AMA TASMANIA
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Fiona Murphy
Secretary
Joint Sessional Committee on Gender and Equality
Parliament House
HOBART TAS 7000

Email: genderandequality@parliament.tas.gov.au

Dear Ms Murphy

Thank you for your correspondence of the 15th of February 2023 inviting submissions on the Joint Sessional Committee on Gender and Equality inquiry into Tasmanian experiences of gender bias in healthcare.

AMA Tasmania has consulted with our members and received many interesting comments. I would particularly like to thank Drs Juliana Ahmad and Kate Bendall for their detailed paper on the issues raised, which has been incorporated into this wider submission. Should the Committee wish to invite AMA Tasmania to speak to its submission, I, with our Vice-President, Dr Annette Barratt and Drs Ahmad and Bendall would be more than happy to appear before your committee on behalf of AMA Tasmania.

As gender is a broad term, it is important to note AMA Tasmania's submission focusses on the general female gender experience within healthcare.

"As a female psychiatrist, I acknowledge that women continue to face significant inequity globally, and that Tasmanian women are a disproportionately disadvantaged group in our country. Particularly with respect to domestic violence, economic deprivation, suboptimal access to primary and secondary health services - particularly reproductive services for termination of pregnancy and breast screening - and overall exposure to complex trauma experiences. For women coming out of prison (at least 70% of whom will have experienced multiple and various traumatic incidents), this lack of services is even more concerning. I frequently send women out to unstable accommodation and inadequate health follow-up."

However, we are cognisant that gender issues go further than that experienced by women, and we do not wish to limit the scope of the committee, as other perspectives are equally important in the experience of gender bias. We are also cognisant that other attributes can also impact a woman's experience of accessing or working within healthcare environments, including for women with disabilities, Aboriginal and Torres Strait Islander women, Culturally and Linguistically Diverse (CALD) women, LBGTIQ + (lesbian, bisexual, gay, transsexual, intersex and queer/questioning) people, and women from rural, regional, or remote backgrounds. This is particularly relevant with regards to intersectionality.

AMA Tasmania has focussed on the first two Terms of Reference subjects; however, you will see in our comments, we cover some of the other questions raised too. The submission also addresses the issue of gender bias for women doctors working within healthcare and for patients receiving healthcare.

Examples of Tasmanian's lived experience of gender bias in healthcare

Gender bias within Medical Colleges, Associations and Government

Medical colleges and doctor associations are addressing the issue of gender bias albeit some more successfully than others. AMA Federal has released a gender diversity report each year since 2019 after a target was set to have 40 per cent women on all Federal AMA Councils, Committees and Boards. The gender diversity target was extended to 50 per cent of Federal AMA representative positions overall being held by women by 2021. While a 40 per cent target has been achieved on Federal Council and on some other AMA bodies, including the Board of AMA Tasmania, the 50 per cent target is yet to be reached overall. The timeframe to reach this target been extended to 2024. (ref. https://www.ama.com.au/articles/ama-diversity-report-gender-2021)

Colleges like the Australasian College of Emergency Medicine (ACEM) have policies to ensure increased female representation, (ref. https://acem.org.au/getmedia/46128f66-ce06-4510-857b-2f1c9bdd92a1/S738_Gender_Equity_Statement. ACEM have mandated that every panel at an ACEM event must contain women, as well as men. We are advised a recent audit showed, 43% of their college's panels are now women. As one member said: "Not perfect equity, but a pretty good start!"

While the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has also published its own discussion paper and data snapshot (ref. https://www.ranzcp.org/membership/gender-equity) promoting female representation, at its recent Tasmanian Branch Conference in October 2022, there was no senior female clinicians on its panel during the final Q&A session of the conference despite suitable women being present in the auditorium. This was noted by our members who felt it was an obvious reflection of gender bias, a gender bias they also experience in the workplace in psychiatry. Female practitioners in this field of medicine still feel – and using the last example, demonstrably are - invisible when it comes to matters of leadership, representation of needs and professional agency. One member said: "I would like to see all professional bodies supporting clinicians in Tasmania bound to a commitment to gender equity beyond passive acknowledgement of gender equity. I think that if clinicians in Tasmania are to set a standard of equitable care for girls and women using health services, we must do so from a position of gender equity within our number."

Gender bias can be seen in many environments. One doctor noted *"One of the examples that comes to mind of gender bias is the persistence in warning people that the doctor is female – by this I mean that organisations, including some of the media, will introduce Dr Saul and Dr Annette Barratt, as though the qualifications of the female need to be qualified by her gender. This seems like a small thing, but it grates and is demeaning to women. It occurs at conferences as well and holds over into the connotation of male and female doctors – we are doctors regardless of our genitalia."*

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/women_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.

Areas of healthcare in which gendered bias is particularly prevalent

Cardiovascular disease

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 author Gemma Figtree is an Australian interventional cardiologist leading much of this work).

There is also a perception that female patients from the Northwest of the state also face regional bias when it comes to being able to access timely cardiology procedures the LGH.

Gynaecology

When it comes to morbidity and quality of life, one of the areas of most concern from a member in the Northwest was the lack of access to public gynaecology consults and procedures, particularly for endometriosis. Added to this is the policy that women who present to an Emergency Department with abdominal pain need to see a gynaecologist before general surgery, which also causes delays and often unnecessary extra tests including CT scans that wouldn't happen for men.

Lack of knowledge and training in women's health

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 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. (ref. https://www.aist.asn.au/Media-and-News/News/2022/Media-Release-Menopause-estimated-to-cost-women-mo) 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.

Discrepancies in funding for female 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.

Gendered base violence

We know that domestic violence affects more women than men. A lack of training and knowledge risks the lost opportunity in identifying victim survivors but also possibly lead to re-traumatisation. One of our members is a trainer in Domestic violence through the Pathways to safety program and has facilitated three different workshops, two in Tasmania. She says that in her experience the male participation rate was close to zero per cent. One workshop was attended by a male GP, but he did not attend the second one thereby essentially not completing the training. Data from a Pathways to Safety pre survey showed that only 15.3 per cent of participants were male and 84.7 per cent were female.

Attention Deficit Hyperactivity Disorder (ADHD)

The science confirms that boys with suspected ADHD are more likely to be referred for clinical evaluation than girls (ref. https://pubmed.ncbi.nlm.nih.gov/35054077/). One doctor stated:

"I treat several adult women who were not diagnosed as children, and they have experienced several disadvantages of having untreated ADHD as children:

- Concerta (long-acting methylphenidate) is a stimulant medication that is only available to patients on the Pharmaceutical benefits Scheme (PBS) for people who were diagnosed before the age of 18 years old. (https://www.pbs.gov.au/medicine/item/2172H-2387P-2388Q-2432B)

- Untreated ADHD can lead to increased rates of suicide, self-harm, substance abuse, unplanned pregnancy, inmate-partner violence and poor academic achievement.

Currently, as a whole the public Tasmanian Mental Health Services do not assess, diagnose or treat ADHD. For males who had a childhood diagnosis there are challenges to continuing access to treatment but it is even harder again for females who are unable to afford the fees for an adult diagnosis with a private psychiatrist. (As an example, it would be commonly in the ballpark of $900 to $1000 for an ADHD assessment, with a varying rebate, up to around $700. A number of my patients cannot afford the fee at all, and others cannot afford the outlay, although could possibly afford the gap if it was possible to pay only ~$200). In my opinion, each of these patients is still accessing care through the RHH, but not in a holistic way - between them, they are seeing the pain clinic, drug and alcohol services, psychiatry, gynaecology, respiratory and more. They have frequent missed appointments, episodes of self-harm, difficulty engaging in helpful/health improving behaviours – all attributed to the untreated ADHD."

Medicare item numbers

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.

The Mercury ran an article on 9/9/22 featuring a woman who was unable to afford a 20-week scan as she could not afford the out-of-pocket fee.

A pregnant woman who tried to book an ultrasound at the Royal Hobart Hospital was told to "go private" because the hospital was fully booked, according to a complaint sent to the Tasmanian Health Service.
The email, sent on Wednesday, showed the woman was booking in for a routine 20 week scan but was told it could not be done at the hospital.
"To my surprise, we were informed that they are fully booked, and unable to do the ultrasound," the woman's partner wrote in a complaint.
"We asked if we could be put on a cancellation waitlist, and were told there is no waitlist.
"We asked if there are any other public clinics where this can be done in the south, and were told there isn't.
"We asked what our options are, and were advised to "go private".
A pregnant woman who tried to book an ultrasound at the Royal Hobart Hospital was told to "go private" because the hospital was fully booked, according to a complaint sent to the Tasmanian Health Service.
The complainant said the fee for an ultrasound at a private clinic was $360, with an out-of-pocket cost of $275.
They said they could afford the cost, only just, but feared many pregnant women would be unable to afford it.
"A substantial number of women are almost certainly missing the 20-week scan altogether because the service is not available," they said.
"I would like to express my utter dismay at this, and implore that something is immediately done to make these services accessible to everyone."
(Judy Augustine)

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

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. (ref. https://womensagenda.com.au/latest/nearly-1-million-australians-are-living-in-severe-poverty-with-women-most-affected/)

Treatment of women with medical conditions related to pregnancy

Nausea affects 70-80% of the pregnant population. One of our members speaks of her experience while pregnant:
"As someone who experienced nausea it is a condition that is seriously underestimated, under-recognised and under-treated, having experienced nausea and vomiting until both my children were born. If I had been asked, it would have been clear that my diet was quite restricted due to the nausea and vomiting. My care would have been better had I been asked at every antenatal appointment about the severity of my ongoing nausea and nutritional intake.

My care was also unnecessarily impeded by over-cautious pharmacists who declined to dispense Restavit (doxylamine) to me in pregnancy. Restavit (https://thewomens.r.worldssl.net/images/uploads/downloadable-records/clinical-guidelines/nausea-and-vomiting-pregnancy_280720.pdf) is considered one of the first line treatments for nausea and vomiting in pregnancy by the Royal Women's hospital. Restavit is an S3 medication which means it is a "Pharmacist only medication". It is considered Category A in pregnancy which means it is in the "Safest" drug category for pregnancy. I tried getting this over-the-counter medication when I was suffering intractable nausea. I was told by the pharmacist to get a script from my obstetrician. The pharmacist only dispensed the Restavit to me when I showed them the guidelines from the Royal Women's Hospital. A local pharmacist told me that pharmacists in training (at university) were advised against dispensing this medication to pregnant women. From then on, I asked my husband to obtain the Restavit from the pharmacist for my ongoing use. He of course was asked minimal questions as a man requesting Restavit. I understand this problem is Australia-wide."

Chronic pelvic pain and/or incontinence in nulliparous or post-partum women

There are insufficient public services for the treatment of women with pelvic pain. Listed public waiting periods for physio are: urgent – 56 days, semi urgent 120 days, non-urgent 128 days, but the list does not tease out waiting times for the pelvic floor clinic which often has much longer waiting times; patients can experience a 3-5 month wait for an appointment. A doctor said she had chronic pelvic pain patients who can wait up to a year for surgery without pelvic floor physio in the interim. There is inadequate access to chronic pain services or multidisciplinary input, especially as the common approach taken is that they have to 'exhaust' or 'complete' the diagnostic process (surgical laparoscopy usually) before having chronic pain service input. Almost invariably they end up taking opioids to manage their pain - with associated side effects, stigma, and potential iatrogenic dependence. Private pelvic floor physio is expensive and usually out of reach for women with pelvic

pain and/or incontinence as these normally involve multiple appointments. A thought must be spared for the women who have caring roles as well, with the heavy lifting that can involve. There are also significant impacts on productivity, relationships, and general wellbeing.

Access to safe and cost-effective terminations

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."*

Workplaces that force carers to get a doctor's certificate

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.

Access to appointments

It is a relatively common occurrence for a mother to have an appointment booked for herself, and then should her children need a more urgent appointment, give her spot to them. With the current difficulty in booking appointments, this can end up delaying care for quite some time for the female patient.

"Hysterical" women

"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 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."

Similarly, many females have had years of anxiety symptoms, partially treated with anxiolytics, eventually diagnosed and treated for ADHD. Again, a lack of knowledge, as well as lack of access to assessment and treatment has left women with suboptimal care. The efficacy (number needed to treat) for stimulant medication for ADHD is far higher than the typical effect of SSRIs on anxiety and depression. As mentioned previously, this happens in the treatment of menopausal women as well.

Post traumatic stress disorder (PTSD)

Women are two to three times more likely to develop PTSD. It is a multifaceted and pervasive condition which can affect physical, mental, and emotional wellbeing.

GPs, general medicine physicians, rheumatologists and mental health professionals are very poorly remunerated for the long-term chronic care management that these conditions require. Long term, trauma-informed psychotherapy (plus/minus EMDR) remains the gold standard for the care of complex PTSD, yet that is exactly what our public health care system does not finance. Instead, patients get shuffled around a medical system that rewards active intervention.
The care of patients with PTSD will intermittently need to be escalated to emergency tertiary services but it is my experience that referrals tend to get rejected (due to the lack of services), which can be a source of moral injury for the treating professional as well as re-traumatising the patient.

An example of how Medicare discriminates against the treatment of mental health in General Practice:

	>40 minute consult where more than one medical issue is discussed	>40 minute consult where only mental health is discussed
Medicare rebate	$113.30 (item number 44)	$75.80 (item number 2713 - ≥ 20 minute mental health consult)

Female health professionals, in particular female GPs

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 (ref. https://www.frontiersin.org/articles/10.3389/fpubh.2022.880061/full). This is an excellent article on the issue – https://www.smh.com.au/culture/tv-and-radio/i-m-a-gp-ted-lasso-s-comments-to-his-therapist-are-where-the-comedy-stops-20230315-p5cs6w.html

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 me consuming presentations. As well as impacting income, a heavy caseload of medically complex patients can be exhausting for female GPs.

Female health professionals who decide to have children usually find barriers on returning to work because of inflexible working arrangements or hours offered by their employers which may clash with care availability. This can reduce the hours she can participate in the workforce. As you can imagine small private businesses usually cannot afford to “hold a spot” for a GP on maternity leave so on her return she usually has to negotiate around a replacement. Some practices may preference the hiring of male doctors for this reason. Proving this form of discrimination is very difficult.

Many female doctors will have faced issues with accessing their own care - complicated by being health professionals themselves. This will include mental health care including ADHD treatment, chronic pain, contraceptive and pregnancy related care, and more. The pressure on many doctors due to rostering/doctor shortages and the culture for ‘presenteeism’ can limit health care seeking, especially in junior and hospital doctors. For GPs, it can be challenging to find a suitable GP for

themselves. This has not been helped by cases of human resource management declining or making it very difficult for doctors to access leave for medical care.

Racial invisibility in COVID antiviral prescribing

Early studies (ref. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7857527/) in the UK suggested that black, Asian and minority communities were disproportionately affected by COVID. COVID antiviral prescribing did not include these groups as vulnerable groups.

A perspective from our male members

While most of our contributors were female with lived experience of a gendered difference in the delivery of healthcare, it would be remiss of me not to also mention comments from our male members too.

One of the issues raised from the male perspective was the issue of perceived discrimination verses ignorance in medicine across the needs of various groups within our community. For instance, in the past there was not much taught in medical school about health issues that affect non-cisgendered people. Therefore, when health issues like AIDS emerged, there was very little knowledge about the plethora of health issues these patients were experiencing. The lack of knowledge was perceived by some as been an example of discrimination. While this may have been true in some instances, it would not have been in all. As we have seen from the previous comments, lack of knowledge can also be true when it comes to women's health issues. As one male doctor said: *"To me, the important thing is to listen to the patient,… and try to find out what they want done, then, maybe ask someone expert in the area, or refer them there. Kindness goes a long way."*

Another member commented more directly on the issue of gender bias against women from his experience:

"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.

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.

Others felt there was not enough emphasis in the Terms of Reference on encouraging comment on what improvements had been made in healthcare to address any real or perceived gender bias.

And, another stated:

"*No conscious bias here, and no complaints from patients.*

I would be most concerned if there is an attempt to accuse doctors acting in good faith of "unconscious bias". While we all have our personal preferences, and obviously cannot agree with everyone who comes to see us on a whole range of social and political matters, we see each patient as an individual and treat their health problems in as unbiased a fashion as possible. For instance, an obvious example is alcoholics and drug addicts. Whatever we think of their lifestyle choices we see them and treat them as a patient to the best of our ability, even though we personally profoundly disagree with their lifestyle choices.

Conclusion

Gender bias exists: it is real and needs to be addressed at all levels of government, healthcare organisations, the AMA and Colleges. That is not to say that there have not been significant improvements in addressing address gender bias within their structures, but more needs to be done to promote and support women in leadership. Once appointed, it is also important to ensure leaders, male and female are well supported. Management/leadership training for instance can be valuable in learning how to best manage a team and reflect upon bias's you may bring to a leadership role, whatever they may be. It is also important for both males and females to understand the differences and the strength and weaknesses of male and female leadership styles.

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

Ideas for consideration

Unfortunately, we do not have a single funder of the state health system which creates gaps in the provision of healthcare and how it is funded. Some of our possible solutions fall within the responsibilities of the Federal Government, such as increasing the Medicare rebates or addressing the PBS.

1. The use of standardised tools according to the presentation – a Wells score when anyone presents with chest pain/shortness of breath. The use of the Pregnancy-Unique Quantification of Emesis and Nausea (PUQE) scoring index whenever a woman presents for an antenatal screen. (ref. https://www.somanz.org/content/uploads/2020/07/NVP-GUIDELINE-1.2.20-1.pdf#page=8)

2. 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 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 – ie. To recognise sexist or racist beliefs in themselves and to challenge them.

3. While patients receive the MBS rebate on a consultation, the initial outlay for the entire cost of the consultation can be cost prohibitive. It would help if patients only had to pay the gap fee (noting bulkbilling is no longer economically sustainable for most general practices), for example, instead of having to outlay $64.75, a patient would only have to pay the gap of $25 for a level 23 consult (rebate 39.75).

4. Increasing Medicare rebates for the first trimester screen and 20- week morphology scan would make them more affordable for pregnant people.

5. Introduce a Medicare item number for mental health consults that go beyond 40 minutes, and allowing GPs to charge for both physical and mental health consultations without fear of audit

6. Provide more state government health funding for psychological therapy like EMDR. Or the federal government increase the rebate for each psychological session under the Better Access Initiative rather than increasing the number of subsidised visits. (ref. http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-10MentalHealthSessions)

7. Support Women's Health Tasmania, or similar services to grow and advertise them more widely for women across the state.

8. Incentives to work in complex mental health, domestic violence, or women's health. This can be in the form of paid education (the doctor is remunerated for their time as GPs are not paid if they don't work), increased CPD points for these topics, extra support (E.g free psychological supervision), financial incentives for training in these areas, appropriate remuneration (e.g Medicare item numbers for liaising with one other service– not a team conference which requires 2 other specialists) or increased remuneration for the services.

9. Being able to claim GP management plan item numbers for medical issues related to pregnancy and breastfeeding. This can help subsidise visits to a private pelvic floor physio or to help treat mastitis with private physiotherapy ultrasound or create a new section specific to pregnancy and breast feeding.

10. A bulk billing incentive for allied health professionals who bulk bill the GP management plan items so that women with a health care card can access the care they need through the private system. We know in general that women earn less, and childbearing often strips them of any income.

11. A public multidisciplinary clinic for pelvic pain in the style of the Back Pain assessment clinic in the South. (ref. https://outpatients.tas.gov.au/clinics/back_assessment)

12. Local Government to include pelvic floor stretching equipment or other exercise equipment near children's playgrounds. Often there is general equipment but not within supervising distance.

13. Change the PBS listing on Concerta so that a retrospective diagnosis is included in the list of PBS indications. This is already the case for Vyvanse on the PBS. (ref.

https://www.pbs.gov.au/medicine/item/10474g-10486x-10492f) Additionally, review the list of oral contraceptives and menopause replacement therapies on the PBS.

14. Ensure Female GPs are included in discussions when it comes to any facet of primary care, because the care they offer is unique and different from that a male GP offers. This may require stronger affirmative action in all levels of governance in the AMA and other medical bodies as well as within government. It would also help to pay women to be involved in medical bodies so they are not doing unpaid labour.

15. Explore in addition to the fee for service model, alternative methods of remuneration for doctors to help cover maternity and carers leave etc. This may include an employment option with all the associated benefits in special circumstances, which could be more enticing to parents of young children.

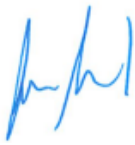
16. Support the Tasmanian public health system to diagnose and manage patients with ADHD. It is almost completely out of reach for certain patients to access this privately, especially given the comorbidities that untreated ADHD can be associated with. GPs can be supported in being the stimulant prescribers, which can take some load off the public health system.

17. A campaign by the TGA or Public health Tasmania to support pharmacists to dispense Restavit to pregnant woman through the dissemination of guidelines.

18. Make it illegal for employers to demand a medical certificate for carer's leave. We support no medical certificate requirement for absences less than seven days.

Thank you once again for the opportunity to comment. I wish your committee well in its deliberations.

Kind regards



Dr John Saul
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