Women's Health Tasmania

Inquiry into Tasmanian experiences of gendered bias in healthcare

APRIL 2023

EQUITY
CHOICE
IMPACT

Introduction

Based in nipaluna/Hobart in southern lutruwita/Tasmania, Women's Health Tasmania has been providing evidence-based services and advocacy for better health outcomes for women since 1988. We are run by women for women, with the vision of women being informed and active decision-makers in our own health and wellbeing. Our definition of 'women' is inclusive and our work supports everyone who identifies as a woman.

Women's Health Tasmania regards equitable access to quality health care as a fundamental right and recognises that for some women this right is limited by barriers relating to age, gender, sexuality, disability, income, housing, literacy, language, culture, immigration status and legal status. Our work with government, health and community sectors seeks to respond to these barriers and to identify opportunities for health service improvement and system reform.

From this vantage point, Women's Health Tasmania is well placed to respond to the Joint Sessional Committee on Gender and Equality's *Inquiry into Tasmanian experiences of gendered bias in healthcare* (the Inquiry). We welcome the opportunity to share with the Committee a range of insights and experiences generously contributed by women across the state.

Our approach to the Inquiry

Women's Health Tasmania has chosen to respond to the terms of the Inquiry by sharing a series of composite case studies reflecting the health care experiences of women in Tasmania. The development of composite case studies—wherein the experiences of multiple participants are combined to create a hypothetical example—is a mode of narrative research designed to provide detailed insight into lived experiences while safeguarding the privacy and confidentiality of contributors.[i]

The experiences collated in the case studies were gathered in a range of ways: by Women's Health Tasmania staff working directly with clients in the community; through our series of *'Talking to…'* research reports;[ii] and via a survey Women's Health Tasmania produced in response to the terms of the Inquiry called 'Your story matters: gender bias in healthcare'. We are grateful to all participants for generously sharing their stories.

In each of the seven case studies, gender plays a role—as a causal factor in the health scenarios described, as a bias within the health system response, or in the social expectation that women be responsible for the health of individuals and families collectively. Each case study is followed by a brief discussion and recommendations.

Together, these narratives demonstrate the importance of shifting from gender neutral (or 'gender-blind') health service delivery towards gender conscious health care models that recognise the specific roles, responsibilities and risks associated with our individual, familial and social identities.

Case Study 1: Hedi

"I can't think about health, I have to think about the Visa."

Hedi is 32 and lives with her husband, Karim, and their 5-year-old son, Omid, in a rental property in Hobart's northern suburbs. The family came to Tasmania from Iran on temporary visas 18 months ago and hope one day to become permanent residents.

Hedi was an accountant in Iran but now works casual shifts as a cleaner on days when Omid is in kinder. Karim is a taxi driver and also takes seasonal agricultural work when it's available. He is often away from home for long hours during the day and night.

Money is very tight for Hedi and Karim and the financial strain is constant, along with the anxiety that they may not be granted permission to stay in Australia. The family are not eligible for Medicare and cannot afford GP appointments, so Hedi manages minor ailments, like Omid's eczema, with home remedies suggested by her family in Iran.

Hedi dearly wants a brother or sister for Omid but has heard it costs thousands of dollars to have a baby at the public hospital in Tasmania. A friend told Hedi hospitals sometimes waive their fees or offer women a repayment scheme, but Hedi cannot risk going into debt and Karim gets upset if she even talks about it.

Recently Omid's teacher told Hedi that Omid is having trouble learning numbers and letters. The teacher said Hedi should have his hearing and eyesight tested before they assess him for learning disorders. Hedi is desperately worried about the cost of the appointments and has not told Karim.

Hedi's story illustrates the stark divide between 'permanent' and 'temporary' residents in Australia and how—for those whose visa status precludes access to Medicare and income support—cascading financial pressures and other situational stressors undermine the health of individuals and families.

These factors are gendered, in part because women tend to be responsible for maintaining the health of families and children—but also because the burden of managing reproductive health is both biologically and socially 'women's work'.

Women on temporary visas tell Women's Health Tasmania the cost of antenatal and birth care in Tasmania is prohibitive, and that if they do become pregnant, they risk delaying or rationing care due to financial circumstances.

The Department of Home Affairs requires temporary visa holders in certain categories to take out private health insurance as part of the application process. However, we spoke to women who had private insurance, only to find many of the costs associated with pregnancy were not covered by their policy. This matter is further complicated for women on temporary visas in rural settings who may not be able to 'shop around' to find the most cost-effective private provider of pregnancy care.

Women on temporary visas say health and financial crises are usually intertwined, and that food and rent have to come before pharmacy goods and GP appointments. Specialist health consultations are rarely an option.

They also say the challenges of navigating a foreign health system are more complex for women, who may be acutely conscious of the power disparity in the patient-doctor dynamic and reticent to disclose medical problems to health professionals, particularly men.

Further, Women's Health Tasmania has spoken with women living in Tasmania on temporary visas who have incurred significant medical debts because of the costs of antenatal and pregnancy care. In many cases, Tasmanian public hospitals can waive or reduce these debts, but this situation highlights:

- A harmful and discriminatory gap in the private health insurance regime as applied to women on temporary visas;
- A system that predisposes women on temporary visas to neglect routine health checks during and after pregnancy;
- A system that places additional financial burdens on women because of their gender and their migration status.

Recommendations:

1. Expand the visa categories that are Medicare eligible.
2. Universal free antenatal and perinatal health care for all people in Tasmania, regardless of their insurance and visa status.
3. Sustained funding for health literacy initiatives for migrant women focusing on sexual and reproductive health.
4. Tasmanian health workforce training on cultural diversity.

Case Study 2: Carmel

"Most health services say I'm the first trans patient they've ever had."

Carmel is 54 and lives in her own home in a suburb of Launceston in northern Tasmania. She works four days a week as a legal receptionist. Carmel's closest friends know she is transgender but most of her colleagues and acquaintances do not.

Carmel is cautious about accessing health care, having encountered many judgemental, and at times hostile, responses from health services over the years. Twelve years ago Carmel found a GP in Launceston who she felt she could trust and she continued seeing her until six months ago when the GP retired and the clinic closed.

Carmel had a good relationship with this GP—the GP always addressed her by her chosen name, and the team at the clinic understood and used Carmel's correct pronouns. Carmel is wary of approaching a new GP clinic. It's hard to find a practice accepting new patients and the prospect of facing discrimination all over again is harrowing.

Two months ago Carmel began having abdominal pain and nausea. She tried cutting dairy and gluten out of her diet and the pain improved temporarily, then returned. The pain got so bad one evening that Carmel called a friend, afraid she might pass out. The friend rang an ambulance and Carmel was taken to hospital where she was diagnosed with diverticulitis.

Carmel was given fluid and antibiotics and had to stay in hospital for four days. A doctor at the hospital chastised Carmel for not seeking help sooner, saying she could have ended up with a bowel obstruction.

While in hospital Carmel was also diagnosed with depression. She was given a leaflet with a number of counselling services listed. Three of the four services were faith-based organisations that Carmel thought could be transphobic. She rang the fourth service and is now on a waiting list for an appointment in three to four months' time.

Research shows LGBTIQ+ people in Australia have poorer health outcomes than the general population, particularly in relation to mental health.[iii] Carmel's story points to the role discrimination plays in these outcomes in a Tasmanian context, both in the attitudes of health care providers and in the reticence of LGBTIQ+ people to engage with services they fear may be discriminatory.

Transgender women tell Women's Health Tasmania there are few options for trans-informed health care in Tasmania and a limited number of practitioners who understand gender affirmation, either medically or socially. The lack of access to inclusive primary health care is linked to a perceived high number of LGBTIQ+ women presenting at emergency departments for issues that could be dealt with by a GP.[iv]

Women also speak about their distrust of church-based medical and other institutions and report examples of recent refusals of service by GPs because they "did not agree" with transgender identities. Women describe being reluctant to access health or community services where workers may hold discriminatory views based on religious or other grounds and say these factors make it harder to participate in preventative health spaces and activities, such as gyms and exercise classes.

In effect, trans women, trans men and non-binary people find themselves at the intersection of both gender discrimination and cisgenderism—the belief that being cisgender is the only way to be—and face both interpersonal and systems-level discrimination in health settings as a result.

For example, trans men and non-binary people presumed female at birth may need to access clinical gynaecological services and breast ultrasound services. Many of these services are highly gendered and delivered in settings with labels such as ‘women’s health’ or ‘women’s clinics’. Other times they may be referred to as ‘gynaecology services’ but the cultural norm is that they provide service to cisgender women only. Trans men and non-binary people who access these spaces for vital medical care report wide ranging and distressing experiences of discrimination.

Recommendations:

5. Tasmanian health workforce training on inclusive practice, including specific education on transgender health.
6. Develop multidisciplinary health spaces with diversity at their core.
7. Restrict funding for the delivery of health and social services, including mental health care, to organisations with a public record of LGBTIQ+ equity and inclusion.
8. Support for health services that traditionally service cisgender populations to provide inclusive care for trans and non-binary people.

Case Study 3: Alana

"It's just a horrible juggling act."

Alana is 23 and has three children with her ex-partner, Matthew: four-year-old Cody, two-year-old Taylor, and one-year-old Bailey. Before Alana and Matthew separated the family lived at Nubeena on the Tasman Peninsula.

After the break-up, Matthew moved to Western Australia to look for work. Alana and the kids first moved to Dunalley to live with Alana's grandmother but left again when she was diagnosed with dementia. The family stayed with friends for a while and have since found short-term accommodation at a women's shelter in the outer Hobart suburb of Kingston.

The family are on a waiting list for housing and most of Alana's time is taken up attending appointments with homelessness sector workers. It can take all day for Alana to get to and from a single appointment using public transport with three children and a pram. If the weather is bad, she doesn't even try.

For now the family's health needs are on hold. Bailey has missed his 12-month immunisations. Cody has been refusing to use the toilet and has chronic constipation. Alana has been told about a GP practice that bulk bills in North Hobart but getting there is a nightmare, and Alana feels she should prioritise finding housing.

Alana has been on the public dental care wait list for two years and now has worsening pain in her teeth and gums. The shelter gave Alana the name of a dentist who may waive his fees if she explains her situation. Alana finds it hard presenting to services as deserving of help, but not too needy or complicated. She plans to wait for a day when she has childcare for a few hours and clean clothes, then will try approaching the dentist.

Against the backdrop of an ongoing housing crisis, Women's Health Tasmania hears increasingly from women with stories like Alana's. Homelessness is a highly gendered and profoundly distressing experience that impacts the physical and mental health of women and children in specific ways—as well as their ability to access the health services and support they need. [v]

Women who have been homeless tell us the experience of being displaced from their community results in disconnection from established health and social supports. They report travelling long distances to find temporary accommodation and say there are many barriers to accessing health care in a new location at a time of crisis, including cost, transport, lack of identification or Medicare Card, and difficulty maintaining appointments or treatment regimes. For women who are homeless with children, the range of health supports they require, as well as the complexity of barriers, increases.

Women say the limited availability of bulk billing GPs in Tasmania together with the stigma that accompanies homelessness impacts their ability to get the health care they need. They describe being conscious in their interactions with services of appearing worthy of support but not too desperate, and say they take extra steps to appear grateful and deserving of help.

Recommendations:

9. Increase the availability of bulk billed primary health care.
10. Design health services with input from women with a lived experience of homelessness.
11. Longer term temporary accommodation solutions, with pathways to permanent housing.
12. Trauma informed health and social services that emphasise dignity and autonomy.

Case Study 4: Maureen

"I was walking on eggshells for 30 years."

Maureen is 61 and lives at St Helens on Tasmania's East Coast. She came to the area when her 30-year marriage to Tony ended. Their relationship was not happy. Tony didn't like Maureen working so she left her career as a teacher when they married. Maureen had a weekly allowance to buy groceries but no money of her own. Her parents lived an hour away and Maureen couldn't afford the petrol to visit them. She felt very isolated.

After their first son was born, Maureen developed postnatal depression. Her doctor prescribed Maureen the contraceptive pill so she wouldn't fall pregnant again. When Tony found out what had happened, he was furious. He accused Maureen of being deceptive and threw the medication in the bin.

Their second son was born a year later. Maureen's depression became more severe and one morning Tony found her collapsed, having overdosed on sleeping pills. Maureen was rushed to hospital in Launceston. Tony told the nurses Maureen was manipulative and he'd long suspected she had mental problems.

Maureen was hospitalised repeatedly over the next five years. On one occasion she disclosed to a nurse that she wanted to leave Tony but couldn't, because he controlled all the money and "would make my life hell". The nurse said it sounded like a bad situation but took no further action. Eventually, Maureen received a diagnosis of bipolar disorder.

When Maureen was 50 and the kids had left home Tony revealed he'd been having an affair for several years. He said it was no longer his responsibility to look after Maureen and he wanted a divorce. Maureen left George Town, where she felt everyone knew her problems, and moved to St Helens. Her new GP suggested she see a counsellor to help her cope with the divorce.

The counsellor noticed Maureen was experiencing symptoms of trauma, including insomnia and hypervigilance. Maureen began learning about the impacts of emotional abuse. While it made her angry to think about how Tony had treated her, it also gave her insight into her mental health and new hope for recovery.

Research shows intimate partner violence is a clear and consistent predictor of depression, anxiety, trauma symptoms, suicidality and substance abuse among women—and that the result is a lifetime deficit in mental and physical health, even after the abuse has ceased.[vi]

For women in Maureen's position, recovery from long term interpersonal abuse is complicated by a legacy of misdiagnosis that saw her natural trauma responses construed as proof of chronic mental illness. Sometimes termed 'medical gaslighting', experts suggest these outcomes are the consequence of health system attitudes that have, historically, framed women's distress as manipulative and non-serious.[vii]

For health systems to better respond to family violence—including recognising symptoms related to the 'hidden' forms of abuse that Maureen endured, such as social isolation, financial control and reproductive coercion—health services must become both trauma and family violence informed.

Recommendations:

13. System-wide training for health professionals on the gendered links between family violence, trauma and mental health.

14. Upskill the primary health sector to recognise and respond to all forms of intimate partner violence, including hidden forms of abuse.
15. Trauma-informed, gender responsive mental health and suicide prevention approaches.

Case Study 5: Tegan

"Each day it's a question of whose health I prioritise."

Tegan is 43 and lives on a farm near Wynyard in Tasmania's North West with her husband Justin and their kids, Chloe, 15, Mason, 13, and Noah, 10. Justin works full-time on the farm and Tegan works part-time in the office at the local primary school.

Tegan's family have a number of health needs. Both boys have diagnoses of autism spectrum disorder (ASD) and Noah has coexisting ADHD and learning disorders. Chloe has struggled with her mental health for several years and was recently hospitalised with an eating disorder. Currently she attends high school about 50% of the time.

Both Justin and Tegan have trouble keeping their weight under control and Tegan has been told she's at risk of diabetes. She has been trying to get more vegetables into the family's diet but it's hard when the boys will only eat certain foods and meals are so difficult for Chloe.

Accessing medical support for the kids is a constant source of worry for Tegan. The boys' paediatrician is two hours away in Launceston and it can take weeks or even months to get an appointment. When they do have an appointment Tegan has to take the boys out of school for the day because of the travel time involved.

When Chloe was acutely unwell she was admitted to the Spencer Clinic in Burnie, an adult psychiatric unit, because there was no inpatient care for adolescents in the region. Chloe found the experience terrifying and says she won't go back, however sick she is.

The family have been on the waiting list for the Child and Adolescent Mental Health Service for six months but staff shortages mean there is no timeline for when they will be offered treatment. For now Tegan has been encouraged to read up on family-based treatment for anorexia and book Chloe in to the GP weekly for medical monitoring.

Tegan often wonders if she and Justin should leave the farm and move the family to Launceston to be closer to the medical services they need. For now Tegan is hoping they can hold on at home, close to their friends and community.

Tegan's story reflects a common thread in the experience of women across Tasmanian communities, which is the role they perform as family health 'case managers'—a task that becomes increasingly overwhelming with the number and complexity of health needs involved.

For women in rural and regional areas of the state where access to health and community services is limited—including child health and parenting services, family support services, respite services, allied health services, and child and adolescent mental health services—these responsibilities can be all-consuming. Women report high levels of physical and emotional fatigue, loneliness, anxiety and depression and say they routinely neglect their own health needs because they are caring for others.

Women suggest health outcomes could be improved in rural communities by implementing family-friendly models of service delivery that include combined family appointment times, childcare-inclusive health activities, and the establishment of local health care coordination services.

Recommendations:

16. Locally based, regional health workers to support health service coordination.
17. Family-friendly health service models offering combined appointment times.
18. Improve access to community based mental health support for all ages.

Case Study 6: Bec

"Doctors should have to explain to women the risks they are subjecting them to."

Bec is 38 and lives with her partner Ollie and their five-month-old daughter, Abby, in Huonville, half-an-hour south of Hobart. Bec is currently on maternity leave from her job as a social worker, while Ollie works for a local building company.

Bec's pregnancy journey was a nightmare. It began six years ago when she experienced several episodes of heavy bleeding between periods and was referred to a gynaecologist for advice. The gynaecologist suggested performing a routine D&C to investigate the bleeding. All being well, she said Bec could start trying for a baby once she'd had a normal menstrual cycle after surgery.

The procedure went smoothly but two months later Bec still hadn't had a period. She contacted the gynaecologist who said not to worry, it could take three or four months for her cycle to return. When there was still no sign of her period after six months, Bec saw a GP. The GP said recovery after surgery varied and Bec should try to reduce her anxiety, as stress may affect her fertility.

Over the next 18 months Bec saw several different doctors and had multiple abdominal ultrasounds and blood tests. It wasn't until Bec saw a fertility specialist that a pelvic ultrasound was performed and Bec was diagnosed with inflammation and scarring caused by the D&C. While she now understands an outcome like this from a D&C is rare, Bec wishes she had been fully informed of the risks at the time of being offered the procedure.

Bec underwent three surgeries over the course of two years at a women's hospital interstate in the hopes of restoring her fertility. The total cost of the treatment, including travel expenses, amounted to around $20,000—savings that Bec had hoped to put towards a house deposit.

Four years after the D&C Bec fell pregnant and Abby was born shortly before Bec's 38th birthday. Bec says she feels both grief and gratitude when she looks at Abby. She says she and Ollie would love to expand their family but that a second pregnancy is unlikely now.

Women's Health Tasmania hears regularly from women who have encountered health system ignorance and apathy on reproductive health matters. Stories of doctors failing to give women comprehensive information about reproductive health interventions and associated risks, and dismissing the concerns and self-advocacy attempts of women like Bec, are common.

Many of the women who talk to us about their reproductive health say it takes a considerable length of time to get a meaningful diagnosis. They tell us about needing to coordinate their own care, self-advocate, change doctors and seek second opinions, and of the financial cost of this journey.

Tasmanian GPs say these experiences reflect low levels of reproductive health literacy in the health workforce, particularly in primary care settings, evidenced by the small percentage of practices offering specialist reproductive services such as medical termination of pregnancy and IUD insertion and removal. The fact that Medicare rebates undervalue the time and complexity involved in delivering reproductive health care, and women's healthcare generally, is likely a factor here.[viii]

Improving the quality of reproductive health care in Tasmania requires changes both to broader health systems like Medicare and within local health care cultures. Tasmanians can wait weeks for a GP appointment in the current primary care landscape, a context in which health consumers and health professionals rarely have time to adequately explore treatment options. Under these conditions, principles of person-centred care—where the autonomy and preferences of individual patients are highly valued—often go by the way.

The Australian Government's new Endometriosis and Pelvic Pain Clinics, delivered in Tasmania by Family Planning Tasmania, are a step in the right direction, however major shifts to health service delivery and culture are required to meaningfully improve reproductive health outcomes for women in Tasmania, especially those living in rural and remote areas.

Recommendations:

19. Increase Medicare rebates for reproductive health services.
20. Overhaul the primary care system to improve GP access with a reform plan that includes blended funding models and multidisciplinary care.
21. Additional resourcing of specialist reproductive public health services across Tasmania.
22. Upskill the primary health sector in sexual and reproductive health care.
23. Develop shared reproductive health care policies and procedures across health sectors.

Case Study 7: Lara

"I was trying to make the right choice."

Lara is 21 and works as a teacher's aide in New Norfolk. She lives with her partner of three years, Ben, who is studying geology at UTAS. Lara travels to Glenorchy to see a GP as the Derwent Valley practice has long wait times and hasn't been taking new patients for some time due to high levels of demand.

When Lara first saw a GP about starting contraception, they suggested the oral contraceptive pill. Lara agreed as the pill was the main contraceptive she had heard of and she knew friends who took it. Lara has had anxiety and depression since her early teens and had been managing this well with SSRI medication and regular exercise. However, she found her mood dropped soon after starting the pill. The GP said it was unlikely to be related to the medication but Lara wasn't keen to continue taking it.

The GP suggested trying a long-acting contraceptive such as Implanon or an IUD, but Lara was concerned about potential mood effects for the Implanon and painful insertion of the IUD. One of her friends had reported an especially painful experience of having an IUD placed earlier in the year. In the end, Lara and Ben decided to use condoms for contraception.

After about 12 months, Lara fell pregnant unexpectedly. She decided she wasn't ready for a baby and Ben supported her decision to terminate the pregnancy. Lara first saw a GP at her usual practice. When she disclosed that she was seeking an abortion, the GP said, "I can help you this time, but in future you need to be more careful." Lara felt judged and criticised. The GP then asked why Lara wasn't using a long-term contraception. When Lara tried to explain the GP cut in, saying, "Well, that wasn't very responsible was it?" The GP then referred Lara to Family Planning Tasmania, as no one in the practice was trained to provide medical terminations.

Lara saw a GP at Family Planning Tasmania and ultimately decided to have a surgical termination, as this would allow an IUD to be inserted while she was anaesthetised for the procedure. Lara was relieved to learn the surgical termination procedure would be free and that the cost of the IUD could be covered by the Youth Health Fund.

Lara missed a week of work following the termination and her anxiety has resurfaced since first learning of the pregnancy. She now feels she should have agreed to get an IUD in the first place and simply endured the pain.

Lara's story is also common. Women say it can be hard to find a contraceptive solution that meets their specific health needs and circumstances and that it is often a process of 'trial and error' that comes with significant financial, physical and emotional costs.

Long-acting reversible contraceptives (LARCs) such as IUDs are relatively low-cost, have few contraindications and higher levels of satisfaction than other contraceptive methods,[ix] however low uptake rates and growing dialogue about the pain associated with their use points to the underestimation of women's pain in health care, and in reproductive health treatments especially.[x]

Health workers in Tasmania say these issues are contextualised by low reproductive health knowledge in the populations they support, particularly in rural areas where the range and quality of sexual and reproductive health education offered by government schools varies, and where fewer doctors and pharmacies mean people travel long distances both to see prescribing GPs and to fill prescriptions.

Women's Health Tasmania has undertaken primary research into the experience of people accessing abortions in Tasmania. Lara's experience of being judged and blamed reflects the lived experiences of some of the Tasmanians we spoke to. In Lara's case, the GP was able to direct her to an appropriate provider of abortion care but delivered the referral in a way that made Lara feel disparaged and was not person-centred or trauma informed.

Our work with people who have accessed abortions indicates several concerning aspects of the gendered nature of reproductive health care in Tasmania:

- Not all GPs understand the legal responsibilities of conscientious objectors as defined in the *Reproductive Health (Access to Terminations) Act 2013*. People report being actively misdirected to pathways intended to delay access to abortion care and being 'talked out of' having an abortion—this is reproductive coercion on the part of the medical practitioner;
- Even where a GP is not a conscientious objector, the advice and referral process for accessing terminations can be laden with judgement and is not trauma informed or person-centred;
- Conscientious objection legislation does not extend to other health care workers involved in the provision of abortion care. People who have accessed abortions in Tasmania report being subject to dismissive and discriminatory comments from a range of health workers including sonographers, pathology services and pharmacists.

Concerningly, some people we spoke to about their abortion experiences also shared that the health system failed to notice and address instances of reproductive coercion in intimate partner relationships—even when these included a disclosure from the woman.

The health system can play a key role in supporting women to make reproductive health choices that are right for them. But it cannot do this without proactively addressing the legacy of abortion stigma and discrimination.

Recommendations:

24. Free contraception for people under 25.
25. Shared pain management protocols for IUD insertion and removal that include cervical anaesthetic options.
26. Standardised, comprehensive sex education in all Tasmanian schools.
27. Continued provision of free, elective surgical terminations through the public hospital system.
28. Training of medical students and GPs on their legal obligations regarding conscientious objection.
29. System-wide training for health professionals on reproductive coercion and how to deliver person-centred, trauma informed abortion care, information and referral.

Conclusion

Collectively, the case studies collated in this submission demonstrate how a lack of gender analysis in the planning and provision of health care in Tasmania results in gender blind services that fail to meet the complex and interconnected health needs of individuals, families and communities.

They also illustrate how health is indivisible from the conditions in which we live—our physical and emotional safety, our access to secure housing and nourishing food, our income and life opportunities—and that improving these conditions is integral to improving the health and wellbeing of all Tasmanians.

Women's Health Tasmania suggests the Tasmanian Government now has an opportunity to reorient the health system, through gender conscious and socially responsive service planning and design, towards whole-of-person, integrated health solutions for Tasmanian communities.

The development of the new *Long-Term Plan for Healthcare in Tasmania 2040* is an ideal mechanism for these reforms and we hope to see gender conscious system design feature alongside other intersectional health responses in the final strategy.

Summary of Recommendations

RECOMMENDATION 1	Expand the visa categories that are Medicare eligible.
RECOMMENDATION 2	Universal free antenatal and perinatal health care for all people in Tasmania, regardless of their insurance and visa status.
RECOMMENDATION 3	Sustained funding for health literacy initiatives for migrant women focusing on sexual and reproductive health.
RECOMMENDATION 4	Tasmanian health workforce training on cultural diversity.
RECOMMENDATION 5	Tasmanian health workforce training on inclusive practice, including specific education on transgender health.
RECOMMENDATION 6	Develop multidisciplinary health spaces with diversity at their core.
RECOMMENDATION 7	Restrict funding for the delivery of health and social services, including mental health care, to organisations with a public record of LGBTIQ+ equity and inclusion.
RECOMMENDATION 8	Support for health services that traditionally service cisgender populations to provide inclusive care for trans and non-binary people.
RECOMMENDATION 9	Increase the availability of bulk billed primary health care.
RECOMMENDATION 10	Design health services with input from women with a lived experience of homelessness.
RECOMMENDATION 11	Longer term temporary accommodation solutions, with pathways to permanent housing.
RECOMMENDATION 12	Trauma informed health and social services that emphasise dignity and autonomy.
RECOMMENDATION 13	System-wide training for health professionals on the gendered links between family violence, trauma and mental health.
RECOMMENDATION 14	Upskill the primary health sector to recognise and respond to all forms of family violence, including hidden forms of abuse.
RECOMMENDATION 15	Trauma-informed, gender responsive mental health and suicide prevention approaches.
RECOMMENDATION 16	Locally based, regional health workers to support health service coordination.
RECOMMENDATION 17	Family-friendly health service models offering combined appointment times.
RECOMMENDATION 18	Improve access to community based mental health support for all ages.
RECOMMENDATION 19	Increase Medicare rebates for reproductive health services.

Summary of Recommendations (continued)

RECOMMENDATION 20	Overhaul the primary care system to improve GP access with a reform plan that includes blended funding models and multidisciplinary care.
RECOMMENDATION 21	Additional resourcing of specialist reproductive public health services across Tasmania.
RECOMMENDATION 22	Upskill the primary health sector in sexual and reproductive health care.
RECOMMENDATION 23	Develop shared reproductive health care policies and procedures across health sectors.
RECOMMENDATION 24	Free contraception for people under 25.
RECOMMENDATION 25	Shared pain management protocols for IUD insertion and removal that include cervical anaesthetic options.
RECOMMENDATION 26	Standardised, comprehensive sex education in all Tasmanian schools.
RECOMMENDATION 27	Continued provision of free, elective surgical terminations through the public hospital system.
RECOMMENDATION 28	Training of medical students and GPs on their legal obligations regarding conscientious objection.
RECOMMENDATION 29	System-wide training for health professionals on reproductive coercion and how to deliver person-centred, trauma informed abortion care, information and referral.

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