to be a standard option and easy to access.*
>
> *…*
>
> *With various conditions, surgical abortion is legal in all Australian states and territories, providing it is done by a registered medical professional. Yet many publicly funded hospitals in Australia that provide maternity and women's health services do not provide abortion services at all; others provide very limited services or have complicated care and referral pathways making access very difficult. One of the reasons is that public hospitals are not mandated through state government directives or funding agreements to provide contraception and surgical abortion care. Each state health authority releases clinical capability framework directives that govern the level of service a public hospital must provide (with hospitals ranked from Level 1, being basic care, through to 6, being high risk or complex care). Yet these directives (and individual funding agreements) do not include any mention of women's health or gynaecological care, let alone the mandated provision of abortion or contraceptive services.* [98]

3.71 The submission from the AMA discussed the current difficulties faced by women in the access of safe and cost-effective terminations, specifically in Tasmania:

> *It is a myth that terminations are difficult to access in Tasmania. Many GPs offer this service and the Women's Health fund can assist with the cost. Unfortunately, this information is difficult to disseminate openly in our relatively small community. A member said: "I have had patients try to buy the terminations medications online as they were not aware that their GPs offered this service or because they were concerned about the cost. The medication they bought from the internet did not work and could have possibly caused them harm."*[99]

3.72 In its submission, FPT also raised the issue of cost barriers to women seeking medical terminations in Tasmania:

> *There are cost barriers to Tasmanian women accessing Medication Termination of Pregnancy (MTOP). Perversely, it is now more affordable*

[98] Submission No. 16, The Royal Women's Hospital Victoria, p. 4.

[99] Submission No. 10, Australian Medical Association Tasmania, p. 7.

for many Tasmanian women to access Surgical Termination of Pregnancy (STOP), than MTOP.

Access to STOP in Tasmania has improved greatly since the service was introduced in Tasmania's public hospitals in October 2021. STOP is now free for all women, including non-Medicare card holders. This approach is strongly supported by FPT.

Nonetheless, non-invasive MTOP is the preferred abortion alternative for many Tasmanian women. FPT provides approximately 400 MTOPs per year in a primary care setting. MTOP is also provided by some GPs. FPT is not specifically funded to provide MTOP, and therefore currently needs to charge 'out of pocket' costs for women who are not eligible for State Government funding. Out of pocket costs for health consumers of MTOP are required because the service requires significant patient preparation, monitoring and follow up.

While the costs of MTOP in Tasmania may be reimbursed for people who can demonstrate financial hardship (with government funding administered via Women's Health Tasmania and The Link) this creates a further barrier for MTOP compared to STOP. Medical practices such as FPT must still 'advertise' the cost of MTOP, and consumers have to declare they can't pay in order to access financial hardship support. There is evidence that some clients are unable or unwilling to make this declaration to FPT, including due to feelings of shame and embarrassment. Some of these women unfairly incur the financial hardship of MTOP 'out of pocket' expenses. Others do not proceed with the MTOP at all, and instead access STOP. An unknown number of women may proceed with an unwanted pregnancy.

Women who would prefer to choose MTOP, but cannot due to out of pocket costs, can instead access free STOP in public hospitals at an approximate cost to the health system of $3,000 per procedure. Conversely, every woman who chooses to access MTOP in a primary health setting, instead of STOP in a public hospital, reduces pressure on the public health system. MTOP also provides options for tele-health delivery that are not possible with STOP, which can be particularly beneficial for women in regional and remote Tasmanian communities.[100]

3.73 FPT indicated that it could, with appropriate funding, improve this situation by providing medical terminations through its clinics and outreach programs:

FPT proposes to provide equitable access to MTOP for all Tasmanian women by fully funding MTOP through FPT clinics in Glenorchy, Launceston and Burnie, and via FPT outreach to remote and regional parts of Tasmania.

[100] Submission No. 12, Family Planning Tasmania, p. 6.

FPT is a proven, high-quality provider of MTOP in Tasmania. FPT has systems, processes, facilities and equipment in place – including nursing support and specialised GP training – to expand on its current provision of 400 MTOP services per year. FPT now provides in-house ultrasound (required prior to some MTOP procedures) and has a focus on providing reliable contraception and support to all MTOP patients to prevent future unplanned pregnancy.[101]

3.74 This possibility for care was also discussed in verbal evidence with FPT as an option to increase available women's centred healthcare:

***CHAIR** - Going back to the funding model, Family Planning has services in three regions of the state. What do you think might be the answer to addressing out-of-pocket expenses and some women making decisions to have a surgical termination at a greater cost to the health system … I am interested in how you think this will work to provide an equity of access service?*

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

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

Family Planning Tasmania was recently selected by the federal health department to specialise in endometriosis and pelvic pain, and they've funded existing clinics to provide specialised services for endometriosis and pelvic pain. In my opinion, with some additional funding, a lot of these issues of gender bias and inequitable access to services could be addressed at a state level simply by extra funding to pay doctors for their time - with the understanding that Medicare rebates do not do that. They do not cover that cost.[102]

3.75 The Royal Women's Hospital Victoria submission expanded their discussion regarding contraception and termination, by supporting the need for national training, research and advocacy in these areas of essential women's healthcare:

[101] Submission No. 12, Family Planning Tasmania, p. 6.
[102] Transcript of Evidence, 14 June 2023, Family Planning Tasmania, p. 25.

All governments support and fund a national training, research and advocacy centre in contraception and abortion to address the systemic and workforce barriers currently limiting access to sexual and reproductive healthcare. We envisage that the centre will:

- *Include both in-hospital training for post graduate specialisation, as well as decentralised training and mentoring in primary care to increase the numbers of practitioners and centres equipped to provide sexual and reproductive health services.*
- *Involve people with lived experience to inform and develop best practice models of care, including groups such as young women, adolescents, First Nations, LGBTIQA+, culturally and linguistically diverse, migrant and refugee populations.*
- *Work with all professional colleges to develop national curricula for trainees and ongoing training for all relevant health professionals in contraception and abortion care.*
- *Look at national quality of care standards and work with representative bodies and government to enable and extend the role of social workers, pharmacists, nurses and midwives in reproductive healthcare service provision.*
- *Develop practice frameworks and standards for nurse practitioner, nursing, and midwifery led models of care.*
- *Undertake and commission research into new and understudied areas of abortion care, service provision and need, including women's preferences, method effectiveness and barriers to care.*
- *Develop a digital resource hub as a repository of best practice and evidence-based resources to guide practice.*
- *Advocate for the development of a national abortion data collection framework to collect data and monitor trends in all states and territories.*
- *Strengthen advocacy efforts to ensure metro and regional public hospitals provide abortion and contraception services enabling people to access care closer to home.*[103]

3.76 The Department of Health, through the Hon. Guy *Barnett*, Minister for Health, informed the Committee, through additional information, of the current arrangements for medical termination of pregnancy in public hospitals:

Medical termination of pregnancy (MTOPs) is provided by qualified healthcare Practitioners, including General Practitioners (GPs), Family Planning Services and other specialist women's health services in the community.

Health practitioners, including GPs require specialised qualifications and training to provide this treatment and are encouraged to refer patients

[103] Submission No. 16, The Royal Women's Hospital Victoria, p. 8.

seeking medical termination of pregnancy to other community-based providers if they have not completed the required training (MS – 2 step training). Women can be referred to the public hospital setting if clinically required, such as complex maternal medical conditions.[104]

3.77 The discussion with Professor Matthews, of the Royal Women's Hospital Victoria, regarding the availability of terminations, turned to the collection of data, noting Tasmania does not collect abortion and contraception related data:

> ***Dr WOODRUFF*** *- … 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…*
>
> *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.*[105]

[104] Additional information, Reply to letter dated 3 November, 1 December 2023, Hon. Guy Barnett MP, p.1.

[105] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 7.

3.78 The Committee requested additional information from the Hon. Guy *Barnett*, Minister for Health, regarding the nature of data collection in the Department of Health, specifically regarding the number of surgical terminations performed statewide and the number of women accessing surgical termination by hospital. The response from the Department stated:

> *We are unable to provide this specific information. Patient information systems group information in accordance with the Australia Refined – Diagnosis Group classification, used in all Australia hospitals. This classification does not differentiate between incomplete spontaneous abortion (miscarriage) requiring surgical intervention and induced surgical termination.*[106]

3.79 The Committee received additional information from the Royal Women's Hospital Vicotria regarding the data on pregnancy terminations they recommend should be collected. The Women's recommends the collection of an amended data set, as contributed to by the Family Planning NSW 2020 framework and a study entitled 'Adolescent abortion in 11 high-income countries including Australia: towards the establishment of a minimum data set', authored by A. R Assifi et al[107]:

Table 7 Minimum data set
Demographic data
Age of woman
Geographic location
Clinical Data
Method
Gestational age at time of procedure
Service location • Urban / Regional / Rural • Hospital / Clinic / GP • Public / Private
Previous delivery (number of previous pregnancies that resulted in a delivery)
Previous abortion (number of previous pregnancies that resulted in an abortion)
STI screening
Major complications (abortion-related morbidity) - Hospital- managed or managed outside hospital
Contraception used before abortion
Contraception prescribed / chosen as part of the abortion care

3.80 The Committee wrote to SA Health to ascertain further information on their systems of termination data collection. Wellbeing SA noted the collection of this data allows them to monitor trends and complications relating to

[106] Additional information, Reply to letter dated 3 November, 1 December 2023, Hon Guy Barnett MP, p.1.
[107] Additional information, 27 November 2023, The Royal Women's Hospital Victoria, p. 1.

terminations, as well as providing a basis for assessing equitable access. Data collected by Wellbeing SA includes:

- *Patient demographics: including name, date of birth, suburb/postcode, medical record number.*
- *Facility information: including name, location, practitioner type, date of admission/discharge.*
- *Termination information: date of termination, gestation, method of termination, use of telemedicine.*
- *Information on genetic testing or structural anomaly ultrasound being conducted, including any suspected congenital anomalies.*
- *Legal considerations/reason for termination only for gestations after 22+6 weeks.*
- *Complications arising from the termination, and readmissions.*
- *Other data relevant to administration of the Termination of Pregnancy Act 2021.*[108]

3.81 The Royal Women's Hospital Victoria submission identified menopause as another area of insufficient women's healthcare support and services. Menopause can often be misunderstood by medical professionals and is an area in need of increased training and appropriate care and treatment options:

> *Menopause is often a hidden and stigmatised process, but it is a part of normal aging. Many women experience varying degrees of menopause symptoms, including hot flushes, headaches, brain fog, loss of memory, body aches and pains and insomnia. Other women, including those who have early menopause as a result of cancer treatment, can experience significant and debilitating symptoms for years. This impacts women's ability to participate in the workforce as well as their inter-personal relationships, mental health and physical health. For women from culturally diverse backgrounds, women with low health literacy and women experiencing socio-economic hardship, this can be particularly impactful. Unfortunately, while menopause affects hundreds of thousands of women every year, there is little acknowledgement of the serious potential impacts, and many women suffer in silence.*[109]

3.82 They also noted that due to the lack of understanding by medical professionals in the management of menopause, many women may not be receiving treatment:

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[108] Letter from Helen Thomas, Interim Executive Director, Prevention and Population Health Directorate, Wellbeing SA, dated 10 November 2023.

[109] Submission No. 16, The Royal Women's Hospital Victoria, p. 5.

Menopause affects almost all women and people with uteruses in their lifetime, with common symptoms including hot flushes and night sweats, anxiety, depression, and disturbed sleep. Despite safe treatments through menopausal hormone therapy (MHT), as well as nonhormonal treatments, over 85% of Australian women with moderate to severe symptoms, are not receiving treatment.

A study published in 2021 reported that many Australian GPs and specialists lack skills and confidence in managing menopause, recommending unproven treatments, and avoiding MHT due to widespread misunderstanding of it (Keedle, H., Keedle, W., & Dahlen, H. (2022). Dehumanised, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years. Violence Against Women, 1-25). MHT also benefits women at high risk of postmenopausal bone loss, a risk that is not being treated and may have long lasting health impacts.

Concerns about MHT are also held by women seeking treatment, with a study published in 2020 reporting that Australian women viewed MHT negatively, due to concerns of cancer risks and over prescription (Herbert, D., Bell, R., Young, K., Brown, H., Coles, J. Y., & Davis, S. (2020). Australian Women's Understanding of Menopause and its Consequences: A Qualitative Study. Climacteric, 23(6), 622-628). Further, whilst Australian women understand the immediate effects and symptoms of menopause, they lacked knowledge of the long term post-menopausal changes, including vulvovaginal atrophy, increased risks of cardiovascular disease, diabetes, osteoporosis, and some cancers.

Women require more information from reliable sources in order to be able to advocate for themselves, and to ensure they are receiving appropriate treatment in their transition to menopause.[110]

3.83 The Chair questioned Mr Dale Webster, Deputy Secretary, Hospitals and Primary Care, Department of Health, as to how the Department limits the occurrence of deficiencies in care for women:

> ***CHAIR** -… 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*

[110] Submission No. 17, Victorian Women's Trust, pp. 6-7.

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.[111]

3.84 Mr Webster continued, noting that there is a need for better data collection to ensure patient needs are being correctly met:

***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? … as I understand it … 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?...*

***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*

[111] Transcript of Evidence, 12 October 2023, Department of Health, p. 5.

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 re-train 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.*[112]

3.85 Further, Dr *Woodruff* asked as to whether the Department of Health currently had someone looking specifically at women's health needs:

***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? …*

***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*

[112] Transcript of Evidence, 12 October 2023, Department of Health, pp. 5-6.

our agency. A request for data goes through them, they extract it and give it back to the area that needs that data.[113]

3.86 The Committee discussed with Professor Matthews, from the Royal Women's Hospital Victoria, the impact of access provided by the hospital to specialised women's healthcare:

> **Ms O'BYRNE** - …. *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.*[114]

Findings

The Committee finds:

3.87 Many women experience gender-based bias when presenting for healthcare, particularly related to cardiovascular disease, abdominal pain and/or reproductive healthcare. This can, and does result in delays to diagnosis, misdiagnosis and poorer health outcomes;

[113] Transcript of Evidence, 12 October 2023, Department of Health, p. 8.
[114] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, pp. 8-9.

3.88 Women are more likely to have the severity of their physical pain and symptoms dismissed by treating medical professionals, delaying timely treatment and pain relief;

3.89 There is not a clear and consistent care pathway for female abdominal pain, in emergency departments;

3.90 Organisations providing Medical Termination of Pregnancy (MTOP) services are inadequately funded to provide equitable, accessible and affordable care across regions;

3.91 Lack of access and affordability of Medical Termination of Pregnancy (MTOP) often results in women seeking Surgical Termination of Pregnancy (STOP), which adds to the burden on acute health services;

3.92 There is a lack of clinical guidelines or formal trauma informed briefings to support women following traumatic birth experiences and miscarriages;

3.93 There is a historical legacy of research, and funding for research, focussed on the male body which has had negative implications for women and women centred healthcare;

3.94 Pay inequity occurs for women in the healthcare profession, including as a result of female GP's being more likely to spend longer periods with patients, resulting in seeing less patients per day;

3.95 There is an inherent gender related bias in Medicare rebates resulting in cost inequity and disadvantage for women specific investigations and care;

3.96 Health data collection has current gaps, particularly in regard to reproductive health, and is acknowledged by the Department of Health; and

3.97 Primary and outpatient healthcare is predominantly a 9am to 5pm service, creating limitations to provide patient centred care accommodating work, caring and personal commitments.

Recommendations

The Committee recommends:

4. **The Tasmanian Health Service establish contemporary and consistent clinical practice guidelines for:**
    a) **the assessment, treatment and admission of women presenting to Tasmanian Emergency Departments with abdominal pain;**
    b) **women presenting with atypical cardiovascular symptoms;**
    c) **birth trauma; and**
    d) **miscarriage.**
5. **The Government increase funding to Family Planning Tasmania to ensure equitable and accessible reproductive healthcare across the state.**
6. **The Government provide additional funding to relevant organisations to provide specialised services in endometriosis and pelvic pain.**
7. **The Government actively seek the support of the Federal Government to remove gender bias in Medicare rebates.**
8. **The Government ensure relevant women's health related data is collected and appropriately reported.**

4 HEALTHCARE TRAINING AND EDUCATION

4.1 This Chapter considers a number of potential improvements in the area of training that could assist healthcare professionals in providing a higher standard of care, including in relation to the consideration of gendered bias. Areas that could be improved by increased training include:

- in the care of the LGBTIQA+ community;
- women's healthcare;
- recognition of gender bias;
- bystander training; and
- for care support staff.

LGBTIQA+

4.2 A lack of training for healthcare professionals was noted, particularly in the area of care for LGBTIQA+ patients, with several submissions and witnesses raising the issue. The Committee Chair questioned Dr Hann about models of care:

> ***CHAIR*** *- From the evidence we've got, including in your submission… it seems to be an additional barrier in the rural and regional areas… But obviously it's even more difficult for members of the LGBTIQ+ community in rural areas. The training that's provided through the GP training programs and Rural Doctors Association of Tasmania (RDAT) programs - are you aware whether they do any particular parts of that? This is those preparing people to be GPs, particularly for rural practice.*
>
> ***Dr HANN -*** *I did not get any training in this specifically during my GP training. We had one lecture on mental health and there was a not well-done comment around gender-inclusive care.*
>
> ***CHAIR*** *- As part of the mental health program?*
>
> ***Dr HANN -*** *Yes. It was part of a mental health lecture. That was one provided element of education that I found quite problematic because it just reinforced stereotypes that are not necessarily accurate or true to everyone's experience… But I also recognise that I'm close to this space so when I feel like things aren't done well, I notice more than perhaps other people would. Otherwise, I haven't received any specific education.*
>
> *There is one topic section that's part of our package of educational materials we were given that included a bit of education around trans and gender-diverse health care. But I think it was a three- or four-page document that you were expected to read on your own. That has subsequently changed because the GP training changed models in*

February. I have not seen the current resources that they've got for this community.[115]

4.3 Mr Croome echoed the limited nature of training regarding care options for LGBTIQA+ patients:

> ***Mr CROOME** -… In medical training schools there isn't much attention at all paid to LGBTIQA+ health, from what I understand. Looking at the analysis of the curricula of all the medical schools in Australia, there's still very little that's done in terms of accrediting healthcare providers when it comes to their competence on LGBTIQA+ health issues - little or nothing. Overseas doctors who come to Australia and who are welcome, obviously, may not have had any acquaintance with LGBTIQA+ issues in their country of origin. So there are a number of different issues, that in terms of training and accreditation, Australia needs to move much further on when it comes to every letter in that acronym.*[116]

4.4 The Chair questioned Ms Sarah Bolt, Anti-Discrimination Commissioner, in relation to addressing gender bias in healthcare for the LGBTIQA+ community:

> ***CHAIR** - What do you say is key, then, to hopefully not taking as long to deal with the gender bias in health care for people who are non-binary, who are transgender?*
>
> ***Ms BOLT -** It comes back, I guess, to education, positive media coverage and really good advocacy by organisations. And I think the key organisations have to be very conciliatory in their approach, as opposed to being viewed by some as being combative and hostile. That, in my observations, turns people away, as opposed to a kind and respectful way of understanding the whole issue, particularly around transgender.*[117]

4.5 The limited formal training provided in medical schools has meant that doctors wishing to improve their knowledge in the area of LGBTIQA+ care must personally seek out any such training opportunities. Dr Hann explained that she had attended additional training interstate, after being unable to locate training opportunities within Tasmania:

> ***Dr HANN -…** Most of my education has been things that I've found on my own. I'm part of AusPATH, which is the Australian Professional Association for Trans Health. They provide a lot of education. I've gone to a number of different lectures and training sessions put on by different states. There's been nothing offered in Tasmania. I had to outsource outside of the state. New South Wales and Victoria often hold training programs. They are a bit*

[115] Transcript of Evidence, 13 June 2023, Dr Hann, p. 4.
[116] Transcript of Evidence, 13 June 2023, Mr Croome & Dr Grant, p. 5.
[117] Transcript of Evidence, 14 June 2023, Equal Opportunity Tasmania, p. 13.

bigger, so that makes sense. I've attended those training sessions, but because I'm not from those states, I actually had to lie about my location in order to attend those training sessions - which I owned up to as soon as I went to the first one. They're not offered to interstate people. In Tasmania, we have nothing so there was no option for me to do any learning or upskilling without getting creative.[118]

4.6 Dr Hann noted that due to the lack of available training in Tasmania she had initiated some training opportunities in rural areas on inclusive medical practice for transgender and gender-diverse community members:

> ***Dr HANN*** *-… I do a lot of education in rural areas, so I work with all the rural interns and RMOs* [Resident Medical Officers] *and do three-monthly educational sessions with them. That's specifically on inclusive trans and gender-diverse health care. I do education sessions with other GPs and we create video links and conferences that GPs will be able to go to.*[119]

4.7 Mr Croome suggested the need for a staged approach to improve training:

> ***Mr CROOME*** *-… One study of particular importance is the Telling Us the Story report that was released in May last year. It was commissioned by the Tasmanian Government and conducted by the University of Tasmania, by Ange [Dwyer] and Ruby [Grant].*
>
> *There were a number of worrying findings by that report in terms of healthcare workers' lacking knowledge about LGBTIQA+ people and the health issues we face and lacking training in dealing with those health issues….*
>
> *Training of healthcare providers is such a big project and one that has so far to go in Tasmania that the Telling Us the Story report and also Equality Tasmania recommend a staged approach where we focus first on doctors and nurses, the frontline providers who are currently treating LGBTIQA+ people in Tasmania. Then we move on to the medical school and to specialist medical service providers in Tasmania.*[120]

4.8 The Chair noted that there have perhaps been some improvements in recent years in the recognition of LGBTIQA+ community members. Dr Grant provided the following:

> ***CHAIR*** *- … Do you think there's probably a better awareness generally of the health needs of, say, gay and lesbian people, where there's been much more legislative reform many years ago in that space?...More recently*

[118] Transcript of Evidence, 13 June 2023, Dr Hann, pp. 4-5.
[119] Transcript of Evidence, 13 June 2023, Dr Hann, p. 3.
[120] Transcript of Evidence, 13 June 2023, Mr Croome & Dr Grant, p. 2.

we've had gender law reform more to do with supporting transgender people… Does the same thing translate here for trans people, and certainly intersex?

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

I think that's a really good point there that while there might be increasing awareness of, say, gay and lesbian health, there are other groups within that community, such as people with intersex variations, trans people and bisexual people, often left out of the specific needs that we still may not be attending to as much. But overall, I think it's fair to say that things are improving.[121]

4.9 Mr Croome agreed that there had been some improvements but urged caution:

***Mr CROOME** - I'd agree with Ruby that there have been improvements, but we don't want to overstate them. There is still a lot of prejudice experienced by gay and lesbian people in health care but perhaps not as much as in the past. Studies certainly show that difficulties in accessing health care, including prejudice and stereotyping, are experienced to a greater extent by trans and gender-diverse people and intersex people. Things have improved and I guess it's a combination of legislative reform, which sends a very positive message to the community, and on-the-ground training. There's no doubt that there's been longer-term training of gay and lesbian health issues than there has been in trans, gender-diverse or intersex health issues. That's simply because of the visibility of those communities but there is still a deficit when it comes to every letter in that acronym.*[122]

4.10 Working It Out, in its submission, raised the inadequacies of training in preparing health professionals to treat those in the LGBTIQA+ community:

From the perspective of Tasmanian healthcare providers, their experiences regarding gender bias in healthcare settings related to LGBTIQ+ topics has also been explored (Grant et al., 2020). This research found clinicians and students report inadequate training to prepare them to treat LGBTI+

[121] Transcript of Evidence, 13 June 2023, Mr Croome & Dr Grant, p. 5.
[122] Transcript of Evidence, 13 June 2023, Mr Croome & Dr Grant, p. 5.

patients, poor awareness of LGBTI+ population needs, and a lack of understanding for appropriate referral pathways in regional Tasmania. On a positive note, Tasmanian clinicians and students also reported that having prior experience working with the population and developed networks helped enable appropriate care. Providers who are LGBTI+ reported this improved better service provision as well indicating the benefits of LGBTIQ+ specific service options.[123]

4.11 The Department of Health indicated in its submission that some work has been done to improve education on inclusive healthcare in the state:

> *With the support of the Reference Group, DoH launched its LGBTIQ+ inclusive healthcare learning resources for Tasmanian health sector staff in December 2021, to train, inform and reorient the public health workforce. The learning resources aim to ensure our health system is inclusive, welcoming, safe, and respectful for LGBTIQ+ Tasmanians.*
>
> *DoH staff are expected to treat patients, clients and colleagues with respect – regardless of their sex, sexual orientation and gender identify. This includes not assuming a person's sex or gender based on things such as name, voice or appearance.*[124]

4.12 In verbal evidence, Mr Webster, elaborated on the training that has been produced following work with the LGBTIQA+ reference group:

> ***Mr WEBSTER -*** *… 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*

[123] Submission No. 3, Working It Out, p. 2.

[124] Submission No. 11, Department of Health, p. 10.

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.[125]

4.13 Despite the measures adopted by the Department, Dr Hann identified there are clearly still gaps in care. In Dr Hann's submission, she reported instances of trauma suffered by LGBTIQA+ community members as a result of poorly informed medical professionals:

I serve a large population of trans, gender queer and gender diverse patients in primary care. I expect that 40-50% of my patients identify with this patient population. As such, I also have heard about the astounding amount of medical trauma experienced by this patient group. Many of my patients have been declined medical care by a health professional, told their identity wasn't real, or told to go elsewhere to have their medical needs met (even if those medical needs were completely unrelated to their gender - aka headache). Many of my patients have navigated unwanted/unrelated questions about their genitalia that were inappropriate and would be consider[d] verbal sexual abuse. Many of my patients have had non-consented/unrelated examinations of their genitalia by health professionals, when no such examination was needed, or had examinations done in front of panels of medical students as a part of "teaching" - both a violating and humiliating experience that I expect few cis men have ever had to experience (this happens in obstetric wards as well, without consent of the patient at times, particularly if they are from different cultural backgrounds). I frequently get told "thank you" for providing a space where someone's health can be addressed without feeling stigmatised or violated.[126]

4.14 The ACRRM noted they have a number of resources available to assist doctors in improving their understanding of gender issues:

The ACRRM Fellowship curriculum standards describe practice approaches informed by recognition of their own internal biases and their potential impacts on healthcare as well as by an understanding of the diversity of

[125] Transcript of Evidence, 12 October 2023, Department of Health, p 3.
[126] Submission No. 1, Dr Hann, p. 2.

> *their patients* (ACRRM Rural Generalist Fellowship Curriculum (2021) https://www.acrrm.org.au/docs/default-source/all-files/rural-generalist-curriculum.pdf). *The College has also been proactive in providing and promoting educational resources to improve ACRRM doctors' understanding of key gender issues in practice such as its course in Transgender Primary Care.*[127]

4.15 The necessity for adequate training of healthcare professionals was also raised by Equal Opportunity Tasmania:

> *Ensuring staff are educated and informed is critical to preventing and responding to gendered bias (or potential bias) which may impact the delivery of health services.*
>
> *For staff of a health facility, a knowledge of the concept of discrimination and harassment is not sufficient. Training should deal with specific attributes and provide more detail than generalised content. The nature of the health facility is also relevant.*
>
> *The case of S. v H [2017] TASADT … highlights the importance of comprehensive staff training. In that case it was submitted that employees of the Respondent received training in discrimination and harassment, however particular nursing staff had not received training on transgender or gender issues.*[128]

4.16 Necessary access to greater healthcare education was also raised in the TasCOSS submission:

> *Academics have also outlined the need for greater education for medical professionals, noting that "[i]mplementation of education about sex and gender related processes, reactions and treatments in medical school curricula and other forms of health education is an important step forward in preventing gender bias." (Hamberg, K 2008, 'Gender bias in medicine,' Women's Health, vol. 4, no. 3, pp. 237-243, 241.)*
>
> *TasCOSS also believes community-wide education in relation to diversity and inclusion would be an effective tool in preventing and addressing gender bias, noting that Tasmanian community organisations are already engaged in education and training, (for example, see diversity and inclusion training offered by A Fairer World in Tasmania, as well as education and counselling around gender and sexual orientation offered by Working it Out) supported by the work of government bodies such as Equal*

[127] Submission No. 4, Australian College of Rural and Remote Medicine, p. 3.
[128] Submission No. 14, Equal Opportunity Tasmania, p. 13.

Opportunity Tasmania who educate and provide advice on issues including discrimination and accessibility.[129]

Bias in Practising Doctors and Training Opportunities for Doctors

4.17 An increased emphasis on training regarding doctor–patient interaction was also discussed at public hearings by representatives from the AMA:

> ***Mr WILLIE*** *- The way doctors interact with their patients. We've had a number of presentations where that's been an issue. Is there any comment on training and best inclusive practice?*
>
> ***Dr BARRATT*** *- The training from the colleges is heading towards doctors being aware of their deficiencies. We know that has improved over the years. When I started as a doctor, women's health was treated very differently - it's a little bit of medicine but ignore it, men are more important. That has changed. There are still a lot of barriers from people having the time as a GP to go into all the gender issues. We are humans. Doctors still have their own unconscious biases when it comes to dealing with things that are complex and things aren't in their usual scope of practice. That's why we still have male doctors who don't treat menopause.*
>
> ***Dr AHMAD*** *- It's one of the solutions in our submission. Training should be provided to medical practitioners with a focus on recognising the limits of our knowledge and accepting the need to refer on when those limits are reached. A targeted medical practitioner education program to recognise when they're offering poor care because of gender or other attributes and to recognise sexist or racist beliefs in themselves.*[130]

4.18 The Chair questioned the AMA witnesses on whether there are compulsory training areas necessary for general practitioners:

> ***CHAIR*** *- Once you focus on GPs, who are at the coalface of everything, in terms of fellowship, is there then any compulsory training or do you have to do your CPD [Continuing Professional Development] in whatever area?*
>
> ***Dr AHMAD*** *- There is no compulsory trainings. This is practising in empathy or practising in recognising your own bias, there's no firm training in that. I would love there to be. But when we reflect on the ability of a doctor to offer empathy in a consult, I don't think it is just down to training. If I had to reflect on a consult, how much time do I have for this patient and I am really burnt out myself, the last patient of the day and at the end of a long*

[129] Submission No. 8, TasCOSS, p. 9.

[130] Transcript of Evidence, 14 June 2023, Australian Medical Association Tasmania, p. 44.

day, this is doctor burnout. The first signs of burnout are depersonalisation and reduced empathy.

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

I would be pleased if it was made mandatory, I have no problem with that. I think that it is much more than training that would determine my ability to show empathy to a patient.[131]

4.19 Ms Adrienne Picone from TasCOSS pointed to the importance of good education not only for healthcare providers but also for the community:

> ***Ms PICONE - ...*** *as gender bias stems from beliefs or attitudes about gender, we also strongly believe there is need for community-wide education and support. This includes more comprehensive training for healthcare providers to increase their awareness of gender bias and how it may impact their work, as well as greater opportunities for diversity and inclusion training across the community sector, including but not limited to health and allied services.*[132]

4.20 The Department of Health submission highlighted current work being undertaken to improve the culture:

> *Systems and organisations are affected by the same culturally embedded gender biases as the broader community. These biases can increase barriers to services and healthcare, particularly for women and gender diverse people. Cultural change in Tasmania at the organisation level is important to deliver a health system:*
>
> - *Where everyone feels valued, staff are recognised, and individuals feel empowered to make positive changes and are given opportunities for growth.*
> - *That provides positive, patient-centric and solutions-focused environments that meet contemporary and best-practice standards.*
>
> *One Health Culture*
> *In December 2022, DoH launched its One Health Culture Program (the Program) to realise this vision for Tasmania's health system. Over the next five years, the Program will undertake activities in five key focus areas:*
>
> *1. Leadership and Accountability*

[131] Transcript of Evidence, 14 June 2023, Australian Medical Association Tasmania, p. 46.
[132] Transcript of Evidence, 13 June 2023, TasCOSS, p. 1.

2. *Building Capability*
3. *Workplace Values and Behaviours*
4. *Health, Safety, and Wellbeing and*
5. *Systems and Processes.*

This Program will transform DoH's culture to be more inclusive and respectful and support the health workforce to deliver the best possible health care for the Tasmanian community.[133]

4.21 In verbal evidence the Hon. Guy *Barnett*, Minister for Health, talked further about the Department's One Health Culture program:

> ***Mr BARNETT*** *-… 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.*[134]

4.22 Professor Matthews of the Royal Women's Hospital Victoria, spoke to the Committee about one of the programs the Hospital has in place to help all members of staff understand the patient experience better:

> ***Prof. MATTHEWS*** *- … 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.*
>
> *…*
>
> *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*

[133] Submission No. 11, Department of Health, p. 6.
[134] Transcript of Evidence, 12 October 2023, Hon. Guy Barnett MP, p. 2.

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.[135]

4.23 Professor Matthews also discussed with the Committee the benefits of nurse practitioners and training initiatives the Royal Women's Hospital Victoria has to assist the challenges in healthcare in rural and regional communities:

Prof. MATTHEWS - *It is a challenge, and a lack of GPs is becoming more and more of a challenge than it had been.... 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...*

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.

[135] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, p. 6.

> ***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.*[136]

Increased Education around Women's Health Conditions

4.24 Ms Duncan highlighted a lack of training for medical professionals regarding women-specific health conditions:

> ***Ms DUNCAN*** *-... I also do not think there is much education in specialties other than gynaecology around endometriosis and how it affects other systems, including gastroenterological and urological. Whenever I tried to explain something, I always had to provide evidence or proof of why I felt the way that I did. I had a photo from a cystoscopy a few years ago from my gynaecologist and it is quite obvious that there is haematuria, which is frank bleeding in the bladder. It is not until I provide that proof or imagery that it is like, 'Oh, okay, this is actually really bad for you', and then I am sort of believed but I have to validify what I am reporting for me to get believed.*[137]

4.25 Ms Duncan continued:

> ***Ms DUNCAN*** *- I think there is a lack of education in gynaecological conditions for women, not only endometriosis, polycystic ovary syndrome and uterine and cervical cancers. From what I observed when I worked in the emergency department, when females came in even with miscarriages or anything of a gynaecological nature, the common resolution was to call the gynaecology team for simple things like speculum exams, which is something the emergency medicine doctor should be able to do. The senior ones could, but a lot people felt like, well, I'm a junior, we may as well get someone who is in this profession to do it.*[138]

4.26 This issue of specialists not wanting to admit patients to their care unless there is a diagnostic certainty has been addressed in Chapter 3.

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[136] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, pp. 10-11.
[137] Transcript of Evidence, 14 June 2023, Ms Duncan, p. 3.
[138] Transcript of Evidence, 14 June 2023, Ms Duncan, p. 4.

4.27 Research into the treatment and management, and the lived experience, of chronic health conditions suffered by women is a significant area of gendered bias in healthcare. This continues to negatively impact patient wellbeing. One such condition is endometriosis. This condition where tissue similar to that which lines the uterus grows outside the uterus, is an example of these conditions that Equal Opportunity Tasmania discussed in their submission to the Committee:

> *Endometriosis is a distinct example of how gendered bias in healthcare and lack of funding into research for conditions experienced by women, transgender and gender diverse people has been neglected over time to the detriment of those seeking medical care. The length of time to receive a diagnosis is abysmal, with many individuals reporting debilitating symptoms which have gone unaddressed despite increasing severity. Overall delays in diagnosing many medical conditions is a current issue of increasing concern.*
>
> *Recently, there has been a significant rise in the awareness of this condition. This has had a number of benefits. More individuals are identifying their symptoms as possible endometriosis and seeking medical treatment as a result, individuals are being empowered to speak up about such symptoms, additional government funding specifically related to the condition is being implemented, significant media coverage of the condition and changes to government policy directly impacting accessibility of care is also occurring. Further, and most importantly, knowledge of the condition within the medical profession is rapidly increasing.*[139]

4.28 The Victorian Women's Trust noted that gendered bias and prejudice in both healthcare and research are structural and institutional:

> *Given that women make up over half of the Australian population, one might expect that the issue of gender bias in healthcare would not be a systemic issue. The reality, however, is that gender bias and prejudice are structural and institutional, and are embedded through healthcare practice, false assumptions, and the 'othering' of women in a patriarchal world.*
>
> *Women are experiencing high rates of trauma and violence in childbirth, resulting in negative outcomes for both the mother and child; healthcare practitioners lack skills and confidence in treating menopause, a transition in which almost all women will experience; and following a miscarriage, women's psychological pain is often dismissed or ignored, despite miscarriage being the most common pregnancy complication. These are*

[139] Submission No. 14, Equal Opportunity Tasmania, p. 14.

not uncommon issues for women. Yet these issues are shrouded in silence and stigmatised.[140]

4.29 The Victorian Women's Trust submission continued, noting that gendered bias starts with the training given to healthcare professionals:

> *This bias begins in the education of healthcare practitioners. A study examining the gender bias in anatomy textbooks used at Australian medical schools, found that the representation of sex in images from these textbooks remain predominantly male, except within sex-specific sections (*Farren, J., Jalmbrant, M., Falconieri, N., Mitchell-Jones, N., Bobdiwala, S., Al-Memar, M., Tapp, S., Van Calster, B., Wynants, L., Timmerman, D., & Bourne, T. (2020). Post-Traumatic Stress, Anxiety, and Depression Following Miscarriage and Ectopic Pregnancy: A Multicentre, Prospective, Cohort Study. *American Journal of Obstetrics and Gynaecology, 222*(4), 367.e1-367.322)
>
> *Further, menopause is excluded from Australian undergraduate and post-graduate medical and allied health training, likely a major factor in practitioners reporting lacking skills and confidence in treating menopause.*
>
> *There are no federal clinical guidelines for healthcare practitioners to provide psychological support following miscarriage, with Queensland Health being the only jurisdiction to provide guidelines. This positions women's bodies and conditions as abnormal and influences potential biases of healthcare practitioners.*[141]

4.30 In verbal evidence before the Committee Ms Mary Crooks, Executive Director, Victorian Women's Trust and Ms Eleanor Lee, Intern, University of Melbourne discussed the need for a change in language for women's health symptoms:

> ***CHAIR** - …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*

[140] Submission No. 17, Victorian Women's Trust, pp. 5-6.
[141] Submission No. 17, Victorian Women's Trust, p. 6.

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.[142]

4.31 Further, Ms Crooks, and Ms Lee, talked about the need to recognise menstrual pain:

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*

[142] Transcript of Evidence, 12 October 2023, Victorian Women's Trust, p. 11.

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.[143]

4.32 The Victorian Women's Trust also noted a deficiency in medical training around female centred health concerns, notably menopause:

> *... menopause is excluded from Australian undergraduate and post-graduate medical and allied health training, likely a major factor in practitioners reporting lacking skills and confidence in treating menopause.*[144]

4.32.1 Recommendations from the Royal Women's Hospital Victoria regarding increased education and training for healthcare professionals into women's healthcare, especially in the areas of sexual and reproductive healthcare, are noted in paragraph 3.74, in Chapter 3 of this report.

Training for Support Staff in the Healthcare Industry

4.33 While training is important for medical staff, the idea of improved training for healthcare support staff was also explored in evidence to the Committee. In verbal evidence Dr Smith, representing ACRRM, noted the need for improved training for reception staff in healthcare settings regarding confidentiality:

> ***Dr SMITH -*** *It is in the training, all the way through. A small community is a small community. You can't change the nature of these small communities. Well, that's not true is it, because the nature of small communities is changing, but in regard to this, that's not something you can effect on a day-to-day basis. I think it's in the training.*
>
> ***CHAIR*** *- Training of your reception staff, as well as your medical nursing staff in a clinic?*

[143] Transcript of Evidence, 12 October, Victorian Women's Trust, pp. 8-9.
[144] Submission No. 17, Victorian Women's Trust, p. 6.

Dr SMITH - *Totally. I think receptionist staff get minimal training in patient confidentiality. They get training in how to book people in, book them out and take their money, but not in confidentiality. That's an area we miss.*[145]

4.34 Dr Smith also discussed the need for training for reception staff in areas such as empathy and de-escalation:

CHAIR *- Going back to the training of reception staff…. What training do you think would be beneficial for them, in addition to confidentiality training?*

Dr SMITH *-… there's formal and informal training, isn't there, in terms of doing, say, a three-day certificate in training for this.*

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

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

Dr SMITH *-Maybe, yes.*[146]

Bystander Training

4.35 The potential for bystander training, to enhance community response and awareness to issues of inequality, was discussed at the hearing by Ms Bolt:

CHAIR *-… do you think there is an important place here for bystander training as well?*

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

There is also a very real misunderstanding of the protection of victimisation. One of the things we keep on saying is the fact that, if you were to lodge a complaint - or if you were to support somebody in lodging

[145] Transcript of Evidence, 14 June 2023, Australian College of Rural and Remote Medicine, pp. 14-15.
[146] Transcript of Evidence, 14 June 2023, Australian College of Rural and Remote Medicine, pp. 15-16.

a complaint, or if you were to support somebody even thinking about lodging a complaint - and then life turns out to be a little prickly for you as the bystander, then you also have a right to make a complaint of victimisation under the legislation.

Again, that just shows people are a little bit unclear about the scope of the act.[147]

Change via the Recognition of Gender Bias

4.36 The Chair questioned Ms Meg Tait from TasCOSS in relation to the ways in which gendered bias in healthcare could be addressed:

> ***CHAIR*** *- … If you had to prioritise where you thought the most impact could be made in the short-term, and then perhaps the most impact in the medium to long-term, what would you focus on? What would you prioritise to address the experiences of gender bias in our healthcare systems? Let's take it as a given that it exists. What do we start with in the short-term, leading to the long-term?*
>
> ***Ms TAIT -*** *I think there's some real low-hanging fruit. Something that could be done immediately would be embedding gender diversity and inclusion training more broadly within the university training of all medical and allied health professionals, maybe alongside ongoing professional development training -*
>
> ***Ms O'BYRNE -*** *When you say 'embedding' it into, you mean not doing a one-off session at some time during their training, but embedding it?*
>
> ***Ms TAIT -*** *Exactly. That would be part of the university curriculum, definitely for general practitioners, but I would say possibly for a range of other allied health professionals, perhaps with the development in consultation with the AMA or other associations, or gender diversity and inclusion training more broadly being part of our ongoing professional development requirements....*[148]

4.37 Recognition of unconscious bias was also discussed in the AMA submission:

> *For patients, more also needs to be done to address the unconscious bias faced by women patients who may not be believed, or have their condition understood by their treating doctors or are constrained by requirements that must be met because they are a female before further treatment can be provided. It is important doctors are trained to consider unconscious bias issues and how that may affect the care they provide to a patient. If patients are truly at the centre of care, then their individual*

[147] Transcript of Evidence, 14 June 2023, Equal Opportunity Tasmania, p. 11.
[148] Transcript of Evidence, 13 June, TasCOSS, pp. 10-11

needs should be addressed and not minimised as described by some of our members.[149]

4.38 The Chair questioned Dr Smith from ACRRM about what changes could assist to progress the healthcare system away from gender bias:

> ***CHAIR*** *- … What would two or three key recommendations from your perspective be?*
>
> ***Dr SMITH*** *- I can think of two. The first one is improved awareness and training, so early training. I hesitate to say compulsory but addition of awareness courses in medical training. It goes to nursing training, physio, OT training, it's not just doctors and nurses. And easier access for people who are no longer in training for these sort of courses and for exposure to these issues...*[150]

4.39 Multiple submissions received by the Committee further denote the role that increased and adaptive training can play in revolutionising the model of care offered by health providers in Tasmania. TasCOSS contextualised the nature of gender bias in the healthcare system and made recommendations supporting the need for enhanced training:

> *As gender bias often stems from personal and/or cultural perceptions, TasCOSS strongly advocates for more comprehensive training in relation to recognising and addressing bias, particularly unconscious bias, which may be impacting how Tasmanians access healthcare and their experience of health services.*[151]
>
> *….*
>
> *5. Comprehensive training to be delivered across Tasmania in relation to recognising and addressing bias, particularly unconscious bias.*
>
> *6. Improved training and education for medical professionals in relation to sex, gender and gender bias.*[152]

4.40 The AMA's submission also recommended there be additional training for medical practitioners to help address current gaps:

> *Additional training should be provided to Medical Practitioners:*
>
> *1. With a focus on recognising a doctor's limits of skills and knowledge and accepting the need to refer on when those limits are reached. The*

[149] Submission No. 10, Australian Medical Association, p. 10.
[150] Transcript of Evidence, 14 June 2023, Australian College of Rural and Remote Medicine, p. 18.
[151] Submission No. 8, TasCOSS, p 9.
[152] Submission No. 8, TasCOSS, p 11.

increasing subspecialisation of general practice, while not ideal, has helped with recognising the breadth of knowledge required by GPs and normalising lateral referral.

2. A targeted medical practitioner education program to recognise when they are offering poor care because of gender or other attributes – i.e. to recognise sexist or racist beliefs in themselves and to challenge them.[153]

4.41 Professor Matthews discussed with the Committee the need to use a gender lens when thinking about healthcare training:

> ***CHAIR*** *- What you were talking about when you said the training and education of all health professionals… 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?*
>
> ***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.*[154]

4.42 Ms Picone, from TasCOSS, further emphasised at a hearing of the Committee that training, and education programs should also be reflective, in allowing opportunities for organisations, key stakeholders and community members to improve their own health literacy:

> *We all have various degrees of bias, both conscious and unconscious. I think part of that is recognising that and working on ways to overcome that. I know there's some great training already happening here in Tasmania and I think that's something we could do a lot more of. TasCOSS also has a program around health literacy. We work with organisations about their health literacy and the way they engage people within the organisation and engage clients. There's many layers; it's not just government's responsibility.*[155]

4.43 Training was also discussed in the context of medical students receiving education around discrimination within their degree:

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[153] Submission No. 10, Australian Medical Association, pp. 10-11.
[154] Transcript of Evidence, 16 October 2023, Royal Women's Hospital Victoria, pp. 14-15.
[155] Transcript of Evidence, 13 June 2023, TasCOSS, p. 3.

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

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

Ms BOLT *- Not really. We've done a couple of sessions with new medical students, but it's been a bit ad hoc, and it's not embedded in that.*[156]

4.44 Ms Bolt further noted that there was some training done within the Tasmanian health system but that training was usually the result of a reaction to an incident:

CHAIR *- What about nursing and other allied health students?*

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

It's like everything. Unless you have every strong leadership from a ministerial secretary or head of agency leading the whole thing, it's not really going to go anywhere. The same with the safe complaint mechanisms and pathways for people who work within the system and also users of the system.[157]

4.45 The Victorian Women's Trust, in its submission, gave a number of recommendations around training and education:

1. *Actively support educational programs for healthcare practitioners on conditions that impact women such as endometriosis and chronic pain, to improve confidence and skill in treating patients, and reduce wait times and misdiagnosis.*

2. *Actively support improvements in education on the ways in which women may present differently to men such as with cardiovascular disease and heart attacks.*

[156] Transcript of Evidence, 14 June 2023, Equal Opportunity Tasmania, p. 9.
[157] Transcript of Evidence, 14 June 2023, Equal Opportunity Tasmania, p. 9.

3. *Encourage a greater educational focus for healthcare practitioners, especially obstetricians and midwives, to understand obstetric violence and birth trauma, and how to provide trauma informed care.*

4. *Encourage a greater educational focus for all healthcare practitioners on effective treatments for menopause, with a focus on menopause during medical training, especially to address misunderstanding and fear of menopausal hormone therapy.*

5. *Support and fund public information campaigns about the long-term effects of menopause and treatment options, so women do not have to suffer in silence.*[158]

Findings

The Committees finds:

4.46 There is a significant gap in training for medical, nursing and allied health professionals in the areas of:

a. LGBTIQA+ patient care;
b. Women-specific conditions (such as endometriosis, menopause and miscarriage);
c. Gender bias;
d. Unconscious bias;
e. Empathy; and
f. Bystander intervention.

4.47 Anatomy books currently used in Australian medical schools and training of medical professionals, utilise the male body as standard and the female body as 'other', which influences diagnosis and treatment of women's health issues;

4.48 Menopause is excluded from Australian undergraduate and post-graduate medical and allied health training;

4.49 The Australian College of Rural and Remote Medicine (ACRRM) has provided educational resources to improve ACRRM doctors' understanding of key gender issues in practice;

4.50 Some medical reception staff lack training in the areas of:

a. Patient confidentiality;
b. Gender bias;

[158] Submission No. 17, Victorian Women's Trust, p. 9.

c. Unconscious bias;
d. Empathy; and
e. Bystander intervention.

Recommendations

The Committee recommends:

5 **The Government:**

a. establish benchmark training for all Tasmanian Health Service employees with regard to gender-inclusive care for women and LGBTIQA+ people;

b. liaise with UTAS and TasTafe to embed gender-inclusive training for women and LGBTIQA+ people in all health-related education programs; and

c. liaise with non-government healthcare providers to embed gender-inclusive practices for women and LGBTIQA+ people in their services.

6 **Medical reception staff be provided with training in the areas of:**

a. Patient confidentiality;

b. Gender bias;

c. Unconscious bias;

d. Empathy; and

e. Bystander intervention.

7 **The Government promote and actively support medical research into the health of women.**

5 MEN'S HEALTH

5.1 This Chapter considers areas of bias relating to men's health. Evidence to the Committee examined:

- the gendered nature of birthing in relation to the non-birthing parent;
- parental leave;
- the gendered presentation to the healthcare system; and
- male employment in the healthcare industry.

Non-birthing Parents

5.2 Mr Jacob Roberts, in his submission to the Committee, raised the issue of gendered bias in relation to his experiences as a non-birthing parent:

> *My own lived examples as a father during the antenatal and post-natal periods for both my children, highlighted various discrepancies and opportunities for equality and inclusion as a father/non-birthing parent. As the non-birthing parent, I was often excluded from assessments and enquiry as to my own wellbeing and inclusion during our appointments with midwifes and child health nurses. The language used at times, was divisive and continued to promote role delineation. There was limited spatial room and seating considerations, and, in some instances, I was not acknowledged or introduced to, by the health care staff at all. This did not provide the environment for me to engage, enquire and advocate for myself or wife and children. I struggled with post-natal anxiety (1 in 10 Australian men experience this 1 in 20 experience post-natal depression), yet when any screening was done with my wife, after I made every effort around work to attend every appointment, I was not provided with the same questionnaires or assessments around mental health and wellbeing that my wife was. I was able to locate online resources for myself but felt that this shouldn't have had to have been the case. As a health care professional with experience in Paediatrics and Mental Health, I felt there was obvious gaps in care based on my gender and parenting 'role perceptions'.*
>
> *My concerns around this are that many non-birthing parents are subjected to this also and research supports that gender biases are prevalent through Tasmania and Australia. With an increasing number of same sex parenting families and differing family parenting structures throughout Australian society, I strongly advocate for increased funding and support for front line services to access the appropriate education and resources to address these issues raised.*[159]

[159] Submission No. 6, Mr Roberts, p. 1.

5.3 Mr Roberts experience was further explored in verbal evidence before the Committee:

> ***Mr ROBERTS*** *- … For me personally, general wellbeing checks, mental health screening would have been appropriate. My mood and my sleep, how I was feeling about things, my anxiety around the pregnancy.*
>
> ***CHAIR*** *- Antenatally and postnatally, you are talking about?*
>
> ***Mr ROBERTS*** *- Yes. I remember postnatal appointments where my darling wife, Katie, got questionnaires around her wellbeing and things like that. I was sitting next to her and did not get offered that and I was really struggling at the time. Katie was flying and doing really well. I wanted to snatch it out of her hands. I wasn't encouraged and I did not have the confidence -*
>
> ***Ms O'BYRNE*** *- To say 'Let me have a go'?*
>
> ***Mr ROBERTS*** *- Yes, this is what I say and this is why I am passionate about this. I am educated, I have worked in the healthcare sector in mental health, in various roles of health promotion, and sitting there in that seat, I didn't have the confidence to speak and advocate for myself in that space. That is saddening for me.*[160]

5.4 It was also noted that feelings of disempowerment for male partners navigating the health system can be significant:

> ***CHAIR*** *- If someone with your background, experience and knowledge is disempowered enough not to say, 'Hang on, it would be helpful if I could do that', there are very few others that would, I would think.*
>
> ***Mr ROBERTS*** *- Yes. Part of my research around this is what concerns me more going forward. It was only this month that Perinatal Anxiety and Depression Australia (PANDA) released a statistic that 67 per cent of expecting dads are stressed and 61 per cent are having anxiety and panic attacks. All of these things pre-natal increase the depression postnatally. We have increasing rates of this but I haven't seen any increase in resources to tackle and highlight this for the issue that it is - that one in 10 men, at a minimum, will have mental health issues. These are the ones we know about.*[161]

5.5 The MRT submission also noted the lack of screening services available:

[160] Transcript of Evidence, 14 June 2023, Mr Roberts, pp. 76-77.
[161] Transcript of Evidence, 14 June 2023, Mr Roberts, p. 77.

> *There is currently no screening program for new and expectant dads, despite the fact that an estimated 1 in 3 new parents who experience depression are men, with around 30,000 new dads affected every year.*[162]

5.6 This issue was also discussed in hearings, with the Chair questioning Mr Jonathon Bedloe from MRT about the provision of such screening for men:

> ***CHAIR*** *- As a former childhood educator and midwife, I never seem to have any trouble getting the male partners along to our natal classes. They may have been dragged, some of them, in fairness, but we also used to include a special dads' approach in most classes. There would be a component where the dads would meet with another dad and that sort of stuff, to try to talk about those matters.*
>
> *You made the point here about the screening. We know that all new mothers have antenatal screening as well as postnatal screening now for depression and other matters. You said that it doesn't happen at all for men - is that your understanding that it doesn't happen at all or would men have to self-identify before they would be administered a screening assessment?*
>
> ***Mr BEDLOE -*** *That's my understanding. It's becoming more of a routine thing for women in maternity spaces. I don't know how formal it has become but I'm not aware of it becoming routine in the same way with dads. I think dads are overwhelmingly probably getting involved in those antenatal classes, but post-birth things are quite different. We've certainly heard stories of child health nurses visiting, doing those early childhood health checks. Dad is at home with the child and the question has been, where's the mother or the main parent or things like that. Hopefully, those things are changing but certainly we've heard plenty of those sorts of stories where dad hasn't been acknowledged as an equal parent and potentially just as interested in the health of the child.*[163]

5.7 The gendered aspect of antenatal care was also discussed by Ms Papavassiliou, who attended the hearing as a lived experience advocate for HCT:

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

[162] Submission No. 9, Men's Resources Tasmania, p. 4.
[163] Transcript of Evidence, 13 June 2023, Men's Resources Tasmania, pp. 2-3.

in that journey somehow and I was to relay all the information to him about my pregnancy.

…

***Ms PAPAVASSILIOU** - … Even genetically, with blood testing, they're testing us, they're not doing blood tests on your partner for anything. It's all about yourself, and obviously I guess they're testing for the baby, for that interaction, but from the get-go, I think it's a very gendered approach that we present with birthing in general, and in terms of pregnancy and that whole experience.*[164]

5.8 In his submission, Mr Roberts noted the impacts of gendered norms on the experiences of men in the reproductive healthcare system:

> *We know traditional social and gendered norms negatively impact men. Harmful notions include: that fertility and child rearing is women's business; that the primary roles for a man are as breadwinner and supporter of their partner; and that men are stoic and strong and have a lesser emotional bond or experience than women, especially when the loss of a child occurs. These prevailing norms impact on whether men raise concerns or advocate for their own needs, with some men feeling pressure to align with these norms. During the perinatal period, pressure to 'stay strong' and 'be a man' can be exacerbated because many fathers feel that they must support their partners. Our health system reflects wider society.*[165]

5.9 Mr Roberts continued to explore the need for structural change to support men in reproductive health services space, which can both impact and be impacted by the analysis of gendered norms in this area:

> *Structural changes and more father inclusive practice across the board would help to support the proactive engagement of men in reproductive health services. This includes the development of a clear health pathway specifically for men from preconception to early fatherhood, including for men who have experienced loss. An integrated, father-inclusive approach to health policies and guidelines would support the consistent care of fathers and potential fathers. Men are calling for more engagement, greater provision of information and support from healthcare services, and for opportunities for peer support.*[166]

[164] Transcript of Evidence, 13 June 2023, Health Consumers Tasmania, p. 11.
[165] Submission No. 6, Mr Roberts, pp. 3-4.
[166] Submission No. 6, Mr Roberts, p. 4.

5.10 MRT discussed the concept of increased male participation in the healthcare system through the lens of international best practice, exploring its context as follows:

> *International best practice tells us that one of the key ways to improve men's access to healthcare is by developing male-friendly services. This fact was acknowledged in Australia's first National Male Health Policy, which called on health professionals to "make their practices more male friendly".*
>
> *Internationally, Ireland's Men's Health Action Plan identifies the ongoing development of male-friendly services as one of its four overarching themes, committing to: "build capacity with those who work with men and boys to adopt a gender competent and men-friendly approach to engaging men and boys at both an individual and an organisational level".*
>
> *Australia's current Men's Health Strategy names the provision of "male-centred information, programs and services" as the first of its guiding principles. This male-centred approach is defined as "consciously considering the needs and preferences of men in the design, delivery, promotion and continuous improvement of programs and services".*[167]

Parental Leave

5.11 In his submission, Mr Roberts detailed the current structure of paid parental leave in Australia:

> *In Australia, men are entitled to what is known as 'Dad and Partner Pay' under the Australian Government's Parental Leave Pay scheme. This is a payment for up to two weeks while you care for your new child. The payment is based on the weekly rate of the national minimum wage, and there are various conditions and timeframes you must meet to access this payment. There is also the option of taking unpaid parental leave — the National Employment Standards entitle employees, male or female, to take up to 12 months of unpaid parental leave but only if you've already worked for your employer for 12 continuous months. (healthymale.org.au/news/importance-parental-leave-dads). From above we can ascertain that less than 1% of dads are accessing the primary parental leave scheme and 4-5% are stay at home dad's, also contributes to the widespread and ongoing discrepancies and inequalities in Australian women's incomes and positions in our society.*
>
> *Personally, knowing many Tasmanian individuals and couples that are delaying starting a family or now not having children, due to economic pressures and cost of living considerations, is considerate [sic]. Addressing the above limited/minimal and often unrealistic or unattainable leave options and entitlements that many families/dads/non-*

[167] Submission No. 9, Men's Resources Tasmania, p. 10.

birthing parents factor in when considering and accessing financial impacts and leave arrangements, will promote and strengthen all the known evidence and outcomes associated present non-birth[ing] partners. This promotes and can result in enhanced connections, engagement, support and relationships with the birth mother and ongoing and future relationship and health outcomes of the child and parents. Considering and addressing this shortfall of poorly paid and limited time frames available, would go a long way to: addressing the decreasing birthing rates in Tasmania (multifactorial); support and incentivise families to have children; reduce the stigma and systemic restraints/barriers for dad's and non-birthing partners to be recognised and supported to engage in these roles and responsibilities. This can help remove the stigma and cultural expectations and perceptions that there is gender-based roles and delineations.[168]

5.12 Further, Mr Roberts detailed to the hearing how future changes to the scheme may impact families into the future:

***Mr ROBERTS** - ….*

In my research I realised that as of 1 July the parental leave is changing, which I wasn't aware of. I have concerns around that. I think it will further alienate non-birthing parents. My understanding is that the 18 weeks are going to extend to 20 weeks but be a combined period of time rather than the designated two weeks for non-birthing parents. Given the evidence that we have and the historical nature of this sense of providing for families, and non-birthing parents, particularly men and fathers returning to work, there may be an increased reluctance or judgment around accessing those two weeks when the birthing mother could have that period of time. That's my own view. In Australia, 4 or 5 per cent are stay-at-home dads, and I don't see that changing with this leave scheme.

I see by 2026 it is going up to 26 weeks, which is fantastic, and I would love to see more. There are fantastic leaders in this space, particularly Finland, Scandinavia, that do two years. A lot of cultural practices are that the dad will then do the one to two years because we know 80-plus per cent of brain development is within those first two years. To have that time, those relationships, those connections is huge. We don't have that. I had two weeks of no sleep then tried to return to work and come back and support the family. That's it, which I think is poor.

… Having men or non-birthing parents, most people that I associate with and chat to in Tasmania can't afford minimum wage for two weeks at the moment with the cost of living. Yes, you have two weeks as an option, you can access other forms of leave and a lot of people do. But there are people I know who are delaying or putting off having children at all because they're

[168] Submission No. 6, Mr Roberts, pp. 2-3.

concerned about the cost of living. They are also concerned that they can't get by on that two weeks of minimum wage. That is a real concern.[169]

Gendered Presentation for Healthcare

5.13 Gendered bias in healthcare was also discussed in the statistical context of men delaying the seeking of help, often due to the impact of socialised stereotypical ideas of male characteristics:

> ***CHAIR*** *- Coming back to your point of taking services to men or helping them to walk in the door, you make the point under accessing healthcare services:*
>
> > *Health services should avoid blaming men and making assumptions about their behaviour, and focus on solutions rather than the problems.*
>
> *That was from Healthy Male Australia, Engaging Men. Can you talk a bit more about how you see that playing out in practice - the blaming men and making assumptions?*
>
> ***Mr ROBERTS*** *- Straightaway I think of how men are presenting and that is late and that is down the track and that is very unwell; that is self-medicating on substances and alcohol, pornography, social media, add/insert here. And then being blamed for taking no responsibility or accountability for their health, or the situation you find yourself in because they haven't been supported or accessed early intervention. That's where I feel that there's that potential blame around that.*
>
> ***Dr WOODRUFF*** *- You mean that men in that situation get judged for their coping mechanisms with their situation, which they find intolerable and, for lots of reasons, don't do something that is healthy about it?*
>
> ***Mr ROBERTS*** *- Yes, and we see that more broadly in all aspects of health care, that men are more reluctant to access health care and primary services: men present later, men present when they are more unwell. There can be that judgment of, 'Where were you six months ago?*[170]

5.14 This was also explored by Equal Opportunity Tasmania in its submission:

> *In relation to gendered bias in healthcare, men face ongoing barriers in relation to the access of mental health supports. Reductive attitudes relating to masculinity lead to isolation and reluctance to access medical care for mental health issues. The rate of suicide for men has been identified as a widespread social issue, requiring a strategic approach which*

[169] Transcript of Evidence, 14 June 2023, Mr Roberts, p. 81.
[170] Transcript of Evidence, 14 June 2023, Mr Roberts, p. 79.

destigmatises the accessibility of mental health services for males and creates accessible, safe and responsive services (such as Mensline Australia and Men's Sheds).[171]

5.15 In his written submission, Mr Roberts noted the need for structural changes in healthcare to address gendered bias:

> *Structural changes to health services, that create male-friendly settings, cater for the time constraints of many men, and integrate telehealth and other new technologies can improve men's access to healthcare. Systemic changes that improve practitioners' ability to relate to male patients, and their knowledge of men's health, will likely increase men's use of healthcare services. Men's willingness to seek healthcare is influenced by past experiences, so enabling positive interactions will facilitate greater use of healthcare services. The health literacy and information needs of men are varied, so tailored approaches to provision of health information are required to ensure men are adequately informed about what is required of them for disease prevention and resolution. Men may be reluctant to raise sexual or mental health concerns with their doctor, but they are generally welcoming of enquiries about these topics by their doctor, and are forthcoming in providing relevant information.*
> *… There is widespread recognition in Australia that traditional masculine stereotypes are both inaccurate and harmful. Freeing men from these restrictive stereotypes will likely be good for their health and wellbeing, and that of society more generally. Health services should avoid blaming men and making assumptions about their behaviour and focus on solutions rather than problems.*
>
> *Promoting and advocating for Men's Health specific considerations to be implemented into health professionals' educational curriculums is essential going forwards.*
>
> *By addressing and reducing the stigma, role/gender delineation and the social and cultural constructs of masculinity, would encourage the promotion and inclusion of a greater percentage of men in health and caring professions, such as nursing, which can assist with the implementation of the strategies and recommendations discussed above tackling gender biases in healthcare. This can also assist in addressing the current and predicted staffing shortfalls in these fields going forwards.*[172]

5.16 The MRT submission also considered the need for health services to take a male-centred approach:

[171] Submission No. 14, Equal Opportunity Tasmania, p. 14.
[172] Submission No. 6, Mr Roberts, pp. 4-5.

The National Men's Health Strategy calls on health services to take a male-centred approach that "consciously considering the needs and preferences of men in the design, delivery, promotion and continuous improvement of programs and services".

At present only Western Australia, New South Wales and the Northern Territory have any form of men's policy. However, both Queensland and Tasmania have developed suicide prevention strategies with dedicated sections that specifically focus on men.[173]

Male Employment in the Healthcare Industry

5.17 Gender bias was also discussed in the context of the employment of men in the healthcare industry:

Ms O'BYRNE *- You talk a little bit about your own workforce and the gender break-up of that workplace. What do you think could be done to encourage greater gender diversity in your profession, because as you say, that leads to changing attitudes and behaviours?*

Mr ROBERTS *- There is that historical nature around role delineation and gender delineation with caring roles, and things like that. We are slowly seeing increasing rates of men in the nursing profession but it is still very slow. We still have a long way to go with doing that. I have tried to advocate for that in some work with Healthy Male Australia, which I'm involved in, around doing health promotion work for men to consider care fields and specialties.*

…There is a greater acceptance with men, particularly nursing, in the health workforce. It has never been an issue with medicine; that is a male-dominated area that is now changing with more women.

Ms O'BYRNE *- When you get down to aged care, the lower salary makes a significant difference for men.*

Mr ROBERTS *- Correct. When you've got the option of an apprenticeship or studying and not earning for three years and then having a HECS debt to then go into something where you are going to earn half of what you could have as an apprentice, that you then have to build into, there's no comparison for a young bloke when they're trying to put food on the table.*

…

Mr ROBERTS *- …But it's really hard when you are competing with apprenticeships and carrots of money dangled in front of you as an*

[173] Submission No. 9, Men's Resources Tasmania, p. 10.

option. I don't know around waiving HECS for nursing or healthcare fields. I would love to see that.[174]

5.18 The need for a diverse workforce in healthcare was also discussed in the MRT submission:

> *A key principle of public service is that its workforces should reflect the diversity of the communities they serve (which includes men).*
>
> *Furthermore, the Government's Workforce Gender Equality Agency (WGEA), a gender diverse workforce has a larger pool of talent to draw from, is more efficient, productive and creative and makes better decisions.*
>
> *In addition, the Federal Government has identified the under-representation of men in female dominated professions like health as a driver of gender equality.*
>
> *The over-representation of one gender in any workforce can create a culture that is more effective at engaging with that gender. As the health workforce is dominated by women, it is inevitable that the culture may be less "male-friendly" than it would be if it employed more men.*[175]

5.19 In verbal evidence Mr Bedloe noted the barriers to and importance of having male workers in the healthcare space:

> ***Mr BEDLOE -*** *It may be a lack of availability of male workers in some workforces ... but for some men seeing another man may be important, though certainly not for all men. The male-friendliness of services and the approaches that are taken by some services, for instance, talking about feelings. If we're talking about depression or suicidality, there's a school of thought from Stop Male Suicide in the Australian Men's Health Forum that shows men are much more concerned about situations and the contexts around their lives than they are about their feelings.*
>
> *We would look at supporting them in terms of the situations they're in rather than the feelings and emotions that they're experiencing. It's sort of taking an outside-in approach rather than an inside-out approach. There are not really any male-friendly services training happening, as such. It has in the past happened occasionally. There's been one or two providers who have done that. But I'm not aware of evidence of it happening on a consistent level out in the community.*[176]

[174] Transcript of Evidence, 14 June 2023, Mr Roberts, p. 82.
[175] Submission No. 9, Men's Resources Tasmania, p. 7.
[176] Transcript of Evidence, 13 June 2023, Men's Resources Tasmania, p. 3.

Findings

The Committee finds:

5.20 A level of disempowerment for people navigating the health system;

5.21 That non-birthing parents can also experience ante- and post-natal anxiety and depression;

5.22 Parental leave in Australia does not fully consider the needs of the non-birthing parent, including their economic and socio-cultural needs;

5.23 Stereotypes of masculinity, the nature of healthcare settings and sometimes the lack of availability of a male healthcare professional, can create barriers to men seeking healthcare;

5.24 There continues to be a delineation with caring roles in society; and

5.25 There is a need for increased diversity in the healthcare workforce.

Recommendations

The Committee recommends:

12. **The Government incorporate more support services to facilitate engagement during ante- and post-natal care to consider the welfare of non-birthing parents.**
13. **The Government responds to the negative stereotypes of masculinity that may influence men's interaction with healthcare, by developing appropriate policies, education and training.**
14. **The Government recommend the Federal Government, in considering further changes to the structure of parental leave in Australia, acknowledges and responds to the economic, socio-cultural context needs of non-birthing parents.**

6 OTHER ISSUES

6.1 The Committee heard gendered bias in healthcare can be more broadly felt due to intersectional circumstances, which characterise an individual's life. Intersectionality, or the combination of intersecting characteristics, identity markers or social identities, create the nature of an individual's experiences in society itself, including impacts of bias. The Committee heard evidence regarding the following topics in these areas:

- intersectionality;
- gendered bias for those with a disability;
- gendered bias in CALD communities; and
- the proposition of a Tasmanian Human Rights Act.

Intersectionality

6.2 A number of submissions to the Inquiry defined the notion of intersectionality in context. Equal Opportunity Tasmania noted that:

> *An intersectional lens is important to understand the differing experiences of gendered bias for varied social demographics. A patient may experience discriminatory treatment because of an intersection of their gender and that they are:*
>
> *• culturally and linguistically diverse*
> *• Aboriginal or Torres Strait Islander*
> *• LGBTIQA+*
> *• of a particular age*
>
> *Actual and anecdotal evidence suggests that developing a comprehensive understanding of the experience of women, in particular, who have encountered gendered bias in a healthcare setting requires consideration of the many interacting elements.*
>
> *Intersectionality is demonstrated by the difference of experiences resultant from 'intersecting' attributes (such as gender and race, or gender and age), for example:*
>
> - *a young woman may have a vastly different experience to an older woman, and a young Afghan woman may have a vastly different experience to a young Caucasian Australian woman*
> - *a man in his twenties may be treated quite differently to an older man, where stereotypes about how receptive older men are to receiving and listening to medical advice may impact the provision of such services*
>
> *Attributes are not always determinative of experience, but can significantly impact how individuals, including those who administer*

health services, come to decisions. There is a risk that decision-making is driven by bias, rather than evidence, or that the perception of evidence is impacted by bias. Positively and negatively held prejudices influence individuals to behave in particular ways, often without consideration given to their biases and how those biases may reinforce and underpin confidence in flawed decision-making.[177]

6.3 ACRRM further explored the potential indicators of lived experiences of intersectional inequality in its submission:

The National Women's Health Strategy 2020-2030 recognises that many women remain disadvantaged and fall into more than one of the identified priority population groups, which can have a compounding effect on health needs and outcomes.

The AIHW[178] *reports that First Nations women are likely to record significantly poorer health and health outcomes than non-Indigenous women and girls. It notes:*

"These poorer health outcomes extend across many key areas including: life expectancy and mortality; incidences of mental illness and chronic conditions; health risk factors, such as smoking, alcohol, physical inactivity and unhealthy eating habits; sexual health and child and maternal health; and potentially avoidable deaths and hospitalisations."

People may experience overlapping forms of discrimination or disadvantage based on Aboriginality; age; disability; ethnicity; gender identity; race; religion; and sexual orientation. Better understanding of the implications of these for patients and communities can improve the quality of their healthcare and improve the fit of health services to their needs and circumstances.[179]

6.4 The Royal Women's Hospital Victoria, also noted the various intersecting areas where bias can be experienced:

Systemic bias, stigma, poor health literacy and low investment in women's specific health research has resulted in serious health disparities for women, particularly First Nations women, women from non-English speaking backgrounds, women living with disability and women from low-socio-economic backgrounds.[180]

[177] Submission No. 14, Equal Opportunity Tasmania, pp. 3-4.
[178] Australian Institute of Health and Welfare
[179] Submission No. 4, Australian College of Rural and Remote Medicine, p. 3.
[180] Submission No. 16, The Royal Women's Hospital Victoria, p. 2.

6.5 Further continuing in its submission:

> *We believe greater attention needs to be paid to the social determinants of health and ways to redress disadvantage and discrimination that affects many women's ability to access high quality, inclusive and culturally safe public healthcare. We need to prioritise improvement in health outcomes for under-serviced groups such as First Nations women and girls by addressing the significant gap in health outcomes. We also advocate for additional health system investment from all levels of government into gender sensitive, accessible and inclusive mental health services specifically for women.*[181]

6.6 The social response to perceived gender–specific health conditions was noted in the submission from MRT:

> *In terms of men's and women's health, where a health condition is predominantly experienced by one gender, it is common for the other gender to experience bias. For example, most people with autism are male and so the systems of diagnosis, treatment and care may be biased against girls and women with autism. The reverse is true of eating disorders, where most patients are female and systems of diagnosis, treatment and care may be biased against girls and women with autism [sic]. A gender inclusive approach to each issue might yield better results for all.*[182]

6.7 Ms Tait, from TasCOSS, further discussed the long-term impacts of social perception on access to adequate support in the healthcare system:

> ***Ms O'BYRNE*** *- What do we currently do that you would undo as quickly as possible? …*
>
> ***Ms TAIT -*** *What's coming to mind is the difficulties we spoke about in the submission in relation to accessing the NDIS. As Adrienne just mentioned, it's a system that was designed with the best of intentions to promote self-advocacy. It has been a fantastic development for so many communities, particularly when we're thinking about the ways women are socialised; women of a certain age, for instance, might simply not be comfortable advocating for themselves or in certain environments, and then thinking about a system where instead of the idea of universal health care, it's this model where people can choose their provider, but that provider can also choose whether or not to work with you.*
>
> *We would say, and the research seems to demonstrate, that women, particularly women who have certain conditions, who might not behave in ways that are consistent with what we would see as socially acceptable behaviour for their gender, are impacted by healthcare providers who*

[181] Submission No. 16, The Royal Women's Hospital Victoria, p. 2.
[182] Submission No. 9, Men's Resources Tasmania, p. 3.

simply don't want to work with them because they're a 'difficult woman'. Women are likely to experience that in a different way to men… [183]

Gendered Bias for those with a Disability

6.8 TasCOSS noted in its submission to the Committee that gendered bias can impact the provision of timely and accurate diagnosis, particularly regarding disability:

> *Research suggests that a timely and accurate diagnosis, and subsequent appropriate treatment, for different kinds of disability can be influenced by gender. For example, it is more common for boys, men or those assigned as male at birth to be diagnosed with autism — this may be the result of under-diagnosing girls, women and those assigned female at birth, partially due to the "[g]endered socialisation of girls and boys, particularly those at the 'higher functioning' end of the autism spectrum… [which] may lead to behaviours that camouflage or mask autism in girls but not boys." This can in turn create further issues, including the development or exacerbation of mental health issues or difficulties in accessing support and/or treatment.*
>
> *Other research has highlighted the impact of gender bias in disability services in Australia, particularly in relation to the National Disability Insurance Scheme (NDIS), which is a scheme to promote choice and the empowerment of individuals, but also requires a high level of skills, knowledge and communication to effectively navigate its systems. This research demonstrates that individualised funding schemes for disability services (including the NDIS), "can widen inequalities along lines of discrimination and disadvantage that already exist in the wider society… [and that] some women accessing the NDIS experience gendered issues that cause or exacerbate barriers to support." Women, girls and those assigned female at birth may be disadvantaged in systems which require a high level of self-advocacy or assertiveness, as they may be "less likely to try and advocate assertively for their needs with service providers or in planning meetings as they worry they will be perceived in a negative way or disliked, and this could lead to them missing out on funding or services." They are also more likely to experience negative consequences for acting assertively, due to gendered ideas about how people should behave and communicate with others.*[184]

6.9 Gendered bias in the diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) was also discussed by Dr Kate Bendall from the AMA in verbal evidence:

[183] Transcript of Evidence, 13 June 2023, TasCOSS, p. 12.

[184] Submission No. 8, TasCOSS, p. 6.

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

...

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

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

***Dr BENDALL** - Most definitely.*

***Dr WOODRUFF** - So you are not recommending another body?*

***Dr BENDALL** - No. It would be nice to access it. Out of the handful of patients I can think of, maybe half a dozen or so are highly engaged with the public health system because they are sick, but their ADHD is not taken into account. That's my working diagnosis. One has just had an involuntary admission for psychiatric issues, one sees a chronic pain clinic and respiratory problems and has missed a bunch of appointments. It is impacting their care but no-one will talk about it.*[185]

Gendered Bias in CALD Communities

6.10 The TasCOSS submission raised the issues faced by members of culturally and linguistically diverse (CALD) communities in accessing healthcare:

> *For women, girls and those assigned female at birth from culturally and linguistically diverse (CALD) communities, there are several factors which may impact their access to effective healthcare. Challenges identified in research include low health literacy and language/communication issues (including a lack of appropriate services, such as interpreters, offered by mainstream healthcare services), and high unmet healthcare needs (for example, in relation to mental health) (*For example, see Khatri, RB,

[185] Transcript of Evidence, 14 June 2023, Australian Medical Association Tasmania, p. 50.

Assefa, Y 2022, *'Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges,'* BMC Public Health, no. 22, p. 880; Birhanu, M, Tinashe, D & Janette, P 2016, *'Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: a systematic review,'* Sexual Health, no. 13, pp. 299-310).

Many studies have also highlighted the need for same-gender healthcare (that is, where the gender of the patient and the professional is the same) for women and those assigned female at birth from diverse cultural and religious backgrounds. For example, a review of Monash Health highlighted the importance of same-gender healthcare in maternity services, particularly for women from diverse religious or cultural backgrounds, including Jewish, Muslim and Aboriginal women (Victorian Equal Opportunity and Human Rights Commission 2015, 'Submission to the Eight-Year Review of the Charter of Human Rights and Responsibilities Act 2006,' p. 31).

Some of the identified barriers for women from CALD backgrounds in accessing appropriate healthcare relate to gender bias, such as socio-cultural values of a person's country of origin and how these may impact access to, or experience of, healthcare. A recent study noted, for example, that African immigrant women in Australia were less likely to undergo routine screenings for cervical cancer, due in part to cultural/social beliefs relating to the procedure itself, as well as its importance as a healthcare measure (Anaman, J, King, J & Correa-Velez, I 2017, 'Barriers and facilitators of cervical cancer screening practices among African immigrant women living in Brisbane, Australia,' European Journal of Oncology Nursing, vol 31, pp. 22-29.) A lack of cultural competency in healthcare providers has also been identified as a challenge, (Khatri, RB, Assefa, Y 2022, 'Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges,' BMC Public Health, no. 22, p. 880), which can also relate to a combination of gender and cultural biases — both flagged as key issues for medical professionals in Australia.[186]

6.11 This was further discussed in verbal evidence before the Committee, with Ms Picone and Ms Tait from TasCOSS:

***Mr WILLIE** - You touched on cultural and linguistically diverse communities and my electorate has quite a few. There are obviously the gendered barriers to health care but there's also culture and language, so it's almost a double whammy. Have you thought about how to activate more of that community-based health care you're talking about? I think a couple of years ago the Bhutanese community organised for a dental practitioner to*

[186] Submission No. 8, TasCOSS, p. 7.

be part of a cultural festival to help check people's dental care at that event, because there are a lot of elderly community members and dental care is a particular issue for them. Have you thought about the sorts of ways you could activate more of that? They tend to rely a lot on community leaders to try to break those barriers down for the broader community.

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

...

***Ms TAIT -** Exactly, I think the success of those initiatives really relies on the fact that they are targeted to that community...*

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

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

There are really simple things and it does go back similar to the inclusion training or cultural awareness. How we can be aware of different cultural needs, particularly for women who have come from diverse backgrounds where there may have been violence or there may have been a different kind of awareness?[187]

[187] Transcript of Evidence, 13 June 2023, TasCOSS, pp. 4-5.

Human Rights Act

6.12 TasCOSS submitted an assessment of the significance of human rights act within the context of the provision of adequate and appropriate healthcare. The organisation suggests that the creation of a Tasmanian Human Rights Act may provide a functioning mechanism for the ignition of social and cultural change through providing support and a forum for education:

> *TasCOSS believes that the Tasmanian framework for the recognition and protection of rights would be greatly supported by the introduction of a Tasmanian Human Rights Act or Charter of Rights. We also believe the impact of a Tasmanian Human Rights Act could also encourage a cultural change in attitudes and beliefs, improved accountability and transparency, greater community awareness and empowerment, and as a tool for legal and social advocacy. As noted by the Human Rights Law Centre in a recent report:*
>
> *"Charters of Human Rights ensure the actions of our governments are guided by values of freedom, equality, compassion and dignity. Charters foster respect for human rights and help everyone, from school children to people who decide to call Australia home, to understand the rights and freedoms that we all share. Charters reflect our values and help to articulate the kind of society we all want to live in. Charters prevent human rights violations by putting human rights at the heart of decision-making when governments are developing laws and policies and delivering services. Importantly, they also provide a powerful tool to challenge injustice, enabling people and communities to take action and seek justice if their rights are violated." (Human Rights Law Centre 2022, 'Charters of Rights Make Our Lives Better: Here are 101 cases that show how,' no. 2.)*
>
> *We therefore strongly recommend the Tasmanian Government prioritises the development and implementation of a Tasmanian Human Rights Act. This should be accompanied by action to raise awareness of, and promote understanding of, the rights of all Tasmanians and ensure the public is provided with education and information on how to take action to respond in situations where their rights, or the rights of others, may have been violated.*[188]

6.13 While the provision of a Tasmanian Human Rights Act may facilitate change in certain aspects of the healthcare system, Equal Opportunity Tasmania also recommend in their submission that the nature of complaints processes should be strengthened and made a source of public education:

[188] Submission No. 8, TasCOSS, p. 10.

The option to make a complaint is vital as a way to access justice, however it is important to understand the barriers and limitations that are inherent to a complaint-based system. These barriers may act as a deterrent to complaining, in particular when an individual already feels disempowered due to their experience.

…

…noting the vast many health facilities which are managed by the Tasmanian Health Service in Tasmania, I would encourage the adoption of model litigant obligations. While such obligations cannot be imposed on private health facilities, where there is the opportunity for the adoption of a consistent standard that government entities are obligated to uphold in their responses to complaints, this should be adopted.[189]

Findings

The Committee finds:

6.15 Intersectionality can amplify the gender-related bias some members of the Tasmanian community experience when accessing healthcare particularly for those:

a. who are culturally and linguistically diverse;
b. who are Aboriginal or Torres Strait Islander;
c. with disability;
d. who are members of the LGBTIQA+ community; and
e. who are of a particular age.

The extent to which this is experienced is not yet fully understood.

6.16 There is a need for greater utilisation of interpreter services and additional training, including cultural awareness and inclusion training to assist medical professionals in treating those from diverse backgrounds;

6.17 Gendered bias can impact the timely diagnosis of conditions such as Attention-Deficit Hyperactivity Disorder (ADHD) and autism;

6.18 A Human Rights Act in Tasmania may improve the experiences of Tasmanians seeking healthcare, particularly those from marginalised groups.

[189] Submission No. 14, Equal Opportunity Tasmania, pp. 7-8.

Recommendations

The Committee recommends:

15. **The Government introduce a Human Rights Act.**
16. **The Government support and, where appropriate, provide additional training for health professionals to meet the needs of patients from culturally and linguistically diverse backgrounds.**
17. **The Government ensure all staff are aware of their obligations in regard to accessing interpreter services.**

APPENDICES

Appendix A - List of Submissions

1. Dr Miranda Hann
2. Working It Out
3. Ms Amanda Duncan
4. Australian College of Rural and Remote Medicine
5. Women's Health Tasmania
6. Mr Jacob Roberts
8. TasCOSS
9. Men's Resources Tasmania
10. AMA Tasmania
11. Department of Health
12. Family Planning Tasmania
13. Equality Tasmania
15. Equal Opportunity Tasmania
16. The Women's, The Royal Women's Hospital Victoria
17. Victorian Women's Trust

Appendix B - Minutes of the Committee

WEDNESDAY, 16 November 2022

The Committee met in Committee Room 1, Parliament House, Hobart at 1:15 p.m.

Members Present:

Mrs *Alexander* (via phone)
Mr *Duigan*
Ms *Forrest*
Mr *Harriss*
Mr *Willie*

APOLOGIES

Apologies were received from Mr *Street,* Dr *Woodruff and* Ms *O'Byrne.*

CONSIDERATION OF POTENTIAL INQUIRY TOPICS – TERMS OF REFERENCE

The Committee considered draft terms of reference for the following inquiries:

-

- …
- Tasmanian experiences of gendered bias in healthcare.

…

An amendment to the healthcare terms of reference was proposed by Ms *Forrest*: -

Insert – "Gender bias in research grant allocation and health related research;"

Resolved, to agree to the terms of reference, as amended, on the topic of healthcare (Mrs *Alexander*).

…

Resolved, to commence an inquiry into the healthcare topic with invitations for submissions to be advertised from 11 February 2023, closing 31 March 2023 (Mr *Willie*).

KEY STAKEHOLDERS - HEALTHCARE

Resolved, to put together a list of key stakeholders to invite to provide a submission to the inquiry and circulate to Members for additional input (Ms *Forrest*)

ADVERTISING

Resolved, to advertise gender bias in healthcare inquiry in the three main papers with invitations to submit to key stakeholders (Ms *Forrest*).

At 1:39 p.m. the Committee adjourned until Monday *21 November 2022*.

Confirmed,

WEDNESDAY, 15 MARCH 2023

The Committee met in Committee Room 1, Parliament House, Hobart at 9:05a.m.

Members Present:

Mrs *Alexander* (via WebEx)
Ms *Forrest*
Mr *Harriss*
Mr *Willie*
Dr *Woodruff*
Mr Young

APOLOGIES

Ms O'Byrne and Mr *Duigan* gave their apologies.

MINUTES

The minutes of the meeting held on 28 November last were read and confirmed. (Dr *Woodruff).*

INQUIRY – GENDERED BIAS IN HEALTHCARE

The Committee considered a draft timeline of the gendered bias in healthcare inquiry and *resolved*: -

- to extend the submissions deadline to 21 April 2023;
- to readvertise in the three major newspapers with the extended date;
- to write to all previously contacted stakeholders to advise them of the extended date; and
- to look at holding hearings for this inquiry in the week of 13 to16 June 2023, with the 13 & 14 to be held for now (Ms *Forrest).*

The Committee also discussed possible additions to the previously agreed to list of stakeholders.

Resolved, to add the following stakeholders to the list and invite a submission: -

- Laurel House (Mrs *Alexander*)
- Multicultural council (Mr *Willie*)
- WYNOT (Dr *Woodruff*)
- Speak out (Mr *Willie*)
- Advocacy Tasmania (Mr *Willie*)
- Health Complaints Commissioner (Ms *Forrest*)
- Tasmanian Aboriginal Council (Mr *Willie*)
- Migrant Resource Centre (Mrs *Alexander*)
- Migrant Resource Centre North (Mrs *Alexander*)
- Australian College of Midwives (Ms *Forrest*).

At 11:40 a.m. the Committee adjourned until a date to be decided, potentially Wednesday 26 April 2023.

Confirmed,

MONDAY, 24 April 2023

The Committee met in Committee Room 1, Parliament House, Hobart at 9:02a.m.

Members Present:

Mrs *Alexander* (via WebEx)
Mr *Duigan* (via WebEx)
Ms *Forrest*
Mr *Harriss*
Ms O'Byrne (via WebEx)
Mr *Willie*
Dr *Woodruff* (via WebEx)
Mr Young

APOLOGIES

No apologies were received.

…

MINUTES

The minutes of the meeting held on 15 March last were read and confirmed (Mr *Harris*).

GENDERED BIAS IN HEALTHCARE SUBMISSIONS

The Committee discussed the highly sensitive nature of submissions to the inquiry, further noting that this level of sensitivity will likely be reoccurring in future inquires.

Noted that further discussion will be had on the mechanism to enhance the public's awareness of opportunities to contribute to the Committee in a private or anonymous manner, which will further allow the Committee to respectfully navigate the process.

Resolved, that a media release regarding the means of privacy and anonymity in the submission process be drafted for consideration at the next meeting of the Committee. This will provide a linguistic pro forma for future advertisements and media releases of the Committee. (Ms *O'Byrne*).

At 11:37a.m. the Committee adjourned until Wednesday *26 April 2023*.

Confirmed,

WEDNESDAY, 26 April 2023

The Committee met in Committee Room 1, Parliament House, Hobart at 2:00 p.m.

Members Present:

Mrs *Alexander* (via WebEx)
Mr *Duigan* (via WebEx)
Ms *Forrest* (via WebEx)
Mr *Harriss* (via WebEx)
Ms O'Byrne (via WebEx)
Dr *Woodruff*
Mr Young (via WebEx)

APOLOGIES

An apology was received from Mr *Willie.*

MINUTES

The minutes of the meeting held on 24 April last were read and confirmed. (Mr *Duigan*).

SUBMISSIONS

Ordered, That the following submissions be received and published in full, with the personal contact details of individuals being removed (Mrs *Alexander*):

Submission 1: Dr Miranda Hann
Submission 2: Working It Out
Submission 3: Amanda Duncan
Submission 4: Australian College of Rural & Remote Medicine
Submission 5: Women's Heath Tasmania
Submission 6: Jacob Roberts
Submission 8: TasCOSS
Submission 9: Men's Resources Tasmania
Submission 10: AMA Tasmania
Submission 11: Department of Health
Submission 12: Family Planning Tasmania
Submission 13: Equality Tasmania

Ordered, That the following submission be received on a confidential basis (Mr *Duigan*):

Submission 7: Name withheld.

PUBLIC HEARINGS

Resolved, That the Committee hold public hearings in Hobart on 13 and 14 June (Mr *Young*).

Ordered, That the following witnesses be invited to attend before the Committee at the public hearings:

Submission 1: Dr Miranda Hann
Submission 2: Working It Out
Submission 3: Amanda Duncan
Submission 4: Australian College of Rural & Remote Medicine
Submission 5: Women's Heath Tasmania
Submission 6: Jacob Roberts
Submission 8: TasCOSS
Submission 9: Men's Resources Tasmania
Submission 10: AMA Tasmania
Submission 11: Department of Health
Submission 12: Family Planning Tasmania
Submission 13: Equality Tasmania

Ordered, That a witness be invited to appear before the Committee *in-camera*. (Ms *O'Byrne*).

INQUIRY MEDIA RELEASE

Ordered, That a media release be issued in advance of the public hearings (Dr *Woodruff*)

PRIVACY AND ANONYMITY MEDIA RELEASE

Resolved, That the media release regarding the privacy and anonymity, as amended, be released (Ms *O'Byrne*)

…

At 2:28p.m. the Committee adjourned until Tuesday *13 June* 2023.

Confirmed,

TUESDAY, 30 May 2023

The Committee met in Committee Room 3, Parliament House, Hobart at 1:11 p.m.

Members Present:

Mr *Duigan*
Ms *Forrest*
Mr *Harriss*
Ms O'Byrne
Mr *Willie*
Dr *Woodruff*
Mr Young

APOLOGIES

No apologies were received.

It was noted that on this day Ms *Johnston* has been elected to the Committee to replace Mrs *Alexander*.

…

GENDERED HEALTHCARE INQUIRY

Resolved, to accept Mr Bruce Levett's, (Health Consumers Tasmania) request to appear before the Committee to give verbal evidence (Dr *Woodruff*).

Resolved, the Chair to get in touch with 'The Bubble' for potential appearance before the Committee in relation to the gendered healthcare inquiry.

MINUTES

The minutes of the meeting held 26 April 2023 were read and agreed to (Mr *Duigan*).

At 2:09 p.m. the Committee adjourned until Tuesday *13 June 2023*.

Confirmed,

TUESDAY, 13 June 2023

The Committee met in Committee Room 1, Parliament House, Hobart at 9:59 a.m.

Members Present:

Mr *Duigan*
Ms *Forrest*
Mr *Harriss*
Ms O'Byrne (via WebEx)
Mr *Willie*
Mr Young
Dr *Woodruff*

APOLOGIES
Ms *Johnston* was an apology.

MINUTES
The minutes of the meeting held 26 April 2023 were read and agreed to (Mr *Duigan*).

GENDERED HEALTHCARE INQUIRY
WITNESS
Dr Miranda Hann was called via WebEx. The witness made the Statutory Declaration and was examined by the Committee in public.

At 10.36 a.m. the witness withdrew.
Redactions

WITNESS
Bruce Levett, CEO, Health consumers Tasmania, Ellen MacDonald, Policy Officer, Health Consumers Tasmania; and Dimitra Papavassiliou were called. The witnesses made the Statutory Declaration and were examined by the Committee in public.

At 3.30 p.m. the witnesses withdrew

Suspension of sitting 3.31 p.m. to 3.34 p.m.

WITNESS

Adrienne Piconne, CEO, TasCOSS and Meg Tait, Policy Officer, TasCOSS were called. The witnesses made the Statutory Declaration and were examined by the Committee in public.

At 4.25 p.m. Mr *Willie* withdrew.

At 4.27 p.m. the witnesses withdrew.

At 4:29 p.m. the Committee adjourned until 9 a.m. Wednesday *14 June 2023*.

Confirmed,

WEDNESDAY, 14 June 2023

The Committee met in Committee Room 1, Parliament House, Hobart at 8:59 a.m.

Members Present:

Mr *Duigan*
Ms *Forrest*
Mr *Harriss*
Ms *Johnston*
Ms O'Byrne
Mr *Willie*
Mr Young

APOLOGIES
Dr *Woodruff* was an apology.

GENDERED HEALTHCARE INQUIRY

WITNESS

The witness was called. The witness made the Statutory Declaration and was examined by the Committee *in-camera.*

At 9.59 a.m. the witness withdrew.

Mr *Duigan* withdrew.

Suspension of sitting 10 a.m. to 10.03 a.m.

WITNESS

At 10.03 a.m. Amanda Duncan was called. The witness made the Statutory Declaration and was examined by the Committee in public.

At 10.37 a.m. the witness withdrew.

Suspension of sitting 10.37 a.m. to 10.45 a.m.

WITNESS

Members present:
Mr *Duigan*
Mr *Harriss*
Ms *Johnston*
Ms *Forrest*
Ms *O'Byrne*
Mr *Willie*

At 10.46 a.m. Dr Colin Smith, Australian College of Rural and Remote Medicine was called via WebEx and was examined by the Committee in public.

At 10.49 a.m. Mr *Young* returned to the Table.

Examination of the witness continued.

At 11.32 a.m. the witness withdrew.

At 11.33 a.m. Ms *Johnston* withdrew.

WITNESS

At 11.33 a.m. Jessica Willis, Clinical Services Manager, Family Planning Tasmania, was called, via WebEx. The witness made the Statutory Declaration and were examined by the Committee in public.

At 11.47 a.m. Dr *Woodruff* came to the Table.

Examination of the witness continued.

At 12.29 p.m. the witness withdrew.

Suspension of sitting 12.30 p.m. to 1.30 p.m.

WITNESS

Members present:
Mr *Duigan*
Mr *Willie*
Mr *Harriss*
Ms *Forrest*
Mr *Young*

Dr Annette Barratt, Dr Juliana Ahmad and Dr Kate Bendall, on behalf of the Australian Medical Association were called. The witnesses made the Statutory Declaration and were examined by the Committee in public.

At 1.53 p.m. Ms *O'Byrne* came to the Table.

Examination of the witnesses continued.

At 2.05 p.m. Dr *Woodruff* came to the Table.

Examination of the witnesses continued.

At 2.33 p.m. the witnesses withdrew.

WITNESS

At 2.35 p.m. Jo Flanagan, CEO and Elinor Heard, Policy Officer of Women's Health Tasmania were called. The witnesses made the Statutory Declaration and were examined by the Committee in public.

At 3.32 p.m. the witnesses withdrew.

Suspension of sitting 3.32 p.m. to 3.40 p.m.

WITNESS

Jacob Roberts was called. The witnesses made the Statutory Declaration and were examined by the Committee in public.

At 4.23 p.m. the witness withdrew

..

At 5:17 p.m. the Committee adjourned until 1.10 p.m. Wednesday *21 June 2023*.

Confirmed,

THURSDAY, 31 August 2023

The Committee met in Committee Room 1, Parliament House, Hobart at 3:03 p.m.

Members Present:

Mr *Duigan (via WebEx)*
Ms *Forrest*
Mr *Harriss (via WebEx)*
Ms O'Byrne (via WebEx)
Mr *Willie (via WebEx)*
Mr Young (via WebEx)

APOLOGIES

Ms *Johnston* and Dr *Woodruff* were apologies.

MINUTES

The minutes of the meetings held 13, 14 and 21 June 2023 were read and agreed to. (Mr *Duigan*)

…

GENDERED BIAS IN HEALTHCARE INQUIRY

Ordered, That the following submission be received and published as redacted, with the personal contact details of individuals being removed (Mr *Willie*):

- Submission 15: Equal Opportunity Tasmania…

Ordered, That the following transcript be received and published as redacted (Mr *Young*):

- Redacted *In-Camera* evidence 14 June 2023

ADDITIONAL CORRESPONDENCE

- *Received*, additional correspondence from Mr Rodney Croome (Ms *O'Byrne)*:

The Committee also discussed possible additions to the previously agreed to list of stakeholders.

Resolved, to add the following stakeholders to the list and invite a submission or attendance at a public hearing: -

- Australian Women's Health Network (Ms *O'Byrne*)
- Royal Women's Hospital Victoria (Ms *O'Byrne*)

- Victorian Women's Trust (Ms *Forrest*)
- The Bubble Tasmania (Ms *O'Byrne*)
- additional local groups (Ms *O'Byrne)*

Resolved, to again invite the following to attend a public hearing of the Committee: -

- Department of Health Tasmania and the Minister for Health (Mr *Harriss*)
- Minister for Women (Ms *Forrest*)

FUTURE MEETING DATES

Resolved, to the following meetings of the Committee:

- Thursday 12 October 2023, 9am – 5pm for potential Public Hearings;
- Monday 16 October 2023, 11am – 2pm for potential Public Hearings;
- Friday 3 November 2023, 9am – 12:30pm for Committee deliberations; and

Friday 10 November 2023, 9am – 1pm for Committee deliberations

At 3:22 p.m. the Committee adjourned until 9 a.m. *Monday 16 October 2023*.

Confirmed,

FRIDAY, 6 October 2023

The Committee met via WebEx, at 9:04 am

Members Present:

Ms *Forrest*
Mr *Harriss*
Ms *Johnston*
Dr *Woodruff*
Mr *Young*

APOLOGIES

Mr *Duigan*, Ms *O'Byrne* and Mr *Willie* were apologies.

MINUTES

The minutes of the meeting held on 31 August 2023 were read and agreed to. (Dr *Woodruff*)

GENDERED BIAS IN HEALTHCARE INQUIRY

Ordered, That the following submissions be received and published in full, with the personal contact details of individuals being removed (Mr *Young*):

Submission 16: The Royal Women's Hospital
Submission 17: Victoria Women's Trust

PUBLIC HEARINGS

Resolved, That the Committee hold public hearings in Hobart on 12 and 16 October (Ms *Johnston*).

Ordered, That the following witnesses be invited to attend before the Committee at the public hearings:

Submission 16: The Royal Women's Hospital
Submission 17: Victoria Women's Trust

At 9:09 a.m. the Committee adjourned until 9.a.m. *Thursday 12 October 2023.*

Confirmed,

THURSDAY, 12 October 2023

The Committee met at Parliament House Hobart, in Committee Room 1, at 11:33 am.

Members Present:

Ms *Forrest*
Mr *Harriss*
Ms *Johnston*
Ms *O'Byrne (via WebEx)*
Dr *Woodruff*
Mr *Young*

NOTICE OF RESIGNATION

The Committee noted a letter received by the Chair from Hon Nick Duigan MLC in relation to his resignation from the Committee (Ms *Forrest*).

APOLOGIES

Mr *Duigan* and Mr *Willie* were apologies.

MINUTES

The minutes of the meeting held on 6 October 2023 were read and agreed to (Ms O'Byrne).

GENDERED BIAS IN HEALTHCARE INQUIRY WITNESSES

At 11.36 am, the Hon Guy Barnett MP, Minister for Health; Dale Webster, Deputy Secretary, Hospitals and Primary Care; George Clark, Deputy Secretary Community, Mental Health and Wellbeing; and Sally Badcock, Acting Deputy Secretary Policy, Purchasing, Performance and Reform, were called.

Mr Webster, Mr Clark and Ms Badcock made the Statutory Declaration. The witnesses were then examined by the Committee in public.

At 12.38 p.m. the witnesses withdrew.

Suspension of sitting 12.38 p.m. to 12.49 p.m.

WITNESSES

At 12.49 p.m. Ms Mary Crooks AO, Executive Director, Victorian Women's Trust and Ms Eleanor Lee, Intern University of Melbourne were called, via WebEx, and examined in public.

At 1.48 p.m. the witnesses withdrew.

At 1.50 p.m. the Committee adjourned until 11 a.m. *Monday 16 October 2023*.

Confirmed,

MONDAY, 16 October 2023

The Committee met at Parliament House Hobart, in Committee Room 2, at 11:01 am.

Members Present:

Ms *Forrest*
Mr *Harriss*
Ms *Johnston* (via WebEx)
Mr *Willie*
Mr *Young*

APOLOGIES

Mr *Duigan* was an apology.

GENDERED BIAS IN HEALTHCARE INQUIRY WITNESSES

Professor Sue Matthews, The Royal Women's Hospital Melbourne was called via WebEx and examined by the Committee in public.

At 11.07 a.m. Dr *Woodruff* came to the Table.

Examination of the witness continued.

At 11.09 a.m. Ms *O'Byrne* came to the Table.

Examination of the witness continued.

At 11.56 a.m. the witness withdrew.

OTHER MATTERS

Resolved, to write to SA Health in inquire as to what pregnancy termination data they collect, what do they consider reasonable data collection and are there any shortfalls in what they do collect (Ms *Forrest*).

Resolved, to invite the Chief Nurse and Midwife to speak to the Committee at a hearing (Ms *Forrest*).

Resolved, to once again invite the Minister for Women to speak to the Women's Strategy (Ms *Forrest*).

MEETING DATES

Resolved, to set aside the following dates for Committee business: -

- 27 November 2023, 9am to 12 pm.
- 8 February 2024, 9.30 am to 3 pm (report deliberation);
- 9 February 2024, 9.30 am to 3 pm (report deliberation)

At 12.10 p.m. the Committee adjourned until *3 November 2023*

Confirmed,

FRIDAY, 3 November 2023

The Committee met at Parliament House Hobart, in Committee Room 2, at 10:58 am.

Members Present:

Ms *Forrest*
Mr *Harriss*
Ms *Howlett*
Ms *Johnston*
Mr *Willie*
Dr *Woodruff*
Mr *Young*

APOLOGIES

Ms *O'Byrne* was an apology.

MINUTES

The minutes of the meeting held on 16 October 2023 were read and agreed to. (Mr *Willie*).

GENDERED BIAS IN HEALTHCARE INQUIRY TRANSCRIPTS OF EVIDENCE

Resolved, the transcripts of hearings held 12 and 16 October 2023 be published (Mr *Willie*).

GENDERED BIAS IN HEALTHCARE INQUIRY CONSIDERATION OF PRELIMINARY REPORT

The Committee considered the preliminary draft report.

At 11.30 a.m. Mr *Young* left the meeting.

The Committee continued to consider the draft report up to the end of Chapter 2.

OTHER MATTERS

Resolved, to write to the Minister for Health asking how health records are managed in Tasmanian hospitals - Is there one consistent system? How are changes in pronouns/names/gender dealt with in a practical sense.

At 12.32 p.m. the Committee adjourned until *10 November 2023*

Confirmed,

FRIDAY, 10 November 2023

The Committee met at Parliament House Hobart, in Committee Room 1, at 9:06 am.

Members Present:

Ms *Forrest*
Mr *Harriss*
Dr *Woodruff*

Via Webex:

Ms *Johnston*
Mr *Willie*
Mr *Young*
Ms *O'Byrne*

APOLOGIES

Ms *Howlett* was an apology.

GENDERED BIAS IN HEALTHCARE INQUIRY
CONSIDERATION OF PRELIMINARY REPORT

The Committee continued to consider the preliminary draft report.

Suspension of sitting 10.33 a.m. to 10.49 a.m.

Consideration of the draft preliminary report continued.

At 11:59am Mr *Willie* withdrew.

Consideration of the draft preliminary report continued up to the end of Chapter 3.

OTHER MATTERS

None.

At 12.40 p.m. the Committee adjourned until *27 November 2023*

Confirmed,

MONDAY, 27 November 2023

The Committee met at Parliament House Hobart, in Committee Room 2, at 9:12 am.

Members Present:

Ms *Forrest*
Mr *Harriss*
Ms *Howlett*
Mr *Willie*
Dr *Woodruff*

Via Webex:

Mr *Young*

APOLOGIES

Ms *Johnston* was an apology.

MINUTES

Resolved, that minutes of the consideration of the draft report not contain all detail of amendments, and

only that the report was considered and any divisions (Ms *Forrest*).

Resolved, that the minutes of 3 November and 10 November, be re-drafted to reflect the above (Dr *Woodruff*).

CORRESPONDENCE

The Committee noted as received the letter from Ms Helen Thomas, Interim Executive Director, Prevention and Population Health Directorate, Wellbeing SA, dated 10 November 2023 (Ms *Forrest*).

Resolved, that the Secretariate write to Wellbeing SA to ensure that the above letter can be used in the report of the Committee (Ms *Forrest*).

The Committee endorsed the outgoing of the letter to the Minister for Health dated 10 November 2023 (Ms *Howlett*).

GENDERED HEALTHCARE INQUIRY – CONSIDERATION OF PRELIMINARY REPORT

The Committee continued to consider the preliminary draft report.

At 9.49 a.m. Ms *O'Byrne* joined the meeting via WebEx.

Deliberation of the preliminary draft report continued.

Suspension of sitting 10.25 a.m. to 10.40 a.m.

Deliberation of the preliminary draft report continued up to the end of Chapter 4.

Findings and recommendations of Chapter 4 to be further considered next meeting.

OTHER MATTERS

None.

At 12.01 p.m. the Committee adjourned until 9.30a.m. *8 February 2024*

Confirmed,

THURSDAY, 8 February 2024

The Committee met at Parliament House Hobart, in Committee Room 1, at 9:38 am.

Members Present:

Ms *Forrest*
Mr *Harriss*
Ms *Howlett*

Via Webex:

Ms *Johnston*
Ms *O'Byrne*

APOLOGIES

Dr *Woodruff* was an apology.

MINUTES

The amended minutes of the meetings held on 3 November and 10 November were read and agreed to (Ms *Forrest*).

The minutes of the meeting held on 27 November were read and agreed to (Ms *Howlett*).

CORRESPONDENCE

The Committee noted as received the letter from Professor Sue Matthews from the Royal Women's Hospital

Melbourne, dated 27 November 2023 (Ms *Forrest*).

The Committee noted as received the letter from the Hon Guy Barnett MP, Minister for Health, dated 1 December 2023, in response to the Committees correspondence dated 3 November 2023 (Mr *Harriss*).

The Committee noted as received the letter from the Hon Guy Barnett MP, Minister for Health, dated 1 December 2023, in response to the Committees correspondence dated 10 November 2023 (Mr *Harriss*).

The Committee noted as received email correspondence from SA Health regarding the drafting of the Committees report.

Resolved, that the Secretariat write to SA Health with the sections of the Report which detail their correspondence (Ms *Forrest*).

GENDERED HEALTHCARE INQUIRY – CONSIDERATION OF PRELIMINARY REPORT

The Committee continued to consider the preliminary draft report.

At 9.46a.m. Mr *Young* joined the meeting via WebEx.

Deliberation of the preliminary draft report continued.

At 11.14a.m. Ms *Johnston* withdrew from the meeting.

Deliberation of the preliminary draft report continued.

At 11.16a.m. Mr *Willie* joined the meeting.

Deliberation of the preliminary draft report continued.

Suspension of sitting 11.58 a.m. to 12.49 p.m.

Members Present:

Ms *Forrest*
Mr *Harriss*
Mr *Willie*

Via Webex:

Ms *Johnston*
Mr *Young*

Deliberation of the preliminary draft report continued.

At 2 p.m. Ms *O'Byrne* rejoined the meeting via WebEx.

Deliberation of the preliminary draft report continued.

At 2.04p.m. Mr *Young* withdrew from the meeting.

Deliberation of the preliminary draft report was continued and concluded.

Committee to finalise the report at its next meeting.

OTHER MATTERS

Resolved, that the Secretariat write to the Department of Health requesting additional information regarding the breakdown of data relating to the number of women in Clinical Director Roles, Regional Director roles, and

Director Roles across the agency and their clinical qualifications, if applicable (Ms *O'Byrne*).

At 2.38 p.m. the Committee adjourned until 9.30a.m., *9 February 2024*

Confirmed,

FRIDAY, 9 February 2024

The Committee met at Parliament House Hobart, in Committee Room 1, at 9:34 am.

Members Present:

Ms *Forrest*
Mr *Harriss*
Mr *Willie*
Dr *Woodruff*
Mr *Young*

Via Webex:

Ms *Johnston*
Ms *O'Byrne*

APOLOGIES

Ms *Howlett* was an apology.

MINUTES

The minutes of the meeting held on 8 February, as amended, were agreed to (Mr *Young*).

CORRESPONDENCE

No correspondence.

GENDERED HEALTHCARE INQUIRY – CONSIDERATION OF PRELIMINARY REPORT

The Committee continued to consider the preliminary draft report.

Front page of the report agreed to.

Contents page of the report, as amended, agreed to.

Chairs Forward, as amended, agreed to.

Findings, as amended, agreed to.

Recommendations 1 – 8 agreed to.

Order of new recommendations 9-10, as amended, agreed to.

Recommendations 12 – 17 agreed to.

Chapter 1, paragraphs 1.1 – 1.11 agreed to.

Chapter 2, paragraphs 2.1 – 2.33 agreed to.

Chapter 2, recommendations 1 -3 agreed to.

Chapter 3, paragraphs 3.1 – 3.97 agreed to.

Chapter 3, recommendations 4 - 8 agreed to.

Chapter 4, paragraphs 4.1 – 4.51 agreed to.

Chapter 4, recommendations 9 – 10, as amended, agreed to.

Chapter 4, recommendation 11 agreed to.

Chapter 5, paragraphs 5.1 – 5.25 agreed to.

Chapter 5, recommendations 12 - 14 agreed to.

Chapter 6, paragraphs 6.1 – 6.18 agreed to.

Chapter 6, recommendations 15 – 17 agreed to.

Appendix A – List of Submissions, agreed to.

Appendix B – Minutes of the Committee, as amended, agreed to.

Resolved, for the Secretary to include the minutes of today's meeting in the final report (Ms *O'Byrne*)

Appendix C – Correspondence, to include as follows, agreed to:

- Letter from Professor Sue Matthews, The Royal Women's Hospital Melbourne
- Letter in response to Committee correspondence sent on 3 November 2023, from Hon Guy Barnett, Minster for Health;
- Letter in response to Committee correspondence sent on 10 November 2023, from Hon Guy Barnett, Minster for Health;
- SA Health response to request for additional information; and
- Pending response from Hon Guy Barnett, Minister for Health to letter regarding breakdown of employment data via gender.

Resolved, that the draft report, as amended, be the report of the Committee (Ms *Forrest*).

OTHER MATTERS
None.

At 10.22a.m. the Committee adjourned until a later date

Confirmed,

THURSDAY, 20 June 2024

The Committee met in Committee Room 1, Parliament House, Hobart at 9:18 a.m.

Members Present:

Mrs *Beswick*
Ms *Brown*
Mr *Edmunds* (via Webex)
Ms *Forrest*
Mr *Harriss*
Mrs *Petrusma*
Ms *Rosol*
Ms *Thomas*

ORDER OF THE HOUSES READ
The Secretary took the Chair and read the Order of the Legislative Council and the House of Assembly appointing the Committee.

ELECTION OF CHAIR
The Secretary took the Chair and read the Order of the Legislative Council and the House of Assembly appointing the Committee.

ELECTION OF CHAIR

The Secretary called for nominations, Mr *Harriss* nominated Ms *Forrest,* who consented to the nomination.

This nomination was seconded by Ms *Brown.*

There being no other candidates nominated, the Secretary declared Ms *Forrest* elected as Chair.

Ms *Forrest* took the Chair.

ELECTION OF DEPUTY CHAIR

The Chair called for nominations for Deputy Chair, Ms *Forrest* nominated Mr *Harriss*, who consented to the nomination.

This nomination was seconded by Mrs. *Petrusma.*

There being no other candidates nominated, the Chair declared Mr *Harriss* elected as Deputy Chair.

PARLIAMENTARY RESEARCH OFFICER

Resolved, That unless otherwise ordered Officers of the Parliamentary Research Service be admitted to the proceedings of the Committee whether in public or private session. (Mr *Harris*)

CHAIR TO BE THE SPOKESPERSON

Resolved, That the Chair be the spokesperson in relation to the operations of the Committee. (Ms *Forrest*)

PRESS STATEMENTS

Resolved, That unless otherwise ordered, press statements on behalf of the Committee be made only by the Chair after approval in principle by the Committee or after consultation with committee members. (Mrs. *Petrusma*)

STANDING ORDERS

Resolved, That unless otherwise ordered the Standing Orders of the House of Assembly be adopted as the Standing Orders of the Committee. (Ms *Forrest*)

Resolved, to receive advice from the Clerk of the House regarding potential to amend the establishing resolution of the Committee to provide for proxy members for specified inquiries or actions of the Committee (Ms *Forrest)*

EVIDENCE

Resolved, to receive the transcripts, submissions and any other evidence and papers of the Joint Sessional Committee on Gender and Equality of the 50th Parliament for consideration by this Committee. (Ms *Forrest)*

REPORT OF THE COMMITTEE ON THE 50TH PARLIAMENT – GENDERED BIAS IN HEALTHCARE

Resolved, to circulate the prepared report to all members, with the inclusion of explanatory paragraphs noting the prorogation and dissolution of the Committee and membership changes. (Mrs. *Petrusma*)

Resolved, to adopt the report at the next meeting of the Committee, in preparation of tabling. (Ms *Rosol*)

Resolved, to write to the Minister for Health regarding outstanding correspondence from 9 February 2024, notifying him that the report will be

tabled in the imminent future. (Mrs. *Petrusma*)

At 9:40 a.m. the Committee adjourned until Friday *9 August 2024*.

Confirmed,

FRIDAY, 9 August 2024

The Committee met in Committee Room 1, Parliament House, Hobart at 8:45 a.m.

Members Present:

Mr *Edmunds*
Ms *Forrest*
Mr *Harriss*
Ms *Rosol*
Ms *Thomas*

Via WebEx:
Mrs *Beswick*
Ms *Brown*
Mrs *Petrusma*

APOLOGIES

There were no apologies.

MINUTES

The minutes of the meeting held on 20 June 2024 were agreed to (Mr *Edmunds*).

CORRESPONDENCE

Resolved, to endorse the outgoing correspondence to the Minister for Health (Ms *Forrest*).

GENDERED HEALTHCARE INQUIRY REPORT

The Committee considered the draft report in light of the amendments pertaining to the prorogation and establishment of the new Committee.

Paragraphs 1.11 to 1.13 were agreed to, as amended.

Resolved, to again follow up with the Minister for Health regarding the outstanding question in relation to gender breakdowns of Director roles in the Department of Health and Tasmanian Health Service, requesting a response by Wednesday 14 August 2024. Should there be no response by this time, note the lack of response in the report (Ms *Forrest*).

Resolved, that the draft report, as amended, be the report of the Committee (Ms *Thomas*).

Resolved, Ms *Forrest* to table the Report in the Legislative Council on 15 August 2024 and Ms *Rosol* to table the Report on the House of Assembly on 10 September 2024 (Ms *Forrest*).

OTHER MATTERS

None.

At 9:00 a.m. the Committee adjourned until a date to be decided.

Confirmed,

Appendix C – Correspondence

i) Wellbeing SA 'Request for information related to the SA Pregnancy Terminations dataset for the Inquiry into Tasmanian experiences of Gendered Bias in healthcare', 11 November 2023;

ii) The Royal Women's Hospital, 'Questions on notice, Response from the Royal Women's Hospital, 27 November 2023';

iii) Hon Guy Barnett MP, Minister for Health, 'Letter in response to correspondence from the Committee on 3 November 2023,' 1 December 2023;

iv) Hon Guy Barnett MP, Minister for Health, 'Letter in response to correspondence from the Committee on 10 November 2023,' 1 December 2023;

v) Hon Guy Barnett MP, Minister for Health, 'Letter in response to correspondence from the Committee on 9 February 2024 and 27 June 2024,' 12 August 2024.

OFFICIAL: [Sensitive]

Executive Director
Prevention and Population Health Directorate
Wellbeing SA
PO Box 388 Rundle Mall
Adelaide SA 5000
ABN 92 815 941 329

Our Ref: CE-2023-16240

Ms Fiona Murphy
Committee Secretary
Joint Sessional Committee on Gender and Equality
Parliament House
HOBART TAS 7000

Email: genderandequality@parliament.tas.gov.au

Dear Ms Murphy

RE: REQUEST FOR INFORMATION RELATED TO THE SA PREGNANCY TERMINATIONS DATASET FOR THE INQUIRY INTO TASMANIAN EXPERIENCES OF GENDERED BIAS IN HEALTHCARE

Thank you for your letter dated 20 October 2023 requesting information related to the South Australian pregnancy termination dataset.

The South Australian Abortion Registry was established in 1969 and is a long-standing epidemiological data collection unique within Australia, and possibly internationally. The data from the registry are of considerable benefit for service planning and research. The South Australian Abortion Registry collects a range of data not ascertainable from other systems and are used to monitor trends and complications and provide insight into assessing equitable access.

From 1969 to 6 July 2022, termination of pregnancy data were collected under the Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011. Since 7 July 2022, termination of pregnancy data are collected pursuant to the *Terminations of Pregnancy Act 2021* and associated Termination of Pregnancy Regulations 2022. Importantly during this transition, data items of importance were retained to enable an uninterrupted collection; some fields were removed that were no longer required.

Data currently collected include:

- Patient demographics: including name, date of birth, suburb/postcode, medical record number.
- Facility information: including name, location, practitioner type, date of admission/discharge.
- Termination information: date of termination, gestation, method of termination, use of telemedicine.
- Information on genetic testing or structural anomaly ultrasound being conducted, including any suspected congenital anomalies.
- Legal considerations/reason for termination only for gestations after 22+6 weeks.
- Complications arising from the termination, and readmissions.
- Other data relevant to administration of the *Termination of Pregnancy Act 2021.*

Importantly in relation to complications arising from terminations of pregnancy, data are only reported if known at the time of termination. To improve the ascertainment of complications that occur after the termination, a data linkage is later conducted with public hospital admissions data.

The above information would be feasible to be collected in other jurisdictions. Considerations would be legal frameworks to support a data collection and to enable notification from public and private health facilities and practitioners. A critical feature of the South Australian data collection has been maintaining identified patient data. This has been essential to enabling data linkages as noted above, and also with the SA Birth Defects Registry which enables data to be captured state-wide on all congenital anomalies, rather than only those resulting in a birth.

The data we currently capture allows us to monitor epidemiological trends and provide some insights into equity of access. Administratively, information such as health practitioner name could be considered for ease of follow up for information.

For further information please contact Stephanie Flak, Acting Director, Epidemiology at [redacted].

Yours sincerely

[redacted]

HELEN THOMAS
INTERIM EXECUTIVE DIRECTOR
Prevention and Population Health Directorate
Wellbeing SA

10/11/2023

Inquiry into Tasmanian experiences of gendered bias in healthcare

the women's
the royal women's hospital

Questions on notice
Response from the Royal Women's Hospital
27 November 2023

In relation to the collection, monitoring and analysing of pregnancy termination data across both public and private providers, what would be the minimum data set that you would recommend Tasmania collect?

In response to this question, the Women's provides an extract from work undertaken by A R Assifi, E A Sullivan, M Kang, A J Dawson[1] and reproduces a version of their minimum data set as it appears in a Family Planning NSW 2020 framework[2].

"Australia lags behind other high-income countries in its surveillance of abortion service provision and outcomes for women of reproductive age and adolescents. Policy, planning and delivery of services are therefore not based on evidence…the development of nationally and internationally consistent data and indicators is warranted. To develop appropriate policies and services and promote transparency, national level standardised disaggregated information needs to be collected and made publicly available…There needs to be equivalency in standards of data collection, availability and how information is disaggregated and made available when it comes to abortion, as compared to other reproductive health areas.

Table 7 Minimum data set
Demographic data
Age of woman
Geographic location
Clinical Data
Method
Gestational age at time of procedure
Service location • Urban / Regional / Rural • Hospital / Clinic / GP • Public / Private
Previous delivery (number of previous pregnancies that resulted in a delivery)
Previous abortion (number of previous pregnancies that resulted in an abortion)
STI screening
Major complications (abortion-related morbidity) - Hospital- managed or managed outside hospital
Contraception used before abortion
Contraception prescribed / chosen as part of the abortion care

[1] A R Assifi, E A Sullivan, M Kang, A J Dawson, Adolescent abortion in 11 high-income countries including Australia: towards the establishment of a minimum data set, The Australian and New Zealand Journal of Public Health, Vol.43, Issue 6 (Dec 2019) pp 577-581

[2] https://whnsw.asn.au/wp-content/uploads/2020/11/Abortion-Access-in-NSW-12Oct2020.pdf

Inquiry into Tasmanian experiences of gendered bias in healthcare

the women's
the royal women's hospital

Could you please provide the Committee with further information about the COSMOS program?

COSMOS is a program that delivers a 'caseload midwifery' model of maternity care and has been operating in Australia for many years.

Considered the "gold standard" of maternal care, caseload midwifery sees a woman assigned to an individual midwife (with back up midwives) throughout their pregnancy, birth and early postnatal period. It has been shown to reduce caesarean births, epidural pain relief during labour, length of hospital stay, episiotomies, low birth weight babies and newborn admissions to special and intensive care.

The midwives refer women to other health professionals as appropriate, and work collaboratively with obstetricians but women stay under the care of their known midwife, even if their particular pregnancy needs more specialised input.

The Women's currently has several caseload midwifery programs:

COSMOS

- Introduced as the largest research trial of its kind in 2007, the COSMOS trial (COmparing Standard Maternity care with One-to-one Midwifery Support) gave the Women's strong evidence to support the continuance of caseload midwifery. Provided to low-risk mothers, the COSMOS program is now well established at the Women's. Midwives in this program work on a 24-hour on call basis so they are consistently available to the women in their caseload.

- In 2023-24, the Women's is employing 12.6 FTE for the COSMOS program and expects to care for 549 women within those resources.

Baggarrook Yurrongi (Woman's Journey)

- The Women's started offering caseload midwifery care to Aboriginal and Torres Strait Islander women and babies in 2017. The program was developed as a partnership between the Women's, La Trobe University, the Mercy Hospital for Women, Sunshine Hospital, Goulbourn Valley Health and The Victorian Aboriginal Community Controlled Health Organisation (VACCHO), with funding from the National Health and Medical Research Council.

- The goal of the program is to improve the health of Aboriginal mothers and their babies, close the health gap in outcomes and deliver services which are culturally sensitive, and responsive to the needs of First Nation communities.

- In 2023-24, the Women's is employing 4.6 FTE for the Baggarrook program and expects to care for 161 women.

Magnolia program

- Commenced in January 2023, the Magnolia program aims to reduce preterm birth among vulnerable and socio-economically disadvantaged women.
- Currently established as a randomised research trial, led by La Trobe University, the Magnolia program is being delivered at the Women's, the Northern Hospital and Bendigo Health and will last three years.
- In 2023-24, the Women's is employing 4.0 FTE for the Magnolia program and expects to care for 190 women.

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Tasmanian Government

01 DEC 2023

MIN23/2667

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Dear Ms Forrest

Thank you for your letter of 3 November 2023. Please see responses below to the Committee's questions:

1. With regard to surgical terminations of pregnancy:

   a) are surgical terminations of pregnancy services being provided in all Tasmanian hospitals where surgical services are provided;
      i. if not, which hospitals do not provide this health service;
   b) Please provide:
      i. the number of surgical terminations that are performed statewide; and
      ii. the number of women accessing surgical terminations, by hospital.

a. Yes

b. We are unable to provide this specific information. Patient information systems group information in accordance with the Australian Refined - Diagnosis Related Group classification, used in all Australian hospitals. This classification does not differentiate between incomplete spontaneous abortion (miscarriage) requiring surgical intervention and induced surgical termination.

2. Can a General Practitioner refer a woman for a medical termination of pregnancy (MTOP) to be performed in a public hospital?

Yes. Medical termination of pregnancy (MTOPs) is provided by qualified healthcare Practitioners, including General Practitioners (GPs), Family Planning Services and other specialist women's health services in the community.

Healthcare Practitioners, including GPs require specialised qualifications and training to provide this treatment and are encouraged to refer patients seeking medical termination of pregnancy to other community based providers if they have not completed the required training (MS-2 step training). Women can be referred to the public hospital setting if clinically required, such as complex maternal medical conditions.

3. Are the any doctors, gynaecologists or anaesthetists in the Tasmanian Health Service conscientious objectors, and if so, how many?

Tasmanian legislation allows health professionals (doctors, nurses, and others) to conscientiously object to participation in termination of pregnancy except in life saving situations. Legislation requires conscientious objectors to refer people seeking termination of pregnancy to other health practitioners who provide termination services.

4. Can you confirm whether or not the youth health services funding to provide access for people to pregnancy termination is being reduced; and

    a. if so, by how much; and
    b. if not, what is the funding for both the women's Health Service and the Youth Health service to access those services?

Funding to Youth Health services is not being reduced. The Youth Health Fund is funded by the Department of Health and administered by the Link Youth Health Service. The funding of $237 931 per annum (ex GST) supports a network of youth access workers who support young people and the current funding Agreement is until 30 June 2024.

The Women's Health Fund is funded by the Department of Health and administered by Women's Health Tasmania. The funding of $350 000 per annum (ex GST) supports an information line and access to sexual and reproductive health services. The current funding agreement is until 30 June 2025.

5. In relation to the Wellbeing Action Plan 2020-2023, please provide the evidence of;

    a. what has been achieved by this plan;
    b. what were the targets at the start of the plan;
    c. which targets were met; and
    d. detail of outcomes achieved under this plan?

The Action Plan includes 46 actions addressing these priorities that are aimed at improving health and wellbeing outcomes for women and girls, including 18 actions allocated to the Department of Health (DoH) to lead or co-lead.

The former Department of Communities Tasmania led the development of the Action Plan, which does not include baseline data or targets. DPaC has advised that the University of Tasmania, DPaC, the Department of State Growth and Homes Tasmania are working in partnership to develop a population-level Outcomes Framework for key wellbeing indicators, including health. Data will be disaggregated by gender and will be a key driver for measuring progress under the new Tasmanian women's strategy, Equal means Equal, and will support gender analysis of policies and budgets.

DoH activities achieved under the Action Plan include a mix of new and existing initiatives, projects and programs that align with the five strategic priorities of the Action Plan. Key achievements include:

- Funding to community sector organisations to improve women's maternal, sexual and reproductive health, including Family Planning Tasmania (FPT), Women's Health Tasmania (WHT), TasCAHRD, Red Cross, The Link Youth Health Service, Scarlet Alliance and Working It Out. These organisations deliver a range of services including training, education, access to information and health promotion strategies to support sexual and reproductive health.

- Funding to FPT and WHT to support action to increase access to a full, safe and effective range of reproductive and contraceptive information and options. Clinical services provided by FPT include prevention, testing, and management of sexually transmissible infections; management of contraception; pregnancy options and medical termination of pregnancies; cervical screening, breast checks; management of menstruation, fertility, and menopause; testing and treatment for common gynaecological symptoms and disorders; sexual and reproductive health information, counselling and referral. WHT administers the Women's Health Fund to cover the cost of specific sexual and reproductive health services and has established the Pregnancy Choices Tasmania website to connect users to local sexual and reproductive health care services.

- Tasmanian Government funding supported FPT with the purchase of ultrasound equipment and provision of training to medical practitioners.

- DoH has continued to progress significant mental health and suicide prevention reform. Rethink 2020: A State Plan for Mental Health in Tasmania 2020-25 (Rethink 2020) is continuing work to build an integrated mental health system, including with alcohol and drug services, housing, children and youth services and education. The 2023 24 Gender Budget Statement notes the strong positive impact of Rethink 2020 on women's economic security, leadership and participation, safety and health, and wellbeing.

- Rethink 2020 is a collaborative effort involving DoH, Primary Health Tasmania (PHT) and the Mental Health Council of Tasmania (MHCT) and represents a shared approach to improving mental health outcomes for all Tasmanians.

- PHT is a key partner, along with the MHCT, in implementing the Tasmanian Suicide Prevention Strategy 2023-2027: Compassion and Connection (TSPS). The TSPS builds on past work and brings together the government, services, communities, and individuals to improve health and wellbeing outcomes and prevent suicide. The first implementation plan of the TSPS covers the period January 2023 to June 2024, and includes actions to improve safe and responsible communications about suicide amongst health professionals and in the community, and reduction of stigma around suicide.

- The release of the TSPS also marked the elevation of mental health and suicide prevention to a Premier's priority in Tasmania. This provides a unique opportunity for targeted actions on suicide prevention, as well as coordinated efforts aligned with Rethink 2020 and the Mental Health Reform Program.

- Mental health literacy is also a priority area under Rethink 2020 and the TSPS. The Tasmanian Communications Charter is being implemented across all Government agencies to promote a shared understanding and common language around mental health and suicide. Under the 2023-24 Rethink 2020 Implementation Plan, DoH is funding the MHCT to deliver a statewide mental health literacy program that builds the capacity of communities to look after their mental health and wellbeing.

- DoH is also partnering with WorkSafe Tasmania to develop a Tasmanian Workplace Mental Health Framework. DoH will also develop a new Promotion, Prevention and Early Intervention Framework(s) for mental health, suicide prevention and alcohol and other drugs in Tasmania in consultation with key partners and stakeholders.

- DoH continues to implement the Tasmanian Immunisation Strategy 2019-24 to facilitate and improve immunisation coverage across the life course, in particular working to improve HPV vaccination coverage through a range of initiatives. These include working with local councils who administer HPV vaccination through the school-based immunisation program and participating in a range of local and national research projects to understand barriers to HPV uptake to inform program improvements. In 2024, National Immunisation Program-funded HPV vaccinations will also be available through participating community pharmacies.

- Under the Healthy Tasmania Five-Year Strategic Plan 2016-2021, a total of $5.6 million in grant funding was provided to support community-driven action on health and wellbeing through the Community Innovations Grants and Healthy Tasmania Fund (95 organisations delivered 101 projects across Tasmania). Initiatives that supported health and wellbeing for women included: a mountain bike skills clinics for women; a health and wellbeing program for women in Jireh House crisis accommodation; a physical activity program for women in Mary Hutchinson Prison; and a program supporting social connection for migrant women.

- The new Healthy Tasmania Five-Year Strategic Plan 2022-2026 was launched in March 2022. As well as addressing healthy eating, physical activity and reducing smoking, the Plan includes new focus areas of priority populations, health literacy, mental health and wellbeing, reducing alcohol harm and climate change and health to achieve its vision of all Tasmanians have the opportunity to live healthy, active lives in communities that support connections to people, place and culture. In 2022-23, a total of $2.7 million in funding was awarded to 102 communities and organisations for 122 projects across four grant streams. Initiatives that support health and wellbeing for woman and girls include promoting pelvic health, a social marketing campaign targeting female risky drinkers to reduce harms caused by alcohol, connecting women from culturally and linguistically diverse (CALD) backgrounds to other women and services, a water safety program for women from CALD backgrounds, and supporting girls and women to participate in ocean-based physical activity.

Yours sincerely

[redacted]

Hon Guy Barnett MP
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Tasmanian Government

MIN23/2371

01 DEC 2023

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Dear Ms Forrest

Thank you for your letter of 10 November 2023. Please see responses below to the Committee's questions in relation to patient health records and personal data collection, particularly with regard to preferred pronoun, prefix and gender marker in the Tasmanian Health Service:

1. **How are patient records managed to ensure timely changes to the preferred pronoun, prefix and gender marker of patients occurs?**

All frontline Department of Health staff are trained to interview patients when presenting to any Acute/Rural Hospital or Community Health facility where patient demographic details including prefix are updated accordingly. Due to current system constraints, there is no capture of pronoun; only sex and not gender information can be captured.

Department of Health Information, Communication and Technology (ICT) is in the planning phase for a system upgrade to enable the capturing and downstream communication of sex and gender information. The sex information must be maintained to ensure appropriate clinical care.

2. **Is there one consistent records system between THS sites that enables a change to be reflected in all patient records; and**

    a. **How does the records system reconcile with this?**

Yes, iPatient Manager (iPM) is the Patient Administration System used in all Department of Health facilities statewide and is the source of truth for Patient Demographic information.

    a. Upon updating patient information in iPM, an interface to all major clinical information systems ensures close to real time updating of this information in these systems.

3. **What process is utilised to enable patients to alter their preferred pronouns to use terms other than Mr/Ms/Mrs?**

Patients can request the altering of their prefix whenever they present to any Acute/Rural Hospital or Community Health facility. However, there is a link between sex and prefix in place. Department of Health ICT is currently undertaking work to break that link to allow patients to choose their prefix freely.

Furthermore, please note that Tasmania's Digital Health Transformation program is underway with $180 million allocated over 4 years, with a projected $476 million over 10 years. Currently, a Request for Tender is in progress, seeking proposals for a Statewide Electronic Medical Record (EMR) and an Ambulance electronic Patient Care Record (AePCR) system. These advancements, alongside the scheduled enhancements to the Statewide Patient Administration System, will transform patient care by streamlining documentation, creating personalised plans tailored to diverse identities, enhancing communication, and fortifying the security of sensitive information, particularly benefitting the LGBTIQ community.

Yours sincerely

[redacted]

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Tasmanian Government

Ref: MIN24/1932

12 AUG 2024

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Dear Ms Forrest Ruth

Thank you for your letter of 27 June 2024 regarding the Inquiry into Tasmanian experiences of gendered bias in healthcare and the Committee's request for a response to the following:

Question:

(1) What is the gender breakdown of individuals in the following roles within the Department of Health and Tasmanian Health Service, including medical qualifications where applicable:

a. Clinical Director roles;

b. Regional Director roles; and

c. Director roles.

Answer:

The Department of Health has provided the response to the Committee in the Table below.

The Department of Health has interpreted the Committee's request and provided a brief description of the type of roles included in each category.

Please contact my office if further clarification is required.

	Female	Male
Clinical director roles (include statewide specialty directors in Statewide and Mental Health Services)	7	16
Regional director roles (include medical roles with responsibilities across a region or statewide such as executive directors of medical services)	6	7
Director roles (includes directors of specialties such as emergency medicine)	5	15

Yours sincerely

Hon Guy Barnett MP
Minister for Health, Mental Health and Wellbeing