the women's
the royal women's hospital

6 October 2023

The Secretary
Joint Sessional Committee on Gender and Equality
Parliament of Tasmania
Parliament House
HOBART TAS 7000

Via: genderandequality@parliament.tas.gov.au

Subject: Tasmanian experiences of gendered bias in healthcare

Dear Committee Secretary,

Thank you for your letter inviting the Royal Women's Hospital to provide a submission to the Joint Sessional Committee on Gender and Equality. Please find our submission attached. We also welcome the opportunity to attend and give evidence at the Public Hearings in October.

We understand that this submission is a public document and may be published on the committee's website and quoted in the committee's report.

[redacted]

Yours sincerely,

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Submission from The Royal Women's Hospital, Melbourne
Tasmanian experiences of gendered bias in healthcare

1. Introduction

Sex and gender play a significant role in determining a person's access to healthcare and treatment and subsequently, their health outcomes. Over their lifetime, women, and other people designated female at birth, face a higher likelihood of health issues compared to men. While on average, women have longer life expectancies, they also experience a higher incidence of chronic health conditions and struggle with poorer mental health. In addition, women have more complex sexual and reproductive health needs that evolve throughout their lives, and the ways in which chronic and serious health conditions present and progress differently in women compared to men are not well understood.

Unfortunately, healthcare systems don't always recognise the sex, gender and social determinants that seriously impact health access, treatment and outcomes for women and girls. 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.

The Women's is concerned by the system-wide barriers and service gaps that continue to exist. This is particularly true in terms of choice and ability to access safe and timely contraception and abortion services, health disparities experienced by rural and regional people, out-of-pocket healthcare costs that specifically affect females, and the low investment in women's health literacy.

We advocate for greater funding and coordination of specialist women's health services nationally, and the introduction of incentives to encourage more medical research into the impacts of sex and gender on healthcare investment, service provision and health outcomes.

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.

The Women's encourages greater representation of women in leadership and STEM, and for a systematic approach that considers sex and gender when designing governance structures, developing policies, and designing person-centred programs and services. We believe there needs to be greater awareness and understanding of sex and gender inequalities in medical and health research and greater adoption of and investment in gender-specific approaches to research funding, translation, recruitment and promotion.

We hope the committee will look at these issues and others raised in this submission to determine the best recommendations for addressing them at a system wide level.

2. About the Women's

Established over 165 years ago, the Women's is Australia's first and largest stand-alone hospital dedicated to improving and advocating for the health and wellbeing of women and newborns.

The Women's cares for women through all stages of life, with services ranging from maternity, gynaecology, sexual and reproductive health - including abortion care - women's cancer services, women's mental health, and specialist care of newborns. The hospital also offers a range of state-wide specialist health care services for pregnant women who use alcohol and other drugs, women with disability, women experiencing homelessness, and Aboriginal women and babies.

As one of Australia's major teaching hospitals, the Women's work goes beyond acute care playing a unique role in Victoria's, and indeed Australia's, healthcare system, advancing research and practice, and providing clinical training, leadership and advocacy. Key advocacy areas include family violence, abortion and contraception, public fertility, sex and gender bias, and the social determinants of health and their impact on health equality.

The Women's is the largest provider of public abortion services in Victoria and, through its Clinical Champion Program funded by the Victorian Department of Health, plays a lead role training nurses, midwives and doctors across the state in the use of long-acting reversible contraception[1] (LARC) and early medical abortion. We also partner with a number of other organisations including Women's Health Victoria and the Centre for Excellence in Rural Sexual Health at the University of Melbourne Medical School to progress improvement in abortion care and access through research, advocacy and other activities.

3. Abortion and contraception – addressing the gaps

By their mid-30s, one in six Australian women report having at least one abortion. Recent research has identified that women with less control over their reproductive health – whether through family violence, drug use or ineffective contraception – are more likely to terminate a pregnancy[2].

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.

3.1 Contraception

In our country, access to comprehensive contraception advice and services is highly variable. For example, there are many barriers preventing women and gender diverse people accessing LARC, which is largely viewed as the most effective reversible method of preventing unintended and adolescent pregnancy. Compounding this issue, very few public hospitals offering women's healthcare provide contraception advice and services. While GPs play a vital role in the provision of LARC, the number of providers trained to deliver these forms of contraception in Australia is low, particularly in rural and remote areas. This is due to a range of factors including a workforce skill

[1] LARC includes intrauterine devices and contraceptive implants.

[2] Taft AJ, Powell RL, Watson LF, Lucke JC, Mazza D, McNamee K. Factors associated with induced abortion over time: secondary data analysis of five waves of the Australian Longitudinal Study on Women's Health. Australian and New Zealand Journal of Public Health. 2019;0(0). At: https://www.ncbi.nlm.nih.gov/pubmed/30727034

deficit, misinformation, inadequate incentives, difficulty accessing peer and expert support, and unclear referral pathways.

In Australia, the Pharmaceutical Benefits Scheme (PBS) subsidy is not available for some LARC, making access even more restricted. However, in the UK, the IUD, the IUS, the contraceptive injection and the hormonal implant are all available free on the NHS and widely accessible through a GP, sexual health clinic, practice nurse or young person's clinic.

3.2 Early medical abortion

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.

Our hope is that recent changes introduced by the Therapeutic Goods Administration enabling doctors, nurse practitioners and pharmacists to prescribe and provide Mifepristone and Misoprostol will make a significant difference. However, we believe this move alone may not have the rapid impact we hope for. There are still significant barriers to medical abortion for many women including: poor access to primary healthcare (GPs and nurse practitioners), particularly in rural and remote areas; there are widely varying costs associated with medical abortion; poor health literacy and awareness of medical abortion as an option; and restrictions of use (only up to 9 weeks gestation).

3.3 Surgical abortion

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[3] 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.

4. Other issues – addressing the gaps

4.1 Endometriosis

In Australia, it is reported that 6.3 per cent of women and people with a uterus aged 40-44 have clinically confirmed endometriosis. This debilitating and painful condition can have serious impacts

[3] For example, see the service description tables on pages 10, 15, 19,22, 24, 27 of Capability frameworks for Victorian maternity and newborn services

on a person's fertility, ability to work, mental health, physical mobility and sexual function. Access to early diagnosis and treatment is critical as at present, there is no cure.

Early diagnosis can help to address some of the symptoms of endometriosis however, the average worldwide diagnostic delay has been reported as seven years from when symptoms start, compared to eight years in both the UK and Australia[4]. This makes early treatment inaccessible for many women. According to a study co-authored by Professor Martha Hickey from the Royal Women's Hospital in Melbourne and the University of Melbourne Department of Obstetrics and Gynaecology: "Clinical diagnosis is difficult, partly because the symptoms are often non-specific and may be attributed to other conditions. For example, endometriosis may mimic or cause irritable bowel syndrome. Symptoms may also be misdiagnosed as functional or psychosomatic or dismissed or normalised (for example, as painful periods)." In addition, women consistently report difficulties in convincing doctors about the severity of their symptoms.

For public hospitals, the delivery of services and procedures for admitted patients is funded by the state government through the National Health Reform Agreement. However, waitlists are high, and many women seek diagnosis and care through the private health system.

Once in the private system, some services, such as laparoscopic surgery (an essential diagnostic tool) are not fully covered by Medicare. The Commonwealth Government's Medical Costs Finder website states "For patients with private health insurance who had a laparoscopy in a private setting across all of Australia, 66% had an out-of-pocket cost". The website goes on to state that those patients typically paid $500 out-of-pocket, non-inclusive of other fees, such as private hospital accommodation, theatre, or medical devices, private insurance excess or co-payment. Some private health insurance companies do not cover the remaining out of pocket fees. Meanwhile, women without private insurance who are seeking a diagnosis in the private health system struggle to pay the excessive cost of appointments, diagnostic procedures and pain management treatments.

4.2 Healthy Aging – Menopause

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.

The World Health Organization states, "Health-care providers may not be trained to recognize perimenopausal and post-menopausal symptoms and counsel patients on treatment options and staying healthy after the menopausal transition. Menopause currently receives limited attention in the training curricula for many health-care workers".[5]

[4] Ye L, Whitaker L H R, Mawson R L, Hickey M. Endometriosis Easily Missed? BMJ 2022; 379 :e068950 doi:10.1136/bmj-2021-068950

[5] https://www.who.int/news-room/fact-sheets/detail/menopause

The British Menopause Society has developed a vision for menopause care that includes three key factors[6].

1. The patient experience – ensuring that women have access to a wide range of types of information and can see a suitably trained healthcare professional to discuss their experience of menopause and the options available to them.

2. A well-educated workforce – making sure that they are 'vision-ready' with the optimum skill mix to cater for a wide population demand.

3. Integrated care – establishing clear referral pathways between services so that care can be integrated around the needs of the individual, not disjointed by institutional or professional silos.

4.3 Women and heart disease

Generally, heart disease is considered a man's disease. However, approximately 20 women die each day in Australia of coronary heart disease, killing almost three times as many Australian women as breast cancer[7]. The risk of cardiovascular disease in women changes throughout the life course but this is not widely researched nor understood by health professionals and the general community.

Women are less likely to report heart issues and women experiencing heart attacks face significant treatment delays. Research consistently indicates that women have poorer outcomes than men following diagnosis. In addition, heart disease presents differently in women and women experience different risk profiles. For example, women who have been diagnosed with either pre-eclampsia or gestational hypertension during pregnancy are at increased risk of subsequent hypertension and cardiovascular disease. Gestational diabetes is also associated with increased risk of Type 2 Diabetes and cardiovascular disease later in life. Women are also more prone than men to sudden coronary artery dissection, a serious heart condition that can lead to death. Yet this too is undiagnosed and poorly understood.

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

[6] https://thebms.org.uk/wp-content/uploads/2021/08/BMS-Vision-MAY2021-01C.pdf
[7] Australian Bureau of Statistics 2020. Causes of Death, Australia 2019. Vol. 3303.0.

- 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.

- 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.

5. Recommended actions

5.1 Abortion and contraception

5.1.1 State governments lobby the TGA to expand the gestational age criteria for medical abortions from 9 to 10 weeks giving women more time to access this important and less invasive option.

5.1.2 State governments mandate that all public hospitals that operate at Level 2 or above service capability provide abortion and contraception services as part of their state funding agreement.

5.1.3 Educational institutions and professional colleges develop and implement evidence-based sexual and reproductive health curricula and clinical practice guidelines to ensure medical, nurse practitioner, nursing and midwifery health professionals are effectively trained and supported in abortion and contraception care on an ongoing basis.

5.1.4 The federal government reduces the cost of essential sexual and reproductive healthcare by providing Pharmaceutical Benefit Scheme subsidies for all long-acting reversable contraceptives and increasing the variety of oral contraceptives available on the PBS.

5.1.5 State governments improve access to referral information by collaborating with Victoria to implement the successful 1800myoptions model across Australia, thus ensuring women have evidence-based centralised information, and know where to access affordable abortion, contraception and sexual health services in their state or territory.

5.1.6 State governments work with the federal government to establish a national approach to the collection, monitoring and analysis of abortion data in all states and territories across public and private providers to inform funding, service and system reform. This will inform the provision and funding of services and serve as benchmark against which we can monitor progress.

5.1.7 State governments lobby the federal government to extend MBS funding to include abortion and contraception for non-Medicare eligible women and girls and negotiate with private health insurance providers to improve coverage for international students and those on working visas to ensure access to sexual and reproductive healthcare throughout their time in Australia.

5.1.8 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.

5.2 **Other women's health issues**

5.2.1 State governments collaborate with the federal government to implement the recommendations of the *National Women's Health Strategy 2020-2030*.

5.2.2 Funding agencies support more investment in the sex-specific features of diseases and conditions, including cardiovascular disease.

5.2.3 Educational institutions and professional colleges develop training and education programs for health professionals on sex difference and how it manifests in the context of different diseases and conditions, as well as risk assessment and treatment guidelines.

5.2.4 To ensure supply, state governments lobby the federal government to develop a not-for-profit entity to register, import/manufacture and distribute essential drugs commonly used (and safe) in pregnancy.

6. Addendum

A snapshot of key health risks for women and girls in Australia (source: *National Women's Health Strategy 2020-2030)*.