COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Universal access to reproductive healthcare

(Public)

FRIDAY, 28 APRIL 2023

MELBOURNE

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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Friday, 28 April 2023

Members in attendance: Senators Askew, Payman, Rice, Marielle Smith, Tyrrell and Waters

Terms of Reference for the Inquiry:

Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to:

a. cost and accessibility of contraceptives, including:

i. PBS coverage and TGA approval processes for contraceptives,

ii. awareness and availability of long-acting reversible contraceptive and male contraceptive options, and

iii. options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;

b. cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas;

c. workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals;

d. best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery;

e. sexual and reproductive health literacy;

f. experiences of people with a disability accessing sexual and reproductive healthcare;

g. experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;

h. availability of reproductive health leave for employees; and

i. any other related matter.

WITNESSES

WITNESSES

HOWES, Ms Samantha, Policy Manager, Organon

LOXTON, Professor Deborah, Director, Australian Longitudinal Study on Women's Health [by audio link]

MISHRA, Professor Gita, Director, Australian Longitudinal Study on Women's Health [by audio link]

TOLSTOSHEV, Ms Nirelle, Managing Director, Organon

Committee met at 09:31

CHAIR (Senator Rice): I declare open this hearing of the Senate Community Affairs References Committee's inquiry into universal access to reproductive health care. I begin by acknowledging the traditional custodians of the land which we're on, the Wurundjeri people, and pay my respects to their elders past and present and to all First Nations people, including to any First Nations people who may be with this or may be joining us today. These are public proceedings being audio streamed live via the parliament's website, and a *Hansard* transcript is being made.

I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It's also a contempt to give false or misleading evidence. Witnesses have a right to request to be heard in camera.

I welcome our first witnesses. I understand that information and payment you privilege and the protection of witnesses giving evidence to Senate committees has been provided to you. I invite each organisation to make a short opening statement, and at the conclusion of that, we will ask you some questions. We'll start with the Australian Longitudinal Study on Women's Health.

Prof. Mishra: I'll start, and my colleague Deb Loxton will do the rest. The study, as you know, has been funded by the Department of Health and Aged Care. It is a longitudinal survey of 57,000 women who have been providing us with survey information since 1996, which are routinely linked with administrative data such as Medicare, MBS and PBS to answer questions about women's health over the last course. In this submission we present findings from women in the youngest two ALSWH cohorts spanning ages from 18 to 48 years, which are highly relevant to this inquiry.

I'm going to touch on the cost and accessibility of contraception. Cost, concern about side effects and poor access to contraception or health services, and not being able to find a suitable method are barriers to accessing contraception. Women in the 1989-95 cohort, who are aged 24 to 30 years in 2019-20, who did not use contraception, reported the reason behind this decision. Thirteen per cent of women indicated that they were concerned about health or side effects. Six per cent of women indicated that they could not find a method of contraception that suited them. Side effects affecting physical and mental health, the lack of information about contraception, negative experiences with health services, contraception failure and difficulty in accessing contraception have all been reported by women as barriers to contraception use.

Higher financial resources may include access to a wider variety of contraception. We know, for instance, that the oral contraceptive pill is one of the most commonly used contraception methods in Australia. Therefore, it is one of the most accessible options for women. However, in 2021 we estimated upwards of 30 per cent of women who reported using an oral contraceptive pill did not have prescriptions supplied through the PBS. So for women who were born in 1989-95 and 1973-78, those women who were supplied an oral contraceptive pill through the PBS were more likely to report difficulty in managing their income when compared with women who were not.

CHAIR: Excuse me, Professor Mishra. You are reading your opening statement that we have as a submission, I think. Is that correct?

Prof. Mishra: Okay, I'll just summarise the last point.

CHAIR: If you could summarise, because we're really short on time.

Prof. Mishra: Yes. Thank you. This points to women who have higher financial resources having a wider access to a variety of contraception, as they're not reliant on government subsidised contraception. That's the key thing about the barriers. I'll pass you over to Deb.

Prof. Loxton: Thanks, Gita. I'll just highlight a couple of points. In addition to the impact of financial capacity, area of residence also impacts on women's access to GPs, which further impacts on their access to contraception. We find that about a third of women rate their access to GP services as fair to poor which, again, has that flow-on impact on accessing contraception. We also mentioned access for LARCs in our submission, saying that their uptake had increased over time but was still quite low, and that there was a need for public health

campaigns and attention to health and health service literacy, with women indicating a lack of information about contraception impacting their choice, access and also access to cervical screening being problematic for young women. I'll stop there.

CHAIR: Thank you very much.

Ms Tolstoshev: Good morning honourable members of the committee. I would also like to acknowledge the traditional owners of the land upon which we meet today and pay respect to any Indigenous people joining us here today, to elders past, present and emerging and especially to Indigenous women and their families, who continue to care for our country. We appreciate the opportunity to appear before you today on this issue of national importance. Sexual and reproductive health has, for far too long, been overlooked and undervalued. Inquiries like these and the conversations that follow are critical to promoting better health outcomes for women and girls.

Organon is a global healthcare company formed in June 2021. Today we are a sizeable company and one of the only companies focused on the health and wellbeing of women. We seek to deliver innovation, improve access and expand choice to help address the unmet medical needs of women. By addressing gender related disparities in health, we believe that we can build a more sustainable future for women, families, the economy and our society. These gender related disparities are a matter of fact, and, for this reason, investment in women's health is long overdue. We are committed to our mission and vision of a healthier every day for every woman.

In our submission to this inquiry, we've made policy recommendations that answer terms of reference a, c and e, relating to sexual and reproductive health literacy, workforce development and the cost and accessibility of contraceptives, including long-acting reversible contraceptives. Planned parenthood has important health benefits for both maternal and infant health, and yet recent analysis shows that an estimated 40 per cent of pregnancies in Australia are unintended. We know that women living in rural areas are 1.4 times more likely to experience an unintended pregnancy, and this rate is also disproportionately higher amongst First Nations women. Our submission draws attention to Australia's high rates of unintended pregnancy and recommends policy solutions to help mitigate this public health issue.

We believe that this advocacy is important not just for patients but for all Australian women touched by this reality. The bipartisan National Women's Health Strategy was a significant step forward, by identifying an increase in the availability and uptake of long-acting reversible contraceptives as a key measure of success. The strategy makes clear the need for Australian women to be supported with knowledge of and access to all of their contraceptive options. We believe that higher uptake can be achieved by improving contraceptive literacy, utilising the entire workforce when it comes to contraception, including task shifting where appropriate and examining the upfront costs associated with contraception.

We hope that this inquiry will improve the current sexual and reproductive health system and look forward to working with the Australian government and federal parliament to ensure that all women have access to safe, high-quality and affordable health care. Thank you for the opportunity to participate, and we look forward to responding to your questions.

Senator WATERS: Good morning, everyone. I'll add my acknowledgement of the First Nations owners of this land and the lands from which witnesses are dialling in from. I'll start with you, Organon, since you're here in person, but I will have some questions for the professors as well. I'm conscious that I have so many questions to ask, but, with lots of interested people here, we don't have a lot of time. So forgive me for cutting to the point. Your submission calls for a national dataset on contraceptive use, live births, miscarriage and abortion. How much of that information is currently available already, what work needs to be done to make sure that data is collected consistently and who should be responsible for doing that?

Ms Howes: It's quite difficult to measure unintended pregnancy. When we spun off as a company in 2021, we thought about measuring that. Part of that was about utilising the current available datasets, the most reliable of which was from the departments of health in WA and South Australia, which had captured pregnancy rates via age group. That was incredibly helpful. But, really, a partnership between state and territory governments to capture data at a national level should be part of that solution. It's impossible to map policy outcomes without appropriate mapping of data.

Senator WATERS: Do you think a particular body should be collecting that data?

Ms Howes: I would just recommend a partnership between the state and territory governments and the national government.

Senator WATERS: Is that something that you think the Women's Health Advisory Council could either undertake or commission?

Ms Howes: Absolutely. The Women's Advisory Council has a role to play when it comes to mapping of data, particularly in assessing the appropriate datasets to be used in solving these problems.

Senator WATERS: You've called for free contraception to be made available, and I think in your submission you said that that should just be for women under 25. Firstly, why limit it to that? Why not make it free for everyone? Can you just run me through a little bit more what your proposal would cover—what type of contraception it would cover—and perhaps compare that with what has been done in other countries, to the best of your knowledge.

Ms Tolstoshev: We know that there's a model in France that talks exactly to the under-25 cohort, and we know that budget constraints are real and that parameters are expected. That 25 is arbitrary, but we're putting a guideline forward, rather than trying to make it too broad. We know that free access would remove the barrier of upfront costs, upfront consult fees and insertion fees for long-acting reversible contraceptives, and we know that free access would broaden for populations such as rural and remote women who are 1.4 times more likely to experience an unintended pregnancy. I'll defer to Sam to add any other points.

Ms Howes: Providing free contraceptive services to women under the age of 25 has been recommended previously, including by SPHERE, who I believe you'll be hearing from later today.

Senator WATERS: We are this afternoon.

Ms Howes: This would bring Australia in line with other countries such as France, and the same thing is happening in Britain. In the US, researchers of the Contraceptive CHOICE Project concluded that when women and girls who were provided with contraception at no cost and educated about the benefits of long-acting reversible contraception methods had lower rates of pregnancy, birth and adoption compared to their cohort. We know that providing free contraception works, and partnered with the right education, it can be incredibly effective.

Senator WATERS: Sticking with LARCs for the time being, do you think that stories about the pain involved in IUD insertion have deterred people from considering LARCs? Is more research needed to find options to reduce the pain or is it an issue of better training for the workforce and better awareness raising amongst the public?

Ms Tolstoshev: It's probably not relevant for us to comment on IUD pain. It doesn't pertain to any of our portfolios, so I'd leave that for other parties to comment on. But on the benefit of LARCs broadly, we know that if a woman doesn't have to take a tablet every day or return to the pharmacy every month to fulfill an oral contraceptive pill script it remove barriers, and then the corresponding efficacy is improved with a long-acting reversible contraception.

Senator WATERS: You talked about uptake rates in your submission. Can you walk us through those for LARCs in Australia?

Ms Howes: Australian uptake of LARCs use—typically most estimates have us at around 10 to 11 per cent, whereas elsewhere we know in other countries uptake is much higher. For example, in Sweden the uptake of LARCs sits around 30 per cent. Echoing some of the statements that have already been made, there was a 2016 study that found that 73 per cent of women who experienced an unplanned pregnancy were using a form of contraception at the time, and the most frequently cited method was the oral contraceptive pill. That speaks to the efficacy of the long-acting reversible contraceptives, but more information is needed to improve contraceptive literacy, as reflected in your question earlier as well.

Ms Tolstoshev: I would add that with the model of care in Sweden, where LARC use is at 30 per cent, the majority of contraceptive consults are carried out by nurses and midwives, so we know that's a model that works. In the UK, where GPs are reimbursed in a pay-for-performance model to have a broad consult around all of the options that a woman can have, we know that's corresponded to a 13.4 per cent increase in LARCs, up to 46 per cent in the UK, and a corresponding decrease in abortion rates. So we know that both enabling GPs to have a broader consult and also enabling nurses to have the consult but also to be inserting and removing LARCs has a corresponding increase in uptake.

Senator WATERS: I was going to ask you about the specific MBS item for contraceptive consultation. Are you proposing that we have a standalone item for that here in Australia to enable that more in-depth conversation for a person wanting contraception with their doctor?

Ms Howes: It's a proposal that's been made before. The UK example would indicate that it works. So, yes, we would propose that an additional 10 minutes or so would be useful in providing a fulsome conversation around all contraceptive options, and that would hopefully help in improving contraceptive literacy too—when it comes to patient led care and women being aware of all of their options.

Senator WATERS: Do you think there's enough awareness amongst GPs of the various options available? What sort of training is provided to GPs so that they're across any new products, whether or not they're on the PBS?

Ms Tolstoshev: The number of healthcare professionals broadly that are willing and able across Australia, we know, is a barrier, and that barrier is due to more training being needed for nurses, midwives and GPs. We know that if more of the workforce was educated and time and reimbursement were created we would see a corresponding uptake.

Senator WATERS: We certainly heard that from witnesses previously, so that's a consistent theme. Thank you very much. I might move now very quickly to the professors online. Thank you so much for calling in to the inquiry today and for not just your submission but the work you're doing in the longitudinal study. A number of submissions have called for better data collection, including the folks here at the table as well. Do you support that call? What have you learnt so far through the longitudinal study about what data needs to be collected and how best to collect it?

Prof. Loxton: I'll start, and Gita can feel free to jump in. We do have national data on miscarriage, abortion and unintended pregnancy for the age groups that we survey. That's probably what the witnesses from Organon are referring to when they say you need complete data. We have a younger group and a group who are in their 40s now—a group in their late 20s and early 30s, and a group in their 40s. Because we're a cohort study, we're not going to capture the [inaudible]. Despite that, we're able to show that increase in uptake of LARCs, for example, over time. That seems to be a time issue but also an age issue. As women complete their families in their early 40s, we find that the uptake of LARC is around 25 per cent, compared to the roughly 11 per cent of women who are in their 20s. So women who are in the childbearing years are just less likely to uptake LARCs than women who are older.

The abortion data we have are complicated, as abortion data always are. Some of our team are working with Danielle Mazza at SPHERE at the moment on an in-depth analysis of those data. When that's ready, we'll be very happy to share that. I think with regard to abortion data it would be great if we had reliable administrative data. We understand that there are issues with the data collected through Medicare for various and complicated reasons. But if there were a way to increase the validity of those data, I think that would be very helpful. We do have data on miscarriage, and that's very reliable data and it is available to the longitudinal study. Gita, I don't know if you'd like to mention anything at this point.

Prof. Mishra: Just one short thing is the issue of having good data on miscarriage. That has to be done through self-report, which is what the Australian long-term study has. The only other place we might get it is through GP records, so that data is difficult to collect routinely, I think.

Senator WATERS: Thank you. I confess I only caught some of that. I'm finding the audio a little fuzzy. Hopefully I can go back and read the *Hansard* later and get some of those great points that you made. Currently, a number of MBS numbers cover multiple procedures, so it's hard to detect from those numbers alone the specific procedures being undertaken. How do you suggest that that be overcome? I'm thinking particularly in relation to abortion procedures. We can't properly design systems for access if we don't have the correct data about the need. How do we assist doctors to consistently report reproductive healthcare procedures in a way that's meaningful and will enable health policy decisions to be made?

Prof. Loxton: I think in part that's a question for the practitioners or the primary sector. From a data point of view, having consistent definitions of actual MBS numbers would be very useful. Gita, I'm not sure if you'd like to add to that as well.

Prof. Mishra: The other thing to add to that is a bit more time. As was suggested before, perhaps for contraception that could be an extra 10 minutes of GP consultation time, because a lot of GPs report that they're time poor. These things do take a bit of time for consultation and recording.

Prof. Loxton: I think that's a really good point, Gita, and it meshes well with our data that show that women don't seem to feel that they have a choice—some of the things that you spoke about at the beginning.

Senator WATERS: Thank you very much, professors. I appreciate your expertise. I'll pass the call over. Thank you.

Senator MARIELLE SMITH: I just wanted to come back to you, Ms Howes. You were talking about the policy space in France around free access to contraception for under-25s. I believe the UK has something similar for those under 26. Is that correct?

Ms Howes: I believe that they have free contraception in the UK.

Senator MARIELLE SMITH: Do you have any evidence you can reflect on in terms of the impact that has had in terms of take-up?

Ms Howes: I can speak to the UK. There was research done after the NHS introduced the policy in relation to primary care to incentivise GPs to discuss all contraceptive options. There's a paper that I can tender for the committee's interest on that, but not so on free contraception, unfortunately.

Senator MARIELLE SMITH: That would be useful. You also mentioned in your evidence to Senator Waters that other jurisdictions have a much higher take-up of LARCs, like Sweden. Can you speak to what those jurisdictions are doing to get that take-up?

Ms Howes: Absolutely. One of the key things that comes up again and again is the utilisation of nurses and the nurse workforce when it comes to the insertion and removal of LARCs. We know that currently in Australia nurses can insert and remove LARCs when they're trained to do so, but it's commonplace abroad for that to be the standard practice in contraceptive care.

Senator MARIELLE SMITH: That comes back to your submission. I noted you spoke about the role nurses play in other jurisdictions in contraceptive care. What would you like to see here? I assume this is within the scope of practice, but it's about making full use of that scope. What would you like to see policy wise?

Ms Howes: It is within scope of practice. We know that they can do this procedure when they're trained to do so. However, there's no way that they can access the MBS item number for the insertion and removal of LARCs; that's only available to doctors, and that's a significant barrier when it comes to the sustainability of this practice. We've seen time and time again through research that it's within scope of practice. In fact, there was a study within a hospital setting that saw nurses upskill successfully in the insertion of the contraceptive implant. The doctors from that study saw unanimously that nurses could play a greater role in the provision of the contraceptive implant in Australia. It's about creating sustainable funding mechanisms for them to fulfil the scope of practice.

Ms Tolstoshev: To add, most primary care centres have nurses on staff who are doing routine counselling, chlamydia checks, assisting with pap smears et cetera, so we know that they're educated appropriately and, when trained appropriately, can really open up more of the workforce for this work.

Senator MARIELLE SMITH: I want to ask about perception of risk around LARCs and the impact of that perception of risks on take-up. What do you think the issue is there and what do you think the potential solutions to address it might be?

Ms Tolstoshev: LARCs do have a rapid return to fertility. There's some misinformation around that one, but the evidence suggests that there is a rapid return. Around side effects, there are side effects to every product. As a relatively new company, Organon is looking everywhere globally and everywhere for more contraceptive options and, where possible, with fewer side effects. They are a reality that can be managed by the healthcare practitioners with the patients. That's what I would say.

Ms Howes: To supplement, we often hear key opinion leaders and clinicians talking about a lack of information when it comes to LARCs. So the greater contraceptive literacy would improve misconceptions and the perceptions of risk in this area.

Senator MARIELLE SMITH: In your view, how is that low uptake for younger women or women of childbearing years best explained? Is it this concern around return to fertility, or is it an access issue? Where do you see the key sticking points which are impacting that take-up? We've talked about cost and other things as well.

Ms Tolstoshev: The key barrier is the number of healthcare providers willing and able to have the conversation and insert and remove. Some of the other points we've talked about, like contraceptive literacy—there are some young women who just don't have an awareness that LARCs are even an option—and the costs and the upfront consults and the toing and froing required to actually have the LARC inserted. They would be the three major barriers.

Senator MARIELLE SMITH: Can I come back to Professor Mishra? In terms of the data that you collect in your study, now that you're into that, are there data sets or areas of data that you think are missing that you would have liked to include in your study that aren't there, or could you identify where you think the key data gaps are?

Prof. Mishra: I'll have a think, but, Deb, do you have anything that we should be including?

Prof. Loxton: It might be useful just to highlight that, every time we send a survey out, we do a consultation. We use various forms of different expertise, including government. If there are things that come from this inquiry that you would like added, we can certainly do it, but perhaps it would be useful if we provided just a clean list of

the different types of reproductive health data that we do collect so that people are aware of the national data across certain variables.

Senator MARIELLE SMITH: I would really appreciate that.

Prof. Mishra: We do have a very comprehensive list of contraceptive use—the pattern of use, the barriers as well—that comes from the questionnaire. Because it's linked to PBS data, we can actually pull those data out for the audience. It is fairly comprehensive, as Deb was saying, because we consult with the stakeholders, with the women, when we're designing our questionnaire.

Prof. Loxton: I'd just highlight that, because of the links with PBS and Medicare data, we do actually have a lot of avenues for examining different aspects of reproductive health—particularly contraception—that are available on the PBS. We can certainly [inaudible].

Senator MARIELLE SMITH: Sorry to interrupt, professors. Are you speaking on speakerphone? It's very hard to hear your evidence. If it's possible for you to speak directly into the handset, it might assist the committee. Thank you. In your submission and at the start of your opening statement, you referred to the low uptake of LARCs amongst younger women, or women of child-bearing years. I think you said that, in your data, the uptake is much stronger for an older cohort of women. Do you agree with the evidence around the misconceptions or concerns around return to fertility as being a significant influencer in that decision, or are there other factors at play that you think we should be aware of?

Prof. Loxton: I think Organon summed it up quite well. We run this study, but a number of years ago we ran a national contraceptive study alongside the longitudinal study, and the types of things that women said were that they needed to have time apart from hormonal contraception, so they needed to quit for a while, and that they had a perception that LARC was almost permanent. In their view, LARC was for once families were completed. Although those data are a little bit old now, I think that that still holds true when we look at the longitudinal study data.

Senator MARIELLE SMITH: Do you think that an effective response in terms of influencing take-up and access is an educational piece?

Prof. Loxton: Yes.

Senator MARIELLE SMITH: If so, is that educational piece targeted at workforce or at women?

Prof. Mishra: Both.

Prof. Loxton: It would be both. When we do work with women, like directly doing qualitative inquiries, they often say that the first thing they're offered at the GP surgery is the oral contraceptive pill. If they front up and ask for contraception, the pill is the first thing that's offered. I think, if we can increase knowledge on both sides, that will really help with that conversation.

Senator MARIELLE SMITH: Is that because the pill is cheaper? Why is that the first point of offering?

Prof. Mishra: It's well known, right? Everybody knows it.

Senator WATERS: Thank you, professors. I'll ask you some more questions, particularly now that I can hear you so much better! Thank you very much for going off speaker. Your data showed that contraception use, needs and choices differed depending on the country that the person wanting the contraception was born in and the language women spoke at home. How can we better factor that into information, counselling and prescription services for contraceptives?

Prof. Mishra: I think the key thing is, again, education and letting the women know, in different languages, all the contraception options that are available. Literacy is a big thing, and increasing that contraceptive literacy, both for the women and for the healthcare providers, needs to be dealt with.

Prof. Loxton: Also, from my point of view, it wouldn't hurt to do a little bit more research in this area, to get a better and more nuanced understanding of what is going on there.

Senator WATERS: Notwithstanding your call for more research to better understand where the barriers to that information are, which I support, do you have a form in mind of how to increase contraceptive literacy, particularly in CALD communities? What's the best method? Is there anything we can look to learn from?

Prof. Mishra: That is such an important question. The federal government is currently funding us to recruit women from CALD communities, and as part of it we are going to embark on a major consultation process with them and collect data from them. I think I can say: watch this space. Maybe next year we'll be able to provide a bit more insight as to how we can help them. Definitely, consulting with the community is the first step.

Senator WATERS: You noted in your submission how important trauma informed care is, given the prevalence of sexual violence. Have you noticed an increase—or a decrease, for that matter—in the availability of trauma informed and culturally aware care over time?

Prof. Loxton: This is more like an observation of people that we work with and people that we know rather than something more directly quantitative, but I think that this has increased. Certainly, over the last few years, trauma informed care, knowledge about it and people's understandings of how it can be, or the need for it to be, delivered has certainly increased.

Senator WATERS: Has anyone done any costings on what budget line item we would need in Australia to replicate what the UK has done and make contraception free—whether that's just for the 25s and under, as you propose, or are you aware of any other costings that go to that issue without that age limit?

Ms Howes: I'm not aware of any costings in relation to free contraception in Australia. I'd suggest that's an interesting area for research.

Senator WATERS: Do you have a sense of the cost for your suggestion, which I know was shared by a few other witnesses, of making it free for under 25s?

Ms Howes: I'm sorry. It's just—

Senator WATERS: It's just a policy proposition, sure. It's a very valid one, which I support, and that's fine. We have means of asking folk to do those calculations for us, so we'll continue to do that. We've talked a little bit about the need for contraceptive information and targeted awareness campaigns. That seems to be an issue no matter the age group, location or cultural background. Do you have a sense of what's going to be the most effective method of delivering that information and increasing literacy about contraceptive options, both for the person wanting it and for the medical workforce?

Ms Tolstoshev: Given the misinformation on platforms such as TikTok and social media, we think that the government plays a real role: to represent the truth, if you like. We think that's really important. We play a role where we can, within the guidelines and regulations that we can, in providing materials via GPs, via nurses, in culturally sensitive translated materials et cetera. We do what we can across those areas, but we see government playing a significant role. Would you add anything?

Ms Howes: I would just add that a public health campaign sponsored by the national government in this area could go a long way in preventing misinformation. There have been a few good examples. I would suggest the government partner with sexual health and family planning organisations. Sexual Health Victoria have some amazing resources that they've used before in advertising. In relation to patient education, further, I think that an additional 10 minutes in a contraceptive consult with a GP could go a long way in alleviating pressure and informing patient-led care.

Senator WATERS: So it's awareness, enough time with your medical professional, enough variety of medical professionals to do the implantation or to provide the advice, and, of course, having the money or, ideally, not needing the money and having it for free—a combination of those things.

Ms Howes: I would just emphasise the utilisation of the full workforce when it comes to the nurses, midwives and nurse practitioners that are able to provide this service. That could alleviate pressure from the primary healthcare system and unlock access in rural and regional areas.

Senator WATERS: What we've heard a lot in this inquiry, which I hope is going to be heard by the folk that get to make these decisions, is to extend out the access to those MBS items—who can access that and claim back the fee for providing that much-needed service. Given the time, I might wrap up. Thank you all very much for your expertise and your time.

CHAIR: Thank you, everyone. Thank you for appearing before us today. I don't think any of you took any questions on notice, but if there was any further information that you thought of that you wanted to provide to the committee, if you could get that to us by the close of business on 5 May, that would be most appreciated. We're going to be reporting to the Senate on 11 May. Thank you, and thank you to Professors Mishra and Loxton as well for joining us via teleconference.

GRZESKOWIAK, Dr Luke, Member, Women's and Newborn Health Specialty Practice Leadership Committee, Society of Hospital Pharmacists of Australia

MATTHEWS, Professor Sue, Chief Executive Officer, The Royal Women's Hospital

MOORE, Associate Professor Patricia, Head of Unit, Abortion and Contraception Service and Early Pregnancy Assessment Service, The Royal Women's Hospital

MURDOLO, Dr Adele, Executive Director, Multicultural Centre for Women's Health

YIK, Mr Jerry, Head, Policy and Advocacy, Society of Hospital Pharmacists of Australia

[10:12]

CHAIR: I now welcome representatives from the Royal Women's Hospital, the Multicultural Centre for Women's Health and the Society of Hospital Pharmacists of Australia. Thank you for all appearing before the committee today. Do you have any comments to make on the capacity in which you appear?

Prof. Moore: I'm a gynaecologist.

Prof. Matthews: I'm also a member of the National Women's Health Advisory Council.

CHAIR: Thank you very much. I now invite each organisation to make a brief opening statement if you would like to do so, and then the committee will ask you some questions. I'll start with you, Dr Murdolo.

Dr Murdolo: Thank you so much for the opportunity to give evidence at this hearing. We really appreciate it. Multicultural Centre for Women's Health is a nationally focused migrant and refugee women's health organisation. We're led and run by and for migrant and refugee women. I would like to take the time that I have to really put up front some of the context of our submission by saying that migrant and refugee women in Australia have much poorer reproductive health outcomes than other women. We see trends like later access to antenatal care; later identification and confirmation of pregnancy, which has a whole lot of flow-on effects; lower rates of contraceptive use; high rates of using barrier methods rather than looking at the full range of contraceptive options; higher rates of birth related conditions, like pre-eclampsia and gestational diabetes; higher rates of intervention during birth; and higher rates of stillbirth. So we're seeing the outcomes of inequity within the health system, so race and gender inequality within the health system.

I want to say that this is not because of culture. A lot of the time we think about migrant communities as bringing some kind of backward culture to Australia and think that that's the reason for some poor outcomes in a whole lot of different settings or attitudes. Culture obviously is an important factor, and we do need culturally safe and culturally appropriate health care. When we're looking at solutions and increasing access to the health system and education, it's definitely an important factor. Really we need to have a look at the health system itself and the way that it excludes, limits and restricts the use of services and also how it interacts with other systems, like the migration system, to exclude many women from having access to services.

There are a number of solutions, but I want to start with systemic change, so a whole lot of changes within the health system that can increase access: make it culturally safe, make sure there is increased health literacy amongst migrant women and truly extend reproductive health care to women regardless of their visa status. At the moment people who are temporarily in Australia do not have access to all of these programs that we're talking about. They don't have access to the PBS and Medicare, so they have to pay out of pocket for contraception.

In relation to international students, a deed was signed in 2011 between the federal government and overseas health insurance companies so that there would be a 12-month waiting list for any pregnancy related claims, so that means termination, contraception and anything to do with pregnancy. That deed is coming up for re-signing in July, so as we're considering universal access to reproductive health care it might be a good time to think about whether we can exclude that clause from the deed.

Other solutions really rely with the community and with migrant women themselves. I note the question that the committee asked of the previous group about what kinds of programs we could bring in. I'm really happy to talk about bicultural and bilingual education, if you'd like me to expand on that later on. That's a fantastic method of reaching women with low literacy, low health literacy and low proficiency in English about a whole range of issues, including contraception and other reproductive health care.

Of course, there's self-advocacy and co-design. As we design health systems we really need to find ways of including migrant women in the design of those system so that they are appropriate for them.

Then there is the workforce. In addition to bilingual and bicultural workers being understood as integral parts of the workforce, we have a whole cohort of health professionals who are overseas trained, particularly women,

who have a lot of difficulty and challenges having their overseas qualifications recognised. So there are lots of barriers that could be overcome federally to support women to join the health system. Nurses end up going to a whole range of other different related health professions but do not go back into nursing once they arrive in Australia. I know there's a nursing shortage, so there are some good synergies there.

Interpreting in the system—we don't have enough interpreters, and we don't have specifically trained interpreters. Imagine that extended consultation of 10 extra minutes with the GP to talk about contraception. That would need to be doubled to use an interpreter, but you would also need to make sure interpreters are trained appropriately on women's health issues so all the stigma or misconceptions about contraception and other women's health reproductive issues aren't undermined or conveyed in that interpreting session by the interpreter.

Prof. Matthews: I'm going to talk on behalf of the Royal Women's Hospital. I start by acknowledging the traditional owners of the land on which we are today, the people of the Kulin nations. But I also acknowledge that Aboriginal women have very poor outcomes compared to others, like Adele talked about refugee and migrant women, so I acknowledge that today. The Women's submission covers a broad range of things, and I'm going to talk mostly today about contraception, medical abortion and abortion services. Please note I'll be using the terms 'woman' and 'women' for the purposes of today. That is inclusive of all people who are assigned woman at birth.

Despite it being a progressive and quite fair country, there are many barriers to affordable, appropriate and effective contraception and abortion in Australia, and much of it is by design; it's not by choice. Today I'm going to briefly outline some of these things. We know that one-third of all women living in Australia will experience an unintended pregnancy in their lifetime, and research indicates that unintended pregnancy is associated with serious consequences, including medical complications, poor health outcomes and socioeconomic disadvantage for girls, women, babies and families. We know that, when women are healthy, communities are healthy.

Advice and provision of contraception is a fundamental right, and it's a mainstream function of health care, mainly through the primary health care system. I heard you talking earlier about the UK. All contraception is free through the NHS. That includes the contraceptive pill, contraceptive injection and the hormonal implant. All are widely accessible through a GP, a sexual health clinic, a practice nurse or a young person's clinic. Yet in Australia we still have significant barriers to this basic human right.

Individual circumstances vary widely, so each person needs a form of contraception that works and is right for them. This includes a variety of oral contraceptives, various long-acting, reversible contraceptives and emergency contraceptives, and people's needs vary for different reasons. Some include pre-existing medical issues, some are life stage, some are side-effects and some are personal preference, living arrangements, cultural reasons and more. But for many people this is due to insufficient sexual and reproductive health training and incentives, in particular for general practitioners; a lack of appropriate, accurate and comprehensive sexual and reproductive health education in school for individuals; issues with confidentiality, stigma and lack of services for some people, particularly in rural and regional areas; poor awareness and understanding of the range of contraception medication and devices that are available; and the costs that are associated with some forms of contraception.

With regard to the cost, one contributing factor is that our system penalises people who need to use particular forms of contraception. For example, the PBS subsidy is not available for some forms of long-acting, reversible contraceptives. It also applies to some forms of oral contraception. Of the 41 different oral contraceptives listed on the Commonwealth government's MedicineWise website, 21 are listed as not available through the PBS, and while we have three methods of emergency contraception in Australia, only two oral methods are subsidised. The emergency copper IUD, which is considered the most effective of the three, is not available through the PBS.

Early medical abortion is an established, safe and straightforward alternative to surgical abortion in early pregnancy, and it's commonly used around the globe. Australia has travelled a long and hard road to have early medical abortion legalised and available, with a highly politicised debate that lasted more than two decades and is ongoing today. Unfortunately, this means we are well behind the rest of the developed world, and medical abortion is still inaccessible for many women, including those experiencing socioeconomic disadvantage and those living outside of metropolitan areas. While early medical abortion is safe and effective, only around 23 per cent of abortions in Australia are medical abortions. Meanwhile, in the UK, where all abortion care is free, the figure is 73 per cent, and even in the US, where there's way less access to reproductive health, it's 39 per cent. It's better than in Australia.

The impediments to early medical abortion in Australia include regulatory barriers set by the TGA which mean that only doctors can prescribe medical abortion medication, but currently only seven per cent of GPs across Australia are registered to provide medical abortions, and this decreases significantly in rural Australia; TGA requirements that prescribing doctors undertake recurrent training and registration and seek an authority script each time the medication mifepristone is prescribed; stigma attached to doctors providing abortion, especially in

small rural communities, where many are choosing to not register as a certified practitioner; and cost. Even though mifepristone is subsidised through the PBS, many women access medical abortions through the private system, and the cost can range between $500 and $800, depending on which state you live in and whether the medication is taken at home or in a clinic. There are also dispensing issues, with pharmacists required to register to dispense the medication. Many are not willing to register, for a number of reasons, including lack of knowledge, fear, conscientious objection and sometimes just purely the red tape to become certified to do it.

In Australia, each state is responsible for the provision of surgical abortion services through public hospitals, while, in the private sector, federal funding is available to subsidise the cost of abortions under the Medicare scheme. In theory, most states and territories have laws allowing abortion up to between 22 and 24 weeks of pregnancy. However, timely, local and affordable access is inequitable and inconsistent across Australia, particularly for women living in rural and regional areas. Barriers to access are very complex. They include pervasive stigma, an acute shortage of trained practitioners, poor and no service provision in some public hospitals, unclear patient pathways and the closure of many private services.

The Women's are the primary provider of abortion services in Victoria, and we are a known and trusted service and advocate. We're the lead provider of advanced abortion training for gynaecologists and obstetricians, in conjunction with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and we lead the Clinical Champions project in Victoria, a unique program that is specifically aimed at training health professionals in early medical abortion and surgical abortion. The aim of this program is to decentralise services to primary care and secondary hospitals.

We believe that regulatory and legislative changes, along with training and capacity building, are key to improving access to abortion care, and that's why we are seeking to establish the first and only national training, research and advocacy centre in abortion provision. Through this initiative we hope to double our capacity to train medical trainees, including beyond our state; change care standards; increase social work, nursing and midwifery staffing levels and training positions; increase training for and provision of nursing and midwifery led models of care; develop pathways for GPs and primary care to expand their scope of practice; drive research into new and understudied areas of abortion services; and involve people with a lived experience to inform and develop best practice models of care, including young women, adolescents, First Nations, LGBTIQA+, culturally and linguistically diverse, migrant and refugee people. We also want to develop a national digital resource hub as a repository of best practice and evidence based resources to guide practice.

We're experts in this area, and we know that women and pregnant people want to make decisions about their own bodies and have access to safe and timely abortion services. Our abortion services care for some of the most complex cases in the state and indeed in the country: victims of family violence, sexual assault and incest; people with very complex mental health issues; victims of crime; and people experiencing alcohol and drug abuse and severe disadvantage. Without us, many of these people would have nowhere to turn. We are extremely concerned about this cohort of girls, women and other pregnant people in our own state and in other states and territories, where access to safe and timely surgical abortion is restricted. Sustained pressure across the system due to the impacts of COVID-19, the reduction of private abortion services and increased demand, along with historical fragilities in the abortion service system, has led to significant barriers to access for many.

In closing, we're looking for the Commonwealth government to consider a review of TGA requirements for early medical abortion medication, in line with international best practice, including expanding gestational age criteria and allowing nurses, nurse practitioners and clinical nurse consultants to prescribe mifepristone and misoprostol. We're looking for a national investment in training for nurses, midwives and those working in sexual and reproductive health to include LARC insertion, contraception counselling and early medical abortion assessment.

We're looking for changes to the PBS so all contraception methods and medications are free; a review of MBS item numbers relating to sexual and reproductive health to reflect the skill, expertise and time required to provide appropriate medical abortion and long-acting reversible contraception; ongoing MBS funding for sexual and reproductive telehealth services, in recognition of a lack of local services and regional and rural areas; a national approach to the collective monitoring and analysis of abortion data in all states and territories across public and private providers to inform the funding system and system reform; and a national strategy to ensure educational institutions and professional colleges develop evidence based curricula and clinical practice guidelines, including abortion services, care pathways and workforce capacity building in the National Women's Health Strategy. And we ask you to consider our offer to lead a national training, research and advocacy centre for contraception and abortion.

Dr Grzeskowiak: Thank you very much for the opportunity to be here and to speak to this. The Society of Hospital Pharmacists of Australia is the peak body representing over 6,000 hospital pharmacists, as well as hospital pharmacy technicians and intern colleagues. Supporting medicine safety, quality use of medicines, access to medicines and high-quality pharmacy services are the core aims of our organisation and its members.

We know medicines play a key role in the lives of many individuals, and medicines are a common treatment option across a range of high-quality reproductive healthcare services, including contraception, abortion care, fertility and also pregnancy. Nationally, we know there are 250,000 medication related hospital admissions each year that cost $1.4 billion, as well as another 400,000 medication related emergency department presentations. While that's necessarily non-specific, a large chunk of that relates to individuals experiencing medication related harm who are receiving reproductive healthcare services.

Pharmacists are a key part of any healthcare team providing reproductive health care, and are medication experts. We believe universal access to high-quality reproductive health care is built on having a competent pharmacy workforce that's accessible, able and willing to support individuals to make evidence based decisions about their care and reduce potential medication related harms. Unfortunately, as a result of workforce shortages and a lack of dedicated funding, we don't have enough specialists for reproductive health pharmacists working across hospitals to ensure safe and effective medication use.

We also need greater emphasis on overcoming recognised barriers to individuals receiving high-quality reproductive health care. For example, we have a chronic problem relating to the availability and dissemination of high-quality evidence regarding potential reproductive effects of medications used during pregnancy and lactation. That leads to considerable uncertainties in treatment and suboptimal treatment outcomes. In some cases, this could lead to a termination of an otherwise wanted pregnancy, where there's a lack of sufficient evidence or inconclusive evidence about whether or not something that someone was exposed to was safe. Pregnant individuals, and healthcare professionals, require better evidence, and the communication of this evidence about risks and benefits of medications can be weighed up rationally.

We need to improve health equity by facilitating access to a broader range of contraceptives, as we've already heard about, but also to other essential medicines that support optimal reproductive health. We should consider providing free contraception with a particular emphasis on priority populations: those in the immediate postpartum period; women with chronic medical conditions and taking medicines that can pose a risk to themselves or their unborn child if they were to become pregnant; or those undergoing an abortion.

To conclude our opening remarks: we must remove the postcode lottery. We don't believe that where you live should determine whether or not you have access to an essential PBS listed medicine, or whether you indeed have access to high-quality, comprehensive, clinical pharmacy care.

CHAIR: Thanks very much for your opening statements.

Senator WATERS: I find myself in furious agreement with all of you. Thank you so much for sharing your views. Happily, I agree with all of them. I'll start where we've just finished, with the Society of Hospital Pharmacists. Thank you for your support for free contraception; that's a very common theme coming through today in particular, which is very welcome. Can I ask specifically: you've suggested that the Pharmaceutical Benefits Advisory Committee include more contraceptives on the PBS—you've mentioned, 'to reflect current guidance'. What guidance is that? And what other options should be on the PBS and why?

Dr Grzeskowiak: We've heard already quite a bit of information—and again I think you've heard from lots of other people making representations around the range of PBS items that should be added. We've heard about the copper intrauterine device, which, for many people, will be the most effective choice for long-acting reversible contraception, and certainly that's something I think would go a long way to improving access—to be able to reduce the costs of that, as well as to make available additional combined oral contraceptives as well as progesterone-only pills. There are some newer progesterone-only pills that have been more recently made available but unfortunately haven't been listed on the PBS yet.

Senator WATERS: We've got the TGA coming this afternoon, and I'm sure others are interested as well but I'm going to ask them: why is it taking so long for these newer pills, in particular, that have fewer side effects for many patients, to be listed? We'll try to work out from them what the barrier is and encourage them to surmount it where possible.

Can I move now to Dr Murdolo. Thank you for your beautiful opening statement. We've taken some evidence in Perth as well from similar organisations that have said similar things, so we're hearing you loud and clear. Can I ask you, firstly: you've recommended extending Medicare to include all migrants and removing waiting periods and restrictions for some visa classes. I think you're suggesting dumping the 12-month restriction completely,

which I think is a good suggestion. Can you talk about the consequences of not having Medicare access and what the federal government could do to remove restrictions.

Dr Murdolo: I'll start with the second question first. There's a deed between the federal government and the overseas health insurance providers, and one of the clauses—I think it's 48—actually allows or enables health insurance providers to bring in this waiting period for pregnancy related matters. It came in in 2011; it wasn't in place before then. One of the issues that that was trying to address was that terminations constituted the majority of claims from international students; there were a lot of unwanted pregnancies. So health insurance providers were a bit concerned about—

Senator WATERS: So rather than acknowledge the need, they decided to make it harder for people to get the healthcare they deserve?

Dr Murdolo: Yes, absolutely.

Senator WATERS: Okay. Interesting!

Dr Murdolo: Going to, then, the implications, as to the first 12 months, you've got a lot of young people coming to Australia, alone for the first time, and, I guess, it's their first opportunity to explore their sexuality and they're in a new place. So we did find that there were a lot—or there was a higher rate, anyway, of unintended pregnancies.

From the international students that we spoke to, there weren't necessarily programs in their countries of origin with health education or reproductive and sexual health education. So they weren't necessarily coming to Australia with a really good knowledge of how pregnancy happens and how you might avoid a pregnancy. Even if they did have the information that they needed, they weren't able to access contraception freely because of that exception in their health insurance. When you're struggling on a budget, of course you try and save money wherever you can. So there are low rates of contraceptive usage and not a lot of information about reproductive health, and, of course, at the other end, even if they were able to access an abortion, they'd have to pay for that out of pocket.

Senator WATERS: We heard that it could be in the thousands for that, which is just unthinkable.

Dr Murdolo: Yes, absolutely. So that's a real concern. And of course, at the other end, if they do go ahead with the pregnancy—and we have spoken to some students who arrive in Australia already pregnant and who want to go ahead with the pregnancy—they then are in debt for many thousands of dollars for the birth. It's up to $6,000 if it's a straightforward birth, but, if the baby needs to be in ICU for a little while or if there's a longer stay, it can really increase quite a bit. In addition to that debt, at the other end of the pregnancy, there was a time in Australia when, regarding hospitals, there wasn't a lot of clarity, and I think there is still some concern in some areas about whether hospitals can provide a service to international students. There were some stories of students giving birth in Victoria in the hospital car park because they'd been sent from one hospital to another to another.

Senator WATERS: Because there was a lack of clarity about whether you could—

Dr Murdolo: Exactly. Even though they could have provided the service to the student—but obviously there would be a charge—they were shunted and shunted and ended up in the Sandringham Hospital car park giving birth.

Senator WATERS: What a nightmare.

Dr Murdolo: Yes, what we would not want to see in Australia in terms of health care. I guess there are all the other disadvantages that arise when you have financial impost. If students who already come with a limited budget then have to pay for a termination or pay for a birth, it then has flow-on effects for them. They're already paying out of pocket for all their education. One of the things that the migration review found this week was that there are many people in Australia that they call 'permanently temporary'. They go, out of necessity, from one temporary visa to another to another, and so they're in Australia for many years. They raise their families in Australia, but they're paying out of pocket over those five, 10 or, sometimes, 12 years, for everything. It's health care, child care and school for their kids. It's compounding the disadvantage as well. As well as not providing access to reproductive health care in an equitable way in our system, it has flow-on effects for people's lives and their families.

Senator WATERS: Thank you. That was very powerful. Has your service received any funding through the Health in My Language, or HIML, program? If so, I understand that that funding expires at the end of June this year. Would that lead to existing programs being cut, if your service is in receipt of that?

Dr Murdolo: Thank you for asking that question. We lead that project. That project bases bilingual health educators in every state and territory around Australia. It's COVID focused at the moment. It's delivering in-

language education on COVID vaccination and protection from COVID itself to people in an outreach capacity. Our organisation has supported all of these partner organisations around the country to recruit, train and provide ongoing support and resources to these bilingual, bicultural workers, and then they go out into the community and provide information about COVID. The reason that was developed was the inequity in COVID information and, of course, the higher death rate amongst migrant communities, sadly. So there was a real need to make sure that there was additional education. Yes, that program does finish at the end of June. We're really hoping for an extension. We won't know until after the federal budget.

Senator WATERS: Should the program be not only extended but expanded in its scope, so it's not just about COVID; it's about all health information, including reproductive health?

Dr Murdolo: Absolutely.

Senator WATERS: Is there no other program that already does that?

Dr Murdolo: No, there is no other program that does that.

Senator WATERS: That's unbelievable. Goodness!

Dr Murdolo: Absolutely. On a national level, there's no other program that does that. We deliver all the programs from a gendered and intersectional perspective, because we're a women's feminist organisation. There are lots of differences even in experiences of COVID, between the way women experience it and the way men experience it—and other genders, of course. We make sure that we tailor all of our programs differently for women, for men and for gender-diverse people. And of course it's so perfectly placed to add other topics onto that program that we deliver. As it is, we can't just deliver COVID information. There's a recognition that COVID obviously exists within a context. For example, pregnant people could be really concerned about taking a vaccination and how that might impact on their pregnancy. So we need to deliver that kind of information to that cohort—that vaccines are safe during pregnancy et cetera.

There are lots of links between the program that we run and reproductive health already, and we do deliver a broader—

Senator WATERS: And that can be built upon.

Dr Murdolo: Absolutely.

Senator WATERS: Thanks, Dr Murdolo. I'm sorry to hasten you along there, but I have one more question. I'm sorry I've unintentionally ended up hogging the time. Thank you for your opening statement. I thought all of your policy asks were very sensible, and I was very pleased to hear you list all of those. I have a couple of questions, building on those. How does your hospital manage conscientious objections? If you have any in your workforce, how do you manage that? It seems there's a lack of a guideline for how to manage that, particularly if that's the only hospital where you can go to get your surgical abortion. Would you like to see public hospitals mandated to provide contraception and surgical abortion care, and how would that be achieved?

Prof. Matthews: Let's start with the first question. At the Women's, when people are interviewed and hired, they are absolutely told, 'We provide termination services. Are you okay with that?' So those people will come; other people choose not to work at the Women's because of the work that we do. I have not been made aware of anyone in the Women's who's been a conscientious objector, but we do work with other faith based organisations that may have conscientious objections to abortion who would refer to us. They send their patients to us or to other hospitals. That's that one.

Should public hospitals be mandated? Yes and no. They shouldn't need to be, because it is a normal part of women's health. It should just be part of what we provide for women's health. But there are some who have made a choice not to, and they should probably be told, 'Yes, you must,' in the first instance. The reason is that it is just a normal part of health care for women. It's an egg-and-sperm—egg-and-chicken thing. You can tell where I work!

Senator WATERS: No pun intended. I love it!

Prof. Matthews: So I think yes, for now. But we work very closely with the faith based organisations who are public, so I'm not saying that we should be forcing them necessarily to do that. But other public hospitals should absolutely be providing it.

Senator MARIELLE SMITH: I might just come to the Multicultural Centre for Women's Health first. I'm just interested in your evidence around continuity of care and the impact on women when that doesn't exist. For the communities you represent, could you speak to where the real sticking points are and the problems which emerge when you don't have that continuity of care?

Dr Murdolo: People living in migrant communities, especially in disadvantaged areas, are less likely to have that one GP who they go and see regularly. There's the larger bulk-billing clinics that people will go and see, and you might get any particular one. That's your first stage of not having continuity in your care, and the GPs don't necessarily communicate with each other. So that's one issue. When it comes to reproductive health care, again, they will access the public system at a later stage because there's that later identification and confirmation of pregnancy, and then there's a waiting period to be seen. You're actually getting later care, and you're seeing whoever is there in the public system. So it would definitely be advantageous to that person's care to be seeing somebody much earlier and to be seeing somebody continuously over that period.

When you think about that being compounded by language issues—the inability to get an interpreter at times or getting one not being a common practice in the health system—you really get some concerns. It's a cohort that would benefit significantly from continuity of care. Trust in the health system can be low as well, for a whole range of reasons. One reason can be that there's not a very robust health system in the country of origin, so there's not that expectation when they come here. But then there is also exclusion of some migrants from the health system. Even if you do have access to the health system, that broader discourse about migrants being excluded and the system not really being there for them is a disincentive for people to use the system. When trust is low, that actually makes it really difficult for women to have good health care.

Senator MARIELLE SMITH: When it comes to having interpreters in the room, for smaller language groups and less represented cultures I imagine there are some pretty big cultural implications when there are a limited number of interpreters from those communities. How do you get around that, and what are some effective policy responses when you've got those sensitive issues?

Dr Murdolo: I think training and support for interpreters is really the key. It's a similar factor with family violence, where again, in small communities, you often get the same interpreters who do that kind of work. They are not properly trained. They don't get debriefing after those consultations. So it can be really difficult for a health practitioner to find not only any interpreter for that community but an interpreter who has been properly trained to deal with that complex issue and who also is getting the support that they need from the company that they work for—because interpreting is contracted out. It's a bit of a gig economy system. So there can be real challenges in finding any properly trained and supported interpreter, but, when it comes to the smaller communities, it is almost impossible. We do have a telephone interpreter system, so that can be really helpful, but again you can't always find the person you need.

One of the issues that we've been told about by women, specifically in rural areas, is that they make their appointment with their GP, the interpreter's booked in, and then the interpreter cancels, so they have to reschedule their appointment with their GP. One woman told us that it happened three times for an appointment that she had with her GP. So that can also contribute to delayed care.

Senator MARIELLE SMITH: Thank you. I want to come to the hospital pharmacists now. In your evidence you spoke about the shortage of specialist reproductive health pharmacists. What's involved in being able to classify yourself as a specialist reproductive health pharmacist? What's the training? What does it look like?

Dr Grzeskowiak: From a training perspective, you graduate as a general pharmacist and then you'll be able to move into a wide range of practice settings, whether that's community or a hospital. If you go into hospital, every pharmacist does a year as an internship, which is mandatory. But then, beyond that, there are no mandatory training programs that would exist. A lot of it's based on your own interests and where it is that you like working. If you're working in a hospital and opportunities arise to undertake specialist training, it's based on whether there's a position available but also whether there are patients that are available that you can work with in that particular setting and whether or not there's an accredited program.

SHPA has been at the forefront of establishing these sorts of advanced practice residency programs. There is one site, which happens to be at the Royal Women's Hospital. It's the only one in all of Australia, so there's only one site where a pharmacist can go to complete one of these advanced practice residency programs to be able to call themselves a specialist reproductive health pharmacist. So obviously one of the priorities is trying to expand that, but that's really a workforce issue, because you need to be able to work at a place that's got someone that can help and train you. If you've only got one person being trained, who's there to train the next lot of people to come through? Unfortunately, we just don't have the workforce to be able to support the next generation coming through.

Senator MARIELLE SMITH: So how do we fix that?

Dr Grzeskowiak: It's a workforce and funding related issue, really. It's about, from multiple perspectives, prioritising reproductive health. Unfortunately, in my experience it does tend to fall down the list in terms of

priority. If you're running a hospital pharmacy service in a general adult hospital, it tends to be that reproductive health is one of the lower priorities. If you don't have enough staff, that's the first place you don't put a pharmacist or you cut their services. So there needs to be enough pharmacists in the system to ensure that that service is considered mandatory and can be appropriately staffed accordingly.

Senator MARIELLE SMITH: Who makes those decisions, though?

Dr Grzeskowiak: There are decisions made at multiple levels. A lot of them are influenced from a regulatory perspective, in terms of the funding that's delivered down through federal and also state governments—the funding available to hospital departments to be able to recruit staff, to retain them and to put them into the right areas. But, ultimately, in many cases, it's the decision of the people running the departments, because they're tasked with trying to deliver a service, often with not enough pharmacists to ensure that everyone can be seen, and having to prioritise who it is that they think is more deserving of a clinical pharmacy service than someone else.

Mr Yik: Overall, I think there needs to be more dedicated funding for hospital pharmacies and departments to have a sufficient pharmacist workforce. In one of our standards of practice we talk about: you need to have one pharmacist for every 30 hospital beds, and that applies broadly to maternity services. But, in our experience, a lot of hospitals around the country have one pharmacist for every 60 to 90 patients, and that's a standard. So we have workforce shortages, which are compounded by existing under-resourcing of our hospital pharmacy departments. So we really can't provide the services where they're needed, let alone even train the next generation of specialist hospital pharmacists in reproductive health care.

Senator MARIELLE SMITH: The sticking point here is this. Say that we wanted to make a difference by increasing the number of pharmacists who have these specialist skills. The Commonwealth increases funding to hospitals, and then the decisions within those hospitals are being made, which deprioritise, as you say, reproductive health in that skill space. I'm just trying to step back to the different steps that need to be taken to have a specific kind of impact on this when we're thinking about our recommendations. It sounds like there are a few levels between what we could recommend, in terms of what the Commonwealth does, and how you get that uptake. I'm happy for you to take that on notice, if you want to have a think about some of those steps. Could you provide some advice or thoughts on them for us, for when we're thinking about these issues. Where are the different points along the line that we need to influence to see some change?

I just had one more question for you both. In terms of the provision of this sort of support and of services in reproductive health, is there an issue here around the scope of practice for pharmacists, or are these sorts of services within the scope of practice but are just not being fully realised within the system?

Dr Grzeskowiak: Yes, definitely. I would say that it's within the scope of practice. They're not being fully realised. We can talk about it from different perspectives, of working in a hospital but also in a community pharmacy environment. I think you have already heard from some organisations that represent largely community pharmacists who are strongly advocating for improving or enhancing the scope of practice for pharmacists, to increase their ability to, say, prescribe medications and to perform other roles that would really help support and advance reproductive health care.

Just on your last point: the only thing to add, I guess, following on from Professor Matthews, is talking about reproductive health being a core component of health care. It's always a tricky bit—talking about having a specialist reproductive health pharmacist, as if that's the only person who can provide information in the context of reproductive health. We spend a lot of our time actually ensuring that all pharmacists have a basic core level of understanding, because individuals are going to be seen across the whole spectrum. What we're talking about with the specialist pharmacist are those really complex cases of people with comorbidities that influence pregnancy or make it really challenging to work out what contraceptive recommendations are optimal. I just want to emphasise that this is core business, and that takes it back to our undergraduate training, which, unfortunately, I think is not adequate in ensuring that the new generation of pharmacists entering the workforce are appropriately equipped with the skills to be able to provide high-quality reproductive healthcare services.

Senator MARIELLE SMITH: So the solutions here, when we're looking at this as a broader policy issue around the country, might actually be simpler than having these specialist-trained pharmacists; it's about making sure that every pharmacist is better equipped and able to provide high quality support and advice in this area—is that correct?

Dr Grzeskowiak: Yes.

Senator MARIELLE SMITH: I know we don't have time for me to keep digging here, so I'd really appreciate it if you could come back to us, having had a think about what we've just spoken about and how it might feed into our recommendations.

Can I just ask a question of the Royal Women's Hospital. I know you're here to speak about other issues, but I want to ask about continuity-of-care models in midwifery practice and the experience at your hospital. I'm a South Australian senator. Our experience is that these models are very limited in terms of access for women. It's a bit of a lottery as to who gets one and who doesn't. I don't know what the case is at your hospital.

Prof. Matthews: We're expanding ours. We have a couple of different models. We have one for Aboriginal women that we just did some research on, and the outcomes are much improved. That's an area that we're really focusing on. It's called the Cosmos trial—Cosmos is our model—and it provides access to a woman to have a single midwife throughout her whole pregnancy and journey. We have probably significantly less than we would like. It's difficult because of the funding for maternity. Maternity funding doesn't cover all of the costs of maternity care. That's a whole other—I won't go there. So that's part of the challenge. We are increasing ours. We will be getting a new hospital—that was one of the Victorian government's commitments—and our model there will be midwifery led. We're hoping that, when that opens, almost all that are appropriate would have access to that model of care.

Senator MARIELLE SMITH: With your hoped ability to expand that to be almost universal for women in your care, what had to change for you to be able to—was it the infrastructure? Was that the key thing or have other things happened which mean you might be able to provide that pretty soon?

Prof. Matthews: Probably a combination of both. We are increasing it now. We've outgrown significantly our current building. We have more midwives who want that model of care, but most of it came from our consumers. The women that we met with and talked to told us that's the model they really want, so we're increasing it to try and balance it to give them more opportunity. It really came from the voices of the women.

Senator MARIELLE SMITH: Could I ask you to come back to me on something. If you're able to have a think about what the key factors for success have been in enabling you to expand that program, it would be really useful as we think about where it's happening or not happening in other parts of the healthcare system. I'm really interested in what the spaces are where we could kind of press against to influence and see it expanded.

Prof. Moore: I wonder if I could just be a wee bit bold and say we've had a moment of synergy here with the pharmacists. Just as you were saying, Professor, there's this dichotomy of wanting some really super trained specialists for the really complex cases, the really socially, culturally and medically complex cases, but we also want to sing from the songbook 'This is health care'. The pill is a pill like every other pill. Emergency contraception should not be overregulated, nor should the morning-after pill and nor should early medical abortion, so we've got to do both of those things. We have commenced a training model that tries to embrace those. We train some specialists in reproductive health, but we train them all in a core, and we have the only spot for a pharmacist. Maybe we can work together. How many super pharmacists, if you wanted to call them that, do we need in this area and how many core? We also have a model of decentralising. It's not all at the big hospital. We really take it outside of the hospital to the community practices and to community pharmacies. I wanted to say across the table that I think we should do some work together

Senator MARIELLE SMITH: If you do, please share it with us because I could keep going for hours.

Prof. Matthews: It's part of a national training model that we're proposing. It would include pharmacists, it would include medical, it would include nurse practitioners et cetera. We think that's one of the ways to do multiple levels.

Senator MARIELLE SMITH: If you could come back to me on both of those questions and any future partnerships you form out of today, that would be appreciated.

CHAIR: Thanks, Senator Smith. It's wonderful to see a Senate inquiry bringing people together. I think you have now taken some questions on notice, so if you could—

Senator TYRRELL: I have some questions I'd like to put on notice for the Justice League over there, if that's okay.

CHAIR: Sorry, Senator Tyrrell.

Senator TYRRELL: No, that's perfectly cool. I think you're all the Justice League—Supermen and Superwomen especially. I'll send them to the secretariat. Is that all right? It's amazing to listen to you. I just give you all so much street cred for pushing through all the barriers.

Senator WATERS: Hear, hear!

CHAIR: So you definitely got some questions on notice, some of which will be provided to you. If you could get them back to us by the close of business on 5 May, it would be really appreciated. It is a short timetable, I

know, but that's what we're operating on. We're going to be reporting to the Senate on 11 May, which doesn't give us much time either. Thank you all for your contributions. It was really valuable for the committee.

Proceedings suspended from 11:05 to 11:22

BATESON, Professor Deborah, Associate Investigator, SPHERE; and Member, SPHERE Women's Sexual and Reproductive Health Coalition [by audio link]

HUTT, Ms Tracey, Chief Executive Officer, Family Planning Alliance Australia

CHAIR: Welcome. Do you have any comment to make on the capacity in which you appear?

Ms Hutt: Family Planning Alliance Australia are the member organisation for the International Planned Parenthood Federation.

CHAIR: Thank you very much. I now invite each of you to make a brief opening statement if you'd like to do so. After that, the committee members will almost certainly ask you some questions. We'll start off with Professor Bateson.

Prof. Bateson: SPHERE is a centre of research excellence in sexual and reproductive health for women in primary care, funded by the National Health and Medical Research Council. SPHERE's research program is focused on generating new evidence that will improve the quality, safety and capacity of primary healthcare services to achieve better sexual and reproductive health outcomes for women, particularly in the areas of abortion, contraception and preconception care. In 2020 SPHERE established the Women's Sexual and Reproductive Health Coalition, to give a strong collective voice to secure high-quality services for women across Australia. The SPHERE coalition is a cross-sectoral, multidisciplinary alliance comprising more than 150 clinician experts and consumers, representatives from a range of peak bodies and key stakeholder organisations, and eminent Australian and international researchers. Our members have collectively produced a series of evidence based consensus statements on relevant issues such as achieving access to effective contraception; equitable access to abortion care, particularly in regional, rural and remote Australia; reproductive coercion; and the implementation and monitoring of the National Women's Health Strategy.

SPHERE welcomes this opportunity to give evidence at this public hearing, as part of the Senate committee's inquiry into universal access to reproductive health care. As part of our submission, we've identified a set of five imperative actions to guide national leadership, investment and policy development for achieving universal access to reproductive health information, treatment and services that empower women with choice and control over decision-making about their bodies. These actions are:

1. Remove barriers to contraceptive access by providing free contraception and incentivising primary care health practitioner training in contraceptive service provision.

2. Ensure availability of essential sexual and reproductive health services (particularly for rural and regional Australian women) through regional level planning, training and accountability for contraception and abortion access via publicly funded community and hospital-based services.

3. Expand the health workforce by enabling nurses, midwives and pharmacists to work to their full scope of practice in contraception and abortion care, with appropriate remuneration and training opportunities.

4. Develop coordinated public health campaigns and related education materials to improve health literacy around rights and options for accessing effective contraception and abortion care.

5. Formally track progress on delivery of the outcomes of the National Women's Health Strategy by developing a transparent, comprehensive, nationally agreed implementation plan and key performance indicators, and report against these on an annual basis.

We call on the Senate committee to strongly consider these actions, developed through a process of consensus through our SPHERE coalition, that we believe are needed to address the critical barriers to cost and accessibility of contraceptives and abortion care, so that we can achieve equitable reproductive health outcomes for women across Australia.

Ms Hutt: I just want to say that we completely agree with all our colleagues and the academics that have been bringing information to you. Over the last 10 to 15 years, we've really struggled to find the appropriate funding streams to step into these gaps, which we would like to close. In fact, we've been subject to budget cuts over that time.

We'd like to offer you our reflections on the overarching policy environment that we feel is causing a significant disconnect in our ability, and the sector's, to respond. In terms of the organisations, in South Australia it's SHINE SA, which you would know in Queensland as True Relationships and Reproductive Health; in Tasmania it's Family Planning Tasmania; and there are similar organisations around Australia. When we experience budget cuts from the state, we get told: 'Primary care is not our responsibility. Go and talk to the Commonwealth.' Then we go to the primary healthcare networks and we get told: 'Terribly sorry; it's not a Commonwealth priority. It's not in our needs assessment.'

The National Women's Health Strategy has a really strong reproductive health theme, but only two states have responded with action plans or strategies in sexual and reproductive health. In actual fact, most of our members now, like SHINE, have been shimmied away from the National Women's Health Strategy and funded through the Communicable Disease Control Branch. That's a suite of five national STI and bloodborne virus strategies, and the most relevant to us, that we can find relevance in, is the national STI strategy. But that's a strategy that doesn't have women as a priority population and doesn't have any peaks around the table in the governance structure representing women or even representing young people.

Any GP can tell you that it's not either/or; it's both/and. When a young person comes into a clinic after having unprotected sex, we talk to them about STIs, about contraception, about unintended pregnancy, about whether or not what happened was consensual, about what their understanding of their own body is and whatever's going on for them, and about how they identify from an LGBTIQ perspective.

We've got one primary ask, out of all the beautiful evidence you've been presented with: we want the federal government to step up and create a national sexual and reproductive health strategy. That strategy would have programmatic commissioning of funding coming out of it. It would have an appropriate governance structure, a robust governance structure. It would have evidence based evaluation, and it would have the right peaks around the table to respond to it and advise into it. That's our one wish. But there's a second element within that: we'd like the Commonwealth to collaborate with the states and require them to develop state action plans as a response into that strategy. They would also need to organise themselves to do programmatic commissioning and have the right governance processes in place and the right evaluation.

There's a risk in asking for this because people think: 'Oh well, that's just another process. It's another committee. There's nothing going to happen now.' But that's not why we're asking for it. There'll be immediate gains that can be made out of the very complex information that's come to you. We're not saying, 'Bat it out to the strategy'; we're saying both/and develop a strategy. That's not just about the initiatives that will come out from this; it's about the last 100 years of progress we've made, and it's about following through with these initiatives so we can weather the changes in government that are inevitable and so we can stand up to the international pressures that are coming to us—and we all know they're coming. We want it so we can keep moving forward and so we can be stronger together.

CHAIR: Thanks very much. When you talk about 'international pressures', what do you mean?

Ms Hutt: I mean the international research that the Planned Parenthood Federation have been doing. Without sounding too nutty about Russian oligarchs and stuff—and I'm sure they've been lobbying you guys as well—it's the same money. Of the money that's being spent internationally trying to suppress our reproductive rights, 80 per cent is the same money that's going into drumming up climate change denial.

CHAIR: You're saying the pressures that are actually impacting upon reproductive health—

Ms Hutt: There's global political pressure, but in Australia we're quite vulnerable. When I speak to young women, they go: 'What do you mean? Of course abortion's legal.' My great-grandmother had 11 children, and that wasn't very many generations away. Our progress has been good but it's not guaranteed.

CHAIR: In terms of the budget cuts you're facing, can you expand on the level of those cuts for us. And, prior to those cuts, was your funding meeting the needs anyway—or was there a need for more funding to make sure there was equitable access?

Ms Hutt: That's not a really straightforward question. I think we're about $55 million or $60 million around Australia, in top line. I know of some data that's been put together that has gone right back in South Australia. My gut feel is that, over 10 to 15 years, we could have easily doubled that in value. That's the degree to which the data is coming out in South Australia.

CHAIR: You're saying over the—

Ms Hutt: If we had kept up with what we were supposed to be doing, with the original intent—we were commissioned in the seventies, as part of that women's movement—we could easily be double where we're at now. The question of 'Will that meet where we're at now?' is a good question. It would be a very good place to start.

CHAIR: Could you expand some more on that state-federal battle and what that's meant for inadequate funding and resources for your work.

Ms Hutt: There have been some positives out of it, which I'll mention first. It's driven a whole lot of integration in our services. That means that, for example, many of us now do clean needle programs, HIV prescribing, gender medicine and all sorts of things that come in that remit of sexual and reproductive health. But

the difficulty has been that we've never had a voice responding to those strategies. Yes, we'll get to see a copy of the national strategy, but we don't get a seat at the table. The FPAA doesn't have a seat at the table.

Sometimes—this happened about five years ago when I first came into the sector in one of the states—we are literally told: 'Oh, you don't need to mention contraception. Just talk about the STI testing in your KPI.' It took about five years. I kept on writing in other strategies, saying, 'This is what we're here for,' but they literally don't want to know because it's not in their policy remit.

So I guess what we're talking about is quite bold, because it would need some restructuring within the federal health department and in the state health departments if they don't already have that. If you look at Victoria, they have their strategy, but in Victoria it is still coming out of the Communicable Disease Control Branch. We said the other day: 'What's going on? Why don't you have a policy person?' Those bureaucrats are very valuable to us because they're very briefed in their topic area. When it works well, you're supporting each other to go to that next level of improvement. But, if you have policy people who only want to hear about 20 per cent of your work and for the rest of it you literally get told, 'You don't need to talk about that at the contract meetings,' the contracts don't speak to them properly. They will just mention the national STI and bloodborne virus strategy, and then they'll just mention, 'Oh, and you're doing a bit of doctor training for IUDs or something.'

CHAIR: Yes. Is there any state that's doing it better than the others, with a focus on women's health as a standalone area?

Ms Hutt: Possibly, but sexual and reproductive health isn't just a women's health issue. Part of my view is that, yes, it should be a strong theme in the Women's Health Strategy, but we are more than our reproductive systems, and there should be lots of health issues in that Women's Health Strategy.

CHAIR: Thank you. Professor Bateson, you talked strongly in your opening statement about the need for equity and equality of access. Have you done any assessment of how big the gap is currently?

Prof. Bateson: Yes, SPHERE has done analysis, and there have been various analyses about that gap and indeed the cost-effectiveness of contraception in filling those gaps. We have strong evidence about those gaps, particularly for rural and regional women, in access to abortion care and to long-acting reversible contraception. We know that the rate of unintended pregnancy is disproportionately higher amongst those women living in non-urban areas. So we've got a very strong evidence base to highlight those inequities, and we can look to other groups as well, such as culturally and linguistically diverse background women. At SPHERE we've got a big coalition. We know there's a large research remit across the country, and certainly the evidence base is there for those inequities.

CHAIR: Have you done any assessment of what extra funding would be required to address those inequities?

Prof. Bateson: I'd have to take that on notice. We have got those cost-benefit analyses. Certainly there's been work done looking at what would be the implications of funding nurses through the MBS to insert LARC, for instance—so IUDs and implants. We know that we're not using nurses to their full scope of practice, of course, and we've also delivered the evidence base to show that of course nurses—I'm a doctor and formerly the medical director of Family Planning New South Wales, and I work closely with nurses—are just as safe and effective at delivering LARC and inserting LARC methods. The cost-effectiveness analyses have been done around that, and we can certainly get back to you with other cost-effectiveness analyses in this area, because we know that that's vital for decision-making.

CHAIR: Thank you very much, Dr Bateson. That would be really good, if you could. Senator Smith.

Senator MARIELLE SMITH: I have a couple of questions around your suggestions for a national strategy. The two states which do have plans are Victoria and Queensland. I know you've mentioned that there are still challenges in Victoria, even with that plan in place, but can you speak to what the benefits of having that higher level strategy have been? Is that actually having an impact?

Ms Hutt: In the states, right now there's still a mixed response to that, but I look to those other major strategies that do have those robust governance structures in place to see the potential of what we could achieve if we did have a national strategy.

Senator MARIELLE SMITH: What is it about a national strategy that you think is going to get a better result?

Ms Hutt: It's what brings people together. It brings researchers together. It brings service providers together. It brings people with lived experience together. So that's what I mean by robust governance structures. If you look at things like MACBBVSTI, which is the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, the BBVS group, which is a subgroup of that, is all the service providers and lived

experience peaks. That's highly effective. That's been so effective that it's driven integrated services into the family planning movement, which hasn't been a bad thing, because, if you look globally, that's what people are calling for. They're calling for the family planning services to merge with the HIV services and vice versa, particularly in developing countries, where HIV is more of a heterosexual disease.

But it's also about the fact that, when you iterate those strategies, good bureaucrats will make sure that sometimes they just dovetail past the political cycle so they're not thrown away willy-nilly, like the Safe Schools program, for example. It gives people solid periods of time to plan what's going on, to do pieces of research and to pitch stuff up to Treasury so it becomes part of the budget cycle and it creates your governance structure in government as your funding and planning cycle. What I see in strategies that don't have that robust kind of structure is that they're not doing the same funding and planning cycles.

Senator MARIELLE SMITH: I'm just trying to understand the specific benefits of having that strategy at a Commonwealth level as opposed to pushing the states to have their own individual plans. Is it that leadership role that the Commonwealth takes?

Ms Hutt: Absolutely. It's because health happens at all levels of government. You've heard from your inquiry that health is very complex. Health is so complex. There's MBS, PBS; there are 21 different national strategies that, as an advocate, I'm supposed to be able to respond to, and that doesn't include the administrative environment—MBS, PBS, Therapeutic Goods, office for technology. It's because it's a complex environment.

And there's more than one player in the game. The states are providing underpinning core funding for our services, and the Commonwealth need to provide some as well. They do a bit, in terms of some MBS billing, but a lot of what we've talked about today are really complex problems, such as how we train more doctors to do IUD insertion. We know that they need clinical supervision, because any doctor is happy to prescribe or carry out procedures within their scope of practice, but it's about the confidence that they have in themselves and their scope of practice. You can deliver education to them or give them the legal rights to do it, but it doesn't make it happen, so you need to have developmental things in place, not just a fee-for-service, run-a-webinar sort of thing. For some of these things, there is no billing that you can bill anyone to do, but it's work that does need to be done on a developmental or capacity-building basis.

Senator MARIELLE SMITH: I think you mentioned before that you think the Commonwealth has similar governance models in place for other issues that it could draw on for this.

Prof. Bateson: Yes.

Senator MARIELLE SMITH: Could you just expand on that a little bit?

Prof. Bateson: Yes. Look at how successful the HIV strategy has been. We're on its eighth iteration, I think—the Eighth National HIV Strategy. That was a really powerful movement. There's a wonderful history book you can buy about how that movement was created. It was a movement that, like any good health movement, was created with the doctors, with the people living with it, with their families that loved them, and with the other health providers and community members around them. They all get together and they advocate for change. HIV has done that. Hepatitis has done that.

Part of what we learnt in Australia from that movement was that they created this structure that was really great. It's a discourse that happens across the community. You've got the Australasian Society for HIV Medicine, ASHM, which is now branching out to do more sexual and reproductive health. You've got AFAO, the Australian Federation of AIDS Organisations. You've got NAPWHA, which is the people living with it. Then you've got this series of strategies that get written. I think the Commonwealth usually sends them out to consultants to actually get written. Then all the states are aligned, so the national strategies come out. Probably not 100 per cent of the states align in the same way, but most of them do. They'll write a state action plan that responds to the national strategy, because there's reporting that goes between them. When the national strategy sets up a governance structure to monitor progress against that plan, so does the state. So the state is commissioning services like family planning services that are responding to this plan.

Senator MARIELLE SMITH: Thank you. That's really useful further explanation.

CHAIR: Senator Tyrrell, do you have any questions?

Senator TYRRELL: Yes, if I can. Professor Bateson, hello. I've taken a look at the graphic on page 70 of the submission, which displays abortion deserts across Australia. I'm keen to know more about Tasmania in particular, as well as maybe a little about the other states. Can you tell me about your research into services and gaps in Tasmania in particular?

Prof. Bateson: Yes. We've looked across Australia. You've seen that nice graphic, as you say. It has looked at the proportion of women where they're having to travel these deserts or where women are travelling more than 160 kilometres to access services. Things have obviously changed in Tasmania. We know there were previously a lot of women needing to travel outside the state—to Victoria, for instance—to access services. There have been significant gaps. So we've really got good data across all of the states and we keep a watching brief on that, because things change, of course. As you can see from that graph, there are gaps. Certainly medical abortion is provided, but again this hospital situation has been challenging. I believe that that's changed recently. I think Tasmania has actually caught up. Apologies, if I'm wrong, to the Tasmanians.

I think these abortion deserts are incredibly important. We know that only 10 per cent of the GP workforce actually supply medical abortion, and that's not often because of not wanting to; it's because sometimes the local public hospitals are not providing any sort of abortion care or support if women do need to present to a hospital. We certainly hear many terrible stories of people sometimes even being turned away from hospitals. Again, we're very happy to share that comprehensive abortion desert research with you.

Senator TYRRELL: That would be amazing. Thank you. I'd also like to ask some questions about data. You refer to a lot of figures in your submission, and I think it's very helpful, but I'm also wondering if this is the full picture. Firstly, would you agree it's difficult to get data about the provision of medical and surgical termination services? If so, can you explain or give an indication as to why this is?

Prof. Bateson: Yes. It's complicated. It's become a little bit easier with medical abortion because we can track prescriptions, but obviously there are gaps with that. We can't always tell where the woman's actually residing, of course. Certainly the telehealth services are very welcome, but that can present challenges with the data. So we're having to make assumptions, and that can be challenging.

With the surgical abortion data, there really are big challenges, because we rely on hospital data. There's obviously clinical data and then there's hospital data, and there's no disaggregation, for instance, of procedures for management of miscarriage. So it's really difficult to get that granularity that we need to be able to use data in the way we want to, look at where the gaps are and evaluate where we need to target services to. I come from New South Wales, where now, in the provision of medical abortion, there is mandatory data reporting, and it's the same across some states. But again it's inconsistent. It's patchy. I think we need to really look at how we can have consistent national data collection such as occurs in many other countries, including the US and the UK, because it's absolutely vital for shining a spotlight on those gaps, targeting services and identifying where the needs are for training. At the moment it's very difficult, as I say, to disaggregate, and we have to make many assumptions. South Australia has a good record, as does Western Australia, of good data collection, so sometimes we make extrapolations from those states. So I think data collection is a key ask and a key issue.

Senator TYRRELL: So basically better data, better collection and better services?

Prof. Bateson: Absolutely. We all run together.

Senator TYRRELL: What does the Family Planning Alliance think the federal government's role in improving physical access to family planning clinics should be? In Tassie we've only got three, and one of those is part time.

Ms Hutt: Sorry, just ask your question again.

Senator TYRRELL: What do you think the federal government's influence on access to family planning clinics should be or could be?

Ms Hutt: I guess it's to accept that we're part of the safety net. We exist where the health system fails. You talk about complex clients. Last time they closed a couple of clinics, I was working in South Australia, and I met with the health minister and he said, 'What do you mean by "complex client"?' I said: 'Well, three children in their pyjamas coming into our clinic. The eldest is 12, and she's pregnant.'

Senator TYRRELL: That's complicated.

Ms Hutt: That's complex. Don't tell me to go to the Commonwealth for the MBS billing for that. So I guess it's just accepting that we can have all these categories about who's in primary care, what's the definition of community care, hospital formulas, cross-border and all this kind of thing but that sometimes the health system's shape doesn't fit the individuals who need the care, and both levels of government need to step up. The states have provided this underpinning funding that's been shrinking. Yes, there's some MBS billing in there, but it's not enough, especially given the current environment that we're in. We know where all the gaps are, but there's just no stream for us. I just keep writing unsolicited bids, because there's no tender. There's no funding stream for them to hit. The national strategy provides a governance framework for the bureaucrats to be able to write their funding and planning frameworks and their proposals to Treasury to keep the money going in future years.

Senator TYRRELL: Thank you.

CHAIR: Senator Waters has just joined us.

Senator WATERS: Please accept my apologies for not being present for the entirety of your evidence. I was just speaking to the media about these very issues and conveying some of the great suggestions that both of your organisations have made in your submissions.

Ms Hutt: That's already implemented, is it?

Senator WATERS: Well, it's been strongly suggested. Let's say that. Firstly, can I start with the Family Planning Alliance. I acknowledge the real help that your state based bodies have provided to people for so many years. Thank you so very much for doing that work. We've heard some excellent evidence in the course of this inquiry from your—I don't know if we call them subsidiaries, but from your state—

Ms Hutt: Member organisations.

Senator WATERS: Member organisations. I just had a great meeting with the Queensland organisation, True, last week as well. So, firstly, thank you. Secondly, to SPHERE, I say the same thing. Your advocacy has just been incredible.

Prof. Bateson: Thank you.

Senator WATERS: Your expertise is really helping to shape our thinking on these issues.

In the minuscule amount of time we've got left, I might start first with Ms Hutt. You've recommended streamlining TGA approval processes to allow a broader choice of contraception options to be available in Australia. We heard earlier there's only about half the pill available and the copper IUDs aren't listed. It's a litany of errors. How could the process be improved? We've got the TGA coming later this afternoon. What do you think we should ask them?

Ms Hutt: I'd have to get back to you with the detail on that—unless Deb, who's online, wants to chime in.

Prof. Bateson: Yes. I can add, if that's all right with everyone. It's true that we know that many women in Australia are using non-PBS listed pills and that copper IUDs are very valuable for people who can't use, or don't want to use, hormones. The copper IUD is a device. I know there are challenges around that, but, in terms of the non-PBS listed pills, I think there are approaches that could be taken—not necessarily open access for everyone to access a subsidy, but certainly for women who need these particular pills because they've got very bad acne, hirsutism or polycystic ovary syndrome. We hear stories of women who've tried every different possible pill and the only ones that work are the expensive ones and they just cannot afford them, so there are real inequities. I think there's potential for the TGA to look at ways—which I believe happens with other medications—where if certain conditions are met then there could be that subsidy. So that's one thing to think about.

Senator WATERS: Thank you. I read your supplementary submission coming in on the plane last night and was reminded that the pill used to be a dollar a month and that was made so by federal intervention.

Ms Hutt: Yes. It became a dollar a month.

Senator WATERS: Is it your view that, given that it's been done before, it could readily be done again to make contraception free or at least more affordable?

Prof. Bateson: Yes.

Ms Hutt: Of course it can. If the mechanisms are in place to charge people for it, the mechanism is there to type 'zero' into the price.

Prof. Bateson: If I can interject, you're right. It was a key ask of our SPHERE submission. We know, for instance, that British Columbia in Canada has just made contraceptives free. It's not just the pill and not just your IUD. It's actually the cost for inserting an IUD, because we know that that can be a big barrier—inserting an implant. I think it's broader than that. But we know that there is a movement in other countries. In France and the UK, of course, it's always been that situation. I really do think it's something we should seriously consider.

Senator WATERS: Yes. Thank you. Well, I'm glad, because I just told the TV cameras exactly that as well.

Ms Hutt: I just want to reiterate what this person was talking about, about international students and Medicare ineligibility. That's a huge issue.

Senator WATERS: Yes. Dr Murdolo, I thought emphasised that beautifully, and we've taken quite a bit of evidence about that, including the cost. You just add an extra 0, basically, if you don't have Medicare access. We've got Dr Bateson online. I've had some useful discussions with your chair, Danielle Mazza. I know she can't be here today, but kudos to her generally. I know that Professor Mazza has said previously that extending MBS numbers is not enough to solve the problem that there's a real workforce shortage.

Prof. Bateson: Yes.

Senator WATERS: We know that is a broader healthcare issue as well as just a reproductive healthcare issue. What do you think can be done to increase the sexual and reproductive healthcare workforce?

Prof. Bateson: Yes, I think there are a few key areas. Firstly, with GPs and other doctors, we know that people want to acquire the skills, particularly to put in IUDs as well as implants, but certainly the training can be very expensive. It can take time, and we need to think about how that can be funded. In particular, I think we need to look to the PHNs to do what they do best, which is to look at the needs analysis of their populations to see where the needs are for having inserters of IUDs. Possibly we can borrow from other areas of health where there are scholarships, for instance, to fund people to have that training. The other key thing is to ensure it's embedded within all medical schools and nursing schools.

The other area is to use nurses and midwives to their full scope of practice. We've done some work on nurses inserting implants immediately postpartum before women leave hospital, and that again can be scaled up. We know nurses are very safe and effective in inserting IUDs, but there's a lack of remuneration for that pathway, which means that in those areas in the country where there are nurses available but there is no-one to put in IUDs women have to travel long distances to get them. We need to focus on training, and wherever we're setting up services, whether that's in hospitals or in community services—we can think about the new endometriosis clinics where they're going to be using IUDs for managing endometriosis—we can use those as training centres. We must always ensure that we are optimising training to build the capacity of the workforce.

Ms Hutt: To build on that, we've seen that family planning organisations have been the primary provider of training on IUD insertion, Impanon insertion, training people how to do cervical screens and even the pregnancy options training. In some states we're the only provider of things like that, so, if we go, you don't want there to be no training. In South Australia they're the trainers for the public hospital people that deliver that pregnancy advisory centre. They're fairly fragile systems, and when you're under pressure then the question is: what do you close? As a training organisation, you hope to centralise pretty much, and that's why you end up with no services in regional and remote. You have to have a critical patient population and be convenient for specialist doctors, so you withdraw into the city to protect your training piece because, without that, what have we got?

That's why they go hand-in-hand. You have to have the clinic to do the workforce development because, in some states, we're the only provider of the in-clinic training for sexual health nurses to become qualified and to have placements for Aboriginal health practitioners and that kind of thing. Because it's more than the public sexual health services, often the public sexual health outpatient clinic is about SDIs. They might do emergency contraception, but then they refer patients to the family planning clinic. Family planning clinics exist to get patients referred by GPs because they're complex patients. It's not just about people not coming forward to go to their GPs, if that makes sense.

Senator WATERS: Is your funding secure? What is the state-federal breakdown of that?

Ms Hutt: No, they're different in every state. I can give you that information perhaps on notice.

Senator WATERS: Thank you.

CHAIR: As Ms Hutt said at the beginning, they're facing budget cuts in the face of increasing demand and need. Thank you, Ms Hutt and Professor Bateson, for your evidence today. You took a couple of questions on notice, so please get your answers to us by close of business 5 May. We're going to be reporting to the Senate on 11 May.

CAMPBELL, Mrs Nikki, Endometriosis Nurse Coordinator, Epworth Healthcare

McNAMARA, Ms Michelle, Chair, Advocacy Board Committee, Transgender Victoria

MOONEY, Dr Samantha, Interim Director, Julia Argyrou Endometriosis Centre at Epworth; and Obstetrician and Gynaecologist, Epworth Healthcare

[12:04]

CHAIR: I now welcome representatives from the Julia Argyrou Endometriosis Centre and Transgender Victoria. Thank you for appearing before the committee today. Would anyone like to add anything about the capacity in which they appear?

Ms McNamara: I'm also the treasurer for Transgender Victoria.

CHAIR: Thank you. I invite both organisations to make a short opening statement, and after that we'll almost certainly ask you some questions.

Mrs Campbell: Thank you for this opportunity to contribute an important perspective on endometriosis care within Australia. Whilst I sit here today with my clinician hat on, it would be impossible for me not to acknowledge that I also carry significant lived experience in this space, having navigated the Australian reproductive healthcare setting for the last eight years for management of endometriosis, chronic pelvic pain and infertility. I'm proud yet somewhat dismayed to say that I'm the first dedicated endometriosis nurse in Australia. I'm dismayed, because how can there only be one dedicated nurse for this condition that affects as many of our population as asthma and cardiovascular disease do and twice as many as diabetes does? And yet we see dedicated nursing support in all tertiary hospitals in Australia to manage those conditions.

Endometriosis is a chronic, complex, systemic inflammatory condition, which commonly affects the reproductive organs. However, it also affects extra pelvic areas and has been found in every organ of the body. Management therefore requires a whole-body approach and is confined to neither the gynaecology team nor the reproductive healthcare space. Effective management relies on interdisciplinary care from other specialities, including colorectal, urologic, cardiothoracic and specialist pain medicine, as well as allied health, including pelvic physiotherapy, dietetics and psychological support. I could go on and on. There are currently no Medicare rebates for nursing in the endometriosis space, and there's very limited access to public services. Further, the current chronic disease management model is insufficient to support patients requiring ongoing multidisciplinary care in the community.

As it's historically been a gendered disease, we do not have good data on the experiences of non-female identifying patients with endometriosis, including cis males. Models of care are essentially insensitive and often inappropriate to the needs of endometriosis sufferers who don't identify as women, and it's not uncommon for these patients to present with a history of healthcare trauma. Traditional endometriosis care pathways, where patients must navigate various gendered multidisciplinary services, may be triggering for this cohort. Mandatory gender sensitivity training for all healthcare professionals is essential to address the prejudice, inappropriate treatment, trauma and fear experienced by this patient group. Endometriosis care in all instances should be provided within a gender affirming environment that encompasses gender affirming care.

Ms McNamara: First, I'd like to acknowledge the traditional owners of the land on which we meet, the Wurundjeri people of the Kulin nation, and pay my respects to their elders past and present and to any First Nations people who may be here or listening today. I'd particularly like to acknowledge sistergirls and brotherboys, the traditional transgender people of the Aboriginal nations, and recognise their unique contribution to gender diversity across and through this land across millennia. Thanks for the opportunity to talk today. Not only do I represent TGV; I'm also speaking on behalf of Jeremy Wiggins, who's the CEO of Transcend Australia and a proud transgender man. When talking about it today, I'll use the term 'trans and gender diverse', but that does include non-binary people and other forms of non-traditional gender expression, if you could note that, please.

Trans and gender-diverse, or TGD, people suffer from a condition called gender incongruence. Gender incongruence is simply feeling uncomfortable with the gender you were assigned at birth and wanting to live in a gender other than that gender. I was assigned male at birth and I'm actually a transgender woman. I'm out and proud and feel much more comfortable presenting as a woman than as a man. The WHO International Classification of Diseases defines gender incongruence as a condition of sexual health, and that is why I'm appearing before you today. Destigmatising gender incongruence was a key point in the decision to move gender incongruence from the conditions of mental health into the conditions of sexual health. The stigma of having it as a condition of mental health was creating enormous pressures in the trans and gender-diverse community. The

ICD recognises that trans and gender-diverse people suffer from disproportionate burdens of poor health, including mental and physical health, and that access to all health care, not just gender affirming health care, is fraught.

I know the Australian community is suffering extreme difficulty with access to health care at the moment. Largely, it was a fragile system to start with. Pandemic pushed it over the edge. However, pre pandemic, trans and gender-diverse people were suffering extreme difficulty in accessing health care, and there's a lot of evidence about that in the submission and in the references used in the submission. All I can say to the Australian community is: welcome to the trans and gender-diverse people's world.

There were three recommendations that we put in the report. I think the most important is to create a trans and gender-diverse health strategy. Trans and gender-diverse people simply can't be encapsulated in women's and health strategies. I have a prostate and I'm a woman. I get sent to a male ward and get treated by male nurses when I need some treatment for that prostate condition. There are many other examples of that in the submission.

My next task is to go and prepare a submission to the Australian Bureau of Statistics on the 2026 census to get trans and gender-diverse people counted in the census. There was a failed attempt in 2016 and a failed attempt in 2021. Senator Rice knows as a result of her questions in the Senate that it was a result of political interference. From my perspective, looking at the anecdotal evidence of all the trans and gender-diverse health clinics, there's an exponentially increasing number of referrals to them. In the US from 2016 to 2022, the numbers have gone from two per cent of the population amongst young people to five per cent of the population. That sort of increase is absolutely critical, especially when you consider that more than half of them have attempted suicide at some stage in their life, 80 per cent of them health harm and there are a whole lot of other negative medical outcomes.

We were talking before about the crisis in HIV, the need for a national strategy for HIV and how that solved it. I think the ABC series *In Our Blood* recently addressed that. I recommend watching it. Even though it's fictional, it is based on fact, and it was very evocative to me. I worked in the HIV area at the time of the crisis.

I don't think it's hyperbolic to suggest that there's a looming crisis within the trans and gender-diverse community because of the adverse effects on the health care, the self-harm and the suicide attempts. It's a real comparison to rival the effect of HIV on the gay community. I will leave it at that from the point of view of talking about it. I could talk for hours.

CHAIR: Thank you for all of your wonderful advocacy in the space. Senator Waters, did you want to start us off?

Senator WATERS: Thank you all for being here. Ms Campbell, you're the only endo nurse in the entire country. Hopefully, you are the first of many, but that's quite a shocking statistic. The ABC reported last week about really poor wait times for specialist appointments, which were even worse in rural and regional areas. In your experience, how long have some patients been waiting for an endo diagnosis and treatment plan?

Mrs Campbell: The average time to diagnosis in Australia is about seven years. Because we're in a private service, many people actually come to my clinic as a first point of contact because they've been sitting on a public waiting list for coming up to 12 months. Dr Mooney will be able to comment, but, once they've seen the specialist, the further wait time to receive surgery to actually have a confirmed diagnosis of endometriosis will probably be that number again.

Dr Mooney: As both of the other speakers have commented, things have been compounded by the COVID pandemic. We sat in limbo for 24 months, not being able to operate on anyone with what we would term a category 3 problem. Anything that wasn't cancerous and wasn't causing life-threatening bleeding got put to the bottom of a pile.

Senator WATERS: That was despite the pain.

Dr Mooney: It was despite pain and despite fertility. Fertility would sometimes get people up a little bit if you were subfertile and of an age where it was becoming threatening to ever being able to have a child, but otherwise they sat. Unfortunately, because of the strain on the public system, they sat unmanaged. There's a lot we can do while waiting for surgery, but, if someone can't access the clinic appointment for that, they're not only not diagnosed; they're unmanaged. We're talking about one in nine Australians assigned female at birth being diagnosed with endometriosis in their lifetime, but more than one in five will suffer chronic pelvic pain. Half of all people assigned female at birth will have a period in their life where they suffer pain below the navel for more than six months of their life that interferes with their life.

Due to numerous barriers—health literacy, societal paradigms, quality of diagnostics, education of our young people, finances and geography—all of those limitations we have in a in a large country with a comparatively good but still limited health system—those patients don't can't seek help early or we can't provide it early. In one

of our major tertiary hospitals in Melbourne, the wait time to get to a public outpatient Medicare funded appointment is three years. If you didn't have a chronic problem when you were referred, you'll have it by the time you get there.

Senator WATERS: That's horrific. Are there any other conditions where the wait time is that long, or is it just reserved for women?

Dr Mooney: It's a good question. I think all public-sector—so similar for colonoscopy screening wait times—are upwards of two years now. But this is the condition of people born female. That is the plight of what we're facing now. One in five—20 per cent—of patients have pain that is unmanaged. If you are in the, thankfully, minority of endometriosis with the severe form of the disease—about 10 per cent of patients with endometriosis will have a surgically severe form of the disease—their referral path may look like three years to get to a clinic that then books you. They've done an ultrasound that hasn't diagnosed the severity, so they think they can manage it in a regional or a secondary setting. You wait two years to have your operation, for the surgeon to go in and say, 'I can't operate on this level of disease. I'll refer you to the tertiary hospital,' and you'll wait another two years to get to the tertiary hospital. Then you've got to wait for the bowel surgeon. This could be an eight-year journey for a person, and that's in a prime of her life, where they're unable to keep regular appointments, they're unable to maintain relationships and finance are a struggle? This is across the public—

Senator WATERS: Sounds like systemic sexism to me. Were you about to say something, Mrs Campbell?

Mrs Campbell: I was agreeing.

Senator WATERS: What are the policy solutions for this?

Dr Mooney: There are a couple of things that we've touched on. Endometriosis is known to be associated with more than a dozen other chronic health conditions, and most of those are in the pain spectrum. The longer that a person suffers the symptoms of endometriosis, the more likely they are to have received additional diagnoses. These are chronic fatigue, fibromyalgia, migraines and bladder pain. Early access to multidisciplinary and interdisciplinary care allows the incorporation of general practitioners, nursing, school teachers—redoing policy that looks at assisting the 16-year-old with heavy menstrual bleeding and pelvic pain so that they don't become the 26-year-old who is incapacitated by those symptoms. I think the federal government has a role in ensuring that people are adequately trained in the coordination of their care.

Now, in researching for this panel today, we have the National Diabetes Services Scheme, which is a coordinated scheme that allows patients to register as having a diagnosis of diabetes. They then have access to nurse practitioners, access to diabetes monitoring, access to preventative health care steps such as eyesight checks and foot checks, and an ability to really coordinate that multidisciplinary care that we know is helpful for diabetes. We also know that's helpful in the endometriosis space at large.

Mrs Campbell: [Inaudible] access as well.

Senator WATERS: So the model works and it should be—

Dr Mooney: The model works for other chronic diseases. It needs to be adapted to the reproductive healthcare sphere.

Mrs Campbell: As a side note to speaking of a 16-year-old who presents with endometriosis symptoms: I've had three patients in the last two weeks who've come to me, who have been seen at a children's hospital and who've been told they're too young to have endometriosis.

Senator WATERS: Oh no.

Mrs Campbell: You don't get endo when you turn 18.

Dr Mooney: There is federal policy too. I listened in on the last part of the earlier section, and I think this came up in Michelle's talk. An overhaul of the PBS is required for reproductive health care. We use medications that were designed as contraceptives, but we use these in the endometriosis sphere to suppress menstrual periods. Menstruation is a trauma to tissues. It's an inflammatory signal. Yes, it's natural. It's only natural if you're wanting to have a baby. It's otherwise painful, and it stops you doing what you want to do. But we've got nine progestins through the TGA at the moment. Only two of those are covered by the PBS, so that equates to a very limited number of pills that are suitable financially to the majority of our patients. When they're on the PBS, they cost next to nothing; otherwise we're looking at a dollar a day for menstrual suppression, and this is a chronic condition. Menstruation will be with you from the age of 11 to the age of 52, and if you're being asked to pay a dollar a day for what seems like a basic healthcare right—

Mrs Campbell: And those patients won't just be on that one medication; they'll be on multiple medications.

Dr Mooney: I think that the overhaul of the PBS, as one of the doctors in the previous talk said, doesn't need necessarily need to be widespread open access straightaway; what it needs to be is having a look at just rejigging those medications and what you can access when you have certain side effects that we would call first line. We also use medications such as Zoladex or Synarel, which are suppressive at the level of the brain, to suppress the gonadotropins that then cause oestrogen and progesterone to be released from the ovaries. Endometriosis, a chronic condition, can be with you for your reproductive lifespan. We get six months on the PBS.

Senator WATERS: Why did they put that time limit in?

Dr Mooney: I think it was because we used to think we could cure everything by surgery, so you would put someone on a suppressive while awaiting surgery. But we're fast learning that, whilst the surgery does have an impact for certain patients, that inability to keep someone on a treatment that is working and, God forbid, potentially even avoid an operation—I probably shouldn't say that in the Senate, sorry—for some people is life changing. They might avoid an operation that could render them with a stoma or a bag sitting on the outside of their tummy for life and chronic pain as a result of extensive dissection, so there are benefits to some of those medications in long-term treatment and arguably cheaper treatment than quite complex surgery that someone might wait eight years to get.

Mrs Campbell: I had a telehealth yesterday with a young woman, a 25-year-old, who's had two surgeries already. She was getting her last Zoladex injection yesterday, and she said to me, 'What am I going to do in four weeks when it runs out?' She had such excellent symptom relief. Whether she can get it off label is to be seen.

Senator WATERS: Thank you; that was very weighty. Michelle McNamara, I've got a couple of questions for you, but I'm sure there'll be others that have questions for both as well. Can you talk about any difficulties gender-diverse people with a uterus experience when accessing sexual and reproductive health care? You've already given voice to it in your opening statement, but here's a chance to elaborate.

Ms McNamara: Appendix B of my submission covers quite a bit of that, and there's a very large report called *TRANScending* about TGD people's access to health care in general and cancer care in particular. Going back to my initial statement, because gender incongruence itself is a condition of sexual health, anything that helps alleviate that is a treatment for sexual health. Things you might not regard as treatments for sexual health, such as legal support for identity documents, by the definition of the ICD become treatments for a sexual health condition, and that's quite different and extraordinary in a women's health context. The barriers are largely that the health system is overwhelmed by the exponential rise, totally unpredicted, because we don't actually count the number of trans and gender-diverse people. If we get to the situation which seems to be happening in the US, where we've got five per cent of the population, again, as a comparator, we'll be rivalling diabetes in terms of conditions.

Gender incongruence is not just some simple discomfort; it leads to life-threatening conditions. It's a life-threatening condition that needs support. The support is given by helping support social transition, by supporting legal transition and by supporting gender-affirming transitions, which include access to hormones, and there are important tweaks to that. There's been a reduction in the number of testosterone treatments available on the PBS, for example, in recent years. We lost an important one due to Bayer wanting to withdraw. The TGA could have objected to Bayer wanting to withdraw, because they still make the product; they just didn't feel they were getting enough money for it in Australia. That's my interpretation. It may be true. It's worthy of investigation, I believe.

It's access to those hormones and then it's access to surgery, something everybody always talks about when you talk about trans and gender-diverse people. I've sat in this room in a consultation with an expert group of surgeons from Spain, and they don't do gender-affirmation surgery; they do facial feminisation surgery, and that was the first surgical intervention I sought a consultation about. It wasn't down there; it was up here, because I don't go flashing my genitals at everybody, but I do show my face everywhere and when I'm on the tram I want to be read as a woman, quite simply. Fortunately, I made the decision not to do it. It's very expensive. But a lot of trans and gender-diverse people in Melbourne and in Australia generally do go to Spain for it, and it can be life changing for some of them, who are very have strong jaws, strong male features, a big frontal brow and so on. For them it's life changing because they go away being read as a male and come back being read as female, and that's quite an extraordinary kind of change.

It could be something like voice training too. La Trobe Communication Clinic runs voice feminisation therapies. My voice sounds very deep. I went into the clinic with this pitch and came out of the clinic with this pitch. What changed was the voice resonance, so my voice is read as much more androgynous now. But it's really hard to get access to speech pathologists outside of that clinic. Just to go back to gender-affirmation surgery, sorry I got sidetracked, Senator—

Senator WATERS: No, that was a fascinating sidetrack.

Ms McNamara: I quoted a book in there. It's referenced, Noah Riseman's *A History of Trans Health Care in Australia*. In it he quotes, at the foundation of what was then called Medibank, there was an inquiry to see whether gender-affirmation surgery should be included as an MBS listing, and the conclusion was made that, because it required expert intervention and some multidisciplinary approach, it was best done in publicly funded clinics. That's a very noble idea; it's just that none of those publicly funded clinics ever eventuated. The Monash Health Gender Clinic is primarily social and psychological support for trans and gender-diverse people, and it has a small amount of funding from the state government, which allows it to do some publicly funded surgery at Monash every year. But apart from that I'm not aware of any publicly funded gender-affirmation surgery, and it's certainly never been listed on the MBS.

I know ACON and Teddy Cook in New South Wales—he may have given evidence to this committee; I'm not aware of it—are considering making a submission to the MBS to have it listed as a treatment. But it's prohibitively expensive, so first he's got to start by making a submission to absolve us from the cost of making the submission. I think it's a disgrace, because gender-affirmation surgery treatments are not cosmetic. Let me emphasise that. They're life affirming and in some cases they're life saving, because the rates of suicide attempts and the rates of actual suicide go down enormously. People's satisfaction of life increases enormously after they've had that. This is a complex area, sorry, but not everybody who is trans and gender-diverse will seek surgery at all. Not all of them will seek hormones. Some of them will just socially transition. But the reality is that, for those who need it, it can be life saving.

Senator WATERS: Thank you; that's wonderful.

Ms McNamara: I did warn you at the end of my opening remarks that, if I get on a roll, I can talk.

Senator MARIELLE SMITH: Just while we're with you, I have a question, and I think I know the answer from your opening statement, around how we improve services and whether specialist models of care are better than increasing training and improving the quality and relevance of services in generalist and mainstream care.

Ms McNamara: I commented on that. I think the Victorian experience is interesting in that regard, and I referred to that in my submission, Senator. There was a private company, Australian Healthcare Associates, which was employed to do it. They did a wide consultation across healthcare providers and the trans and gender-diverse community. I gave evidence to them on this on this matter. What came out of that was some mainstreaming and a centre-of-excellence model. They started implementing that in 2019, then the pandemic hit and really disrupted everything. We're finding it hard to access GPs. Post pandemic, if I can loosely use that word—it's post pandemic from a political perspective but not from a reality—

Senator MARIELLE SMITH: We appreciate what you mean.

Ms McNamara: Sorry, I stumbled into that. I was having discussions with Ada Cheung from Trans Health Research group about submissions to Minister Kearney's initiative in this LGBTI health area supporting sexual orientation and gender diversity models of delivery of health care, and I'm quite entranced by Ada's model, which at the moment is in formation, so I apologise to her for talking about it. Essentially, she's got a model where GPs can call a friend. They can call on an endo. Because she's an endocrinologist, she's talking about the supply of hormones, which is a big initial barrier when you're meeting the gender-affirming healthcare situation. I think that dual model of having a primary healthcare worker, be they a nurse or be they a GP, consult with an endocrinologist and get guidance in very routine cases, is no more complex, really, than prescribing the pill, basically, for a transgender woman like me. I take Progynova, and once we've established a baseline of hormones it's a very simple prescription.

I've been quite entranced by the Queensland model for simplifying the healthcare system and that pharmacists in Queensland can now issue scripts or renew scripts for Progynova without any reference to the initial issuing GP. That's cut one healthcare professional out of the system entirely in those cases where reissuing a script is very simple, and that's a valuable model too. I know it's controversial and the AMA does not like it, but that's the reality in Queensland. Women can access Progynova renewals from the pharmacist without reference to a GP. I would advocate that a great model for trans and gender-diverse people, the affirmed male-at-birth ones who want it, is to adopt that system.

There are lots of things you can do. That's for the simple cases, but there's a lot of complexity—in neurodiversity, in culturally and linguistically diverse communities, in Aboriginal and Torres Strait Islander communities, in people with physical disabilities and other physical health conditions—around treating them, and for those sorts of situations you really need that kind of centre of excellence or the phone-a-friend situation, where the GP has a relationship with an endocrinologist and they're in a community of care for the person involved.

Senator MARIELLE SMITH: Thank you; that's really helpful.

Ms McNamara: I spat out quite a bit there. I must say in the mental health area in Victoria there's a situation where the immediate past director of the Monash gender clinic, named Fintan Hart, and Jaco Erasmus, who's the current director, have had a scheme, and I'm not sure whether it's still running, where psychologists who see trans and gender-diverse people can essentially do that, phone a friend. So, where they've got a complex situation arising with a trans and gender diverse patient, they can ring Jaco or Fintan and ask for their advice and get expert guidance.

Senator MARIELLE SMITH: Thank you. That's very valuable.

I just want to come back to Epworth Healthcare now. I'll start by thanking you for your advocacy. I think, of all the issues we've seen in women's health where women's voices have been dismissed and ignored and their lived experiences dismissed and ignored, endometriosis care must be one of the worst in recent years. Because of that advocacy, we've seen quite a significant amount of change in the approach from practitioners and government as well. So I want to start by acknowledging all the work that went into that.

Mrs Campbell, in terms of your experience as Australia's only specialist nurse, might be helpful for us for you to explain why it is important to have that specialist care in nursing. It gets spoken about a lot in terms of medical practitioners at the GP and the surgical level, but why does it matter in nursing?

Mrs Campbell: As mentioned in the opening, because endometriosis is a whole-body disease and it requires multi-disciplinary management where you might have upwards of three, four, five different practitioners involved in your care, navigating that in and of itself can be one of the biggest barriers to patients. Patients will present to their clinic and say: 'I've got all these symptoms, but I don't know what to do. I don't know where to go. I've seen my GP, and they've popped me on the pill, but I've not really improved.' We figure out what the next steps from that are. As mentioned, if you've got the significant wait time to see a gynaecologist, so you can manage yourself in other ways whilst waiting to receive that care, whether that's medical or surgical. Knowing the right people to contact for that can be one of the barriers.

Every single day at my clinic I ask people about their bowel, bladder and sexual symptoms, and in the vast majority—about 70 per cent—coexisting with endometriosis have pelvic floor muscle dysfunction. People will say to me: 'I've had my surgery. I'm on the pill; I don't get a period. But I've still got these horrible pains.' And I'm like, 'That's your pelvic floor.' Had they never had that assessed or brought to their attention, they would have continued to live with those symptoms, and it's easy enough for me to ask a couple of questions and say: 'I think that's your pelvic floor muscles. Let's get you along to a specialist physio. They can do an assessment and give you some exercises.' That improves their quality of life significantly. But without that education they can't access that.

Very broadly: accessing education, ongoing support and care navigation are really huge and essential. I think the really unique thing about our clinic is because it's (1) free, and (2) doesn't require, therefore, a Medicare referral, patients can self-refer to me. For example, these young women who I've seen recently don't need a GP referral to come and see me, to then say: 'These are the people you need to see. This is my suggested plan, within my scope of practice, of course.' And I can write that in a letter to Dr Mooney or whoever of my colleagues and back to their GP and say: 'Based on my assessment of their symptoms, I would suggest X, Y and Z. I would be most grateful for your assistance in providing referrals to these clinicians, supporting them to get on a chronic disease management plan.' We might liaise regarding some initial prescribing to get them, maybe, on a more targeted hormonal contraceptive pill before they even see the gynaecologist. So it's speeding up access, in that sense.

Ideally, I would be a nurse practitioner, and maybe that's to come in the next few years. Even within that scope I could say: 'Here's your referral to the doctor. I'm going to start you on this pill for now. I'm going to get you on a chronic disease management plan. I'm going to send you for a high-quality pelvic ultrasound.' By the time you see the specialist, you're a third or half of the way there, and they can see and assess how that's working for you.

Would you add anything?

Dr Mooney: I think it's paramount. This is where chronic disease management has gone for so many other conditions. Nicky's role in our organisation—it's Nicky and the patient and all of us feed off, if you want to think of it as a diagram. I would love to see a day where public and private hospitals all have endometriosis nurse specialists and practitioners. That ability of referralship and prescribership will hopefully come within the scope of the nursing practice. That ability is a specialist to assess a patient—Nicky will write a two-page long referral letter highlighting an hour-long consult with a patient. That is invaluable. It's also empowering for the patient, because a lot of the endometriosis symptomatology requires education, and that's education that is time-

consuming but vital. That pain science, that autonomy for the patient, that education, is a massive role for nursing, and it's a great and passionate role for nurses to take on in the women's health sphere.

Mrs Campbell: The majority of the care for endometriosis is primary care, because it's a lifelong condition, so expecting that to sit with the GPs is actually a very big ask, because they are not specialists in endometriosis. Having this hybrid model where they can access a nurse specialist for whom this is all they do, day in and day out, and they know all the local providers of all the multidisciplinary services and can look up someone local for you et cetera—I see it as an adjunct to the GP role. I work in very closely with the GPs. I'll be in contact with them about symptoms. It's not a subtraction from the GP role; it's an addition, and it means people just get that higher-level or more specialised care for their needs. It means working alongside the GP, rather than expecting the GP to be experienced in every single thing, which we know they can't be. But, in something this prevalent, we really need that additional access.

Senator MARIELLE SMITH: You'd be aware of the Commonwealth government's announcement to open 20 specialist endometriosis and pelvic care clinics. What's your perspective on that model and those new clinics?

Mrs Campbell: I don't know how they're going to staff them. That's my biggest concern. I don't know who the clinicians are who will be working in that role. There is inter-clinician variability in terms of their approach to care, their models of care. Within our centre, we're very much aligned in our approach to how we manage patients and the broader management of chronic pelvic pain and what that means in terms of central sensitivity, and not just purely focusing on surgical management or hormonal management but looking at that whole-body approach, a biopsychosocial approach, to managing pain as well. My concerns would be that there will be a lot of variability between the clinics and that they may have very different models between them. At the same time, of course, we have to express our thanks and gratefulness that there are these services which didn't even exist 12 months ago. It is a huge step forward, but, as I mentioned in my opening, I worked in the public sector for my whole career until this job, and I always had an asthma nurse that I could page on the ward, and I always had a cardiac nurse, a diabetes nurse, who were specialists in that, in every single hospital in Australia and New Zealand, where I'm from. To be the only one is quite daunting, as my referral list grows longer and longer and I can only service patients who are seeing clinicians.

Senator MARIELLE SMITH: I think the objective of these clinics is to be interdisciplinary and have nurse practitioners and specialist nurses within them, so hopefully, when they get online and we get through the workforce issues, you won't be alone.

Mrs Campbell: Yes. I hope that they will become experts within endometriosis and pelvic pain. It's difficult to translate directly from primary care into this sphere. My background was actually in palliative care before this role.

Senator TYRRELL: I have some questions that are very Tasmania-specific, because I know that we have services in Tasmania for your speciality but they're probably not as resourced. I know that they would access you a lot. Would that be fair to say?

Mrs Campbell: They do, yes.

Dr Mooney: We would receive referrals to Melbourne from Tasmania, which obviously at a geographical level is quite an undertaking for the patients themselves.

Senator TYRRELL: We do share the same area code apparently.

Dr Mooney: I think there's one of the new specialist clinics in Tasmania, so again it's geographically tricky, but there are also only two in South Australia and one in ACT. I understand, at a governmental level, that decision-making, but I think Tasmania is quite a tricky spot to resource adequately, due to the geography. I would hope that these clinics allow an ability to improve our diagnostics, improve our screening. We don't have a diagnostic test for endometriosis. We have the ability to do an ultrasound, but one ultrasound doesn't necessarily equal a good ultrasound. That's also where Tasmania are particularly lacking—and this is not any take on anyone—in their ability to do quality diagnostic ultrasound. The people who do our endometriosis scanning have been doing this for over 20 years and only scan female pelvises. The request to ask someone who scans people's brains, kidneys, spleens and every other organ of the body—

Senator TYRRELL: It's a whole different world, isn't it?

Dr Mooney: It's a totally different world. It's a real-time ultrasound. It's an ultrasound done communicating with the patient that you're scanning, and it's very different to all other scans. We're incredibly happy that there's now federal funding for MRI, but, again, they're complementary. We've researched it. MRI doesn't necessarily outperform an ultrasound; it's complementary, and it's for a specific group of patients. Again, the MRI is only as good as the person reading the MRI. Until we can have a blood test—I know the media got all excited because

they thought we had a blood test in France; we don't yet—that can tell us what's going on, I think those pathways, particularly for the geographically remote groups—and I'll put Tasmania in there only because they don't have the endoscopic surgery—

Senator TYRRELL: And we're rural and regional, completely.

Dr Mooney: That referral pathway for someone, if we can't yet diagnose them to know where they need to be managed, is really tricky.

Mrs Campbell: We should mention that the MBS rebate for a male pelvis is higher than for a female pelvis ultrasound.

Unidentified speaker: And a lot easier. Fewer organs.

Mrs Campbell: The female pelvis is much more complex to scan.

Senator WATERS: Who made that decision, and when? Like 150 years ago?

Senator TYRRELL: I have a similar question for you, Ms McNamara, in regard to Tasmanian services, which can be limited. Do you get, similarly, a lot of people coming to you as a Victorian arm?

Ms McNamara: I'm not an expert in that area, but I believe that we do. I did make reference to facial feminisation surgery. Never mind Tasmania and the area codes. We're not in the same hemisphere as Spain. The surgical options for facial feminisation in this country are extremely limited, and that's why people go to Spain. I'm sorry; I don't really think I'm equipped to answer the question. I do know that there are some referrals from Tasmania to the Monash Health Gender Clinic and possibly—I don't know whether it's current—Michelle Telfer at the Royal Children's has treated children.

Senator TYRRELL: I'd be happy to put the questions on notice, because I do have some more specific ones for you as well. I did have another question, but you're probably going to keep the answer real short. Because your area of expertise is so broad and ranging, do you think that it needs its own specific little inquiry?

Ms McNamara: I think that would be very helpful. I think that we need resources put in to develop a strategy focused on the breadth and complexity of the trans and gender diverse community. I think you gasp at the seven years to diagnosis for endometriosis. Well, what about 50 years? I lived quietly in the closet for 50 years suffering with this condition, and there are friends of mine who will never come out because of the discrimination that they've seen or experienced. The physical fear of walking out for the first time as a transgender woman is palpable, and you live in a hypervigilant state for quite a time. It probably takes 10 years, friends say, to develop. I've been out 10 years and it's dropping, but it's still hypervigilant. I think, yes, it does need its own inquiry. Thank you for that suggestion. I'd love to be involved.

Senator TYRRELL: Thank you.

CHAIR: Thanks, Senator Tyrrell.

Ms McNamara: Can I just quickly say one thing?

CHAIR: Yes.

Ms McNamara: I've noted the motions that the senators voted on in recent years on transgender people, and I note that two of them were raised by One Nation: one by Pauline Hanson and one by Malcolm Roberts. Some of you voted for them, I believe, from memory, because I checked. They were ones based on the concept of rapid onset gender dysphoria. It's a totally discredited idea, but it's one that's been promulgated by that national disgrace which calls itself a national newspaper, the *Australian*. They are simply echoing misinformation that's been peddled by that scurrilous rag.

CHAIR: Thank you—which has huge health implications.

Ms McNamara: Absolutely. We see that referrals to mental health support services for LGBTI people, including trans people, rise enormously when those sorts of statements are made in the media.

Senator WATERS: Shame on them.

CHAIR: Thank you for your evidence, Ms McNamara. I just really did want to point out the statement in your submission that 50 per cent of trans and gender diverse people report not receiving the health care they need, which is such a statement of the unmet need that we need to be addressing. Thank you, and thank you, Dr Mooney and Mrs Campbell, for your evidence. For any questions on notice, could you get answers back to us by the close of business on 5 May. Obviously, Senator Tyrrell's questions will be sent to you very quickly. I know that's only a short space of time, which I apologise for, but we're reporting to the Senate on 11 May, so we haven't got much time to waste. Thank you once again.

CROSS, Dr Marjorie, Executive Member, Australian Federation of Medical Women [by audio link]

DORRINGTON, Dr Melanie, Young AFMW, Australian Federation of Medical Women

DUNCAN, Dr Catherine (Kate), AM, Chair, Governance Committee, Australian Federation of Medical Women [by audio link]

McMAHON, Ms Kit, Chief Executive Officer, Women's Health in the South East

SHANNON, Ms Lucinda, Acting Chief Executive Officer, Women's Health Tasmania [by audio link]

SIMONIS, Associate Professor Magdalena, President, Australian Federation of Medical Women

[12:50]

CHAIR: I now welcome representatives, both via teleconference and in person, from Women's Health in the South East and the Australian Federation of Medical Women, and from Women's Health Tasmania, who are appearing via teleconference. Thank you for appearing before the committee today. Do you have any comments to make on the capacity in which you appear?

Dr Duncan: I'm an obstetrician who is based in Melbourne.

Prof. Simonis: Dr Cross may or may not arrive. She is a rural general practitioner out of the Australian Capital Territory and has vast experience in providing sexual and reproductive health services.

CHAIR: I'll ask each organisation to make an opening statement. We might start off with Women's Health in the South East and then go to Women's Health Tasmania and then go to the Australian Federation of Medical Women, by which stage, hopefully, Dr Cross will be with us. Ms McMahon, do you have an opening statement?

Ms McMahon: Yes, I do. I just want to acknowledge that we're here today on Wurundjeri Woiwurrung lands. I want to pay my respects to the traditional owners of the land. These lands and waters were never ceded. The organisation that I represent works across the southern metropolitan area of Melbourne. That's from the Mornington Peninsula into Port Phillip, up through Stonnington council, across Dandenong and to the Cardinia shire. We have 10 local government areas, comprising some of the most diverse communities in Australia. I also want to note that when I talk today I will be recognising that it's women and people with uteruses that our work speaks to and supports. We thank the Senate for holding this hearing and for giving WHISE the opportunity to provide a submission and attend today.

I'd like to open with a few key points. The right to sexual and reproductive health is an integral part of humans' right to health and good health, and so says the United Nations Committee on Economic, Social and Cultural Rights. It is a right that is not afforded in a consistent, universal way. The access to this right is gendered. Furthermore, as an organisation that works directly with women from all walks of life in these lands and lands across the globe, who seek to make this country their home, we know that these barriers are not only in place because of a person's sex or gender. We also establish barriers to access this human right based on the language they speak, the colour of their skin, their ability, their education and their socioeconomic status.

What we know in our work at WHISE and across decades of evidence and practice of others in our system is that to address these barriers and to provide access to a health service that enables human rights, we need to address the systemic barriers by enabling healthcare providers to complete the trainings so that they can administer and dispense medical abortion; we need to amend Medicare item numbers that prevent adequate reproductive health care; and we need to directly address the blockages in the system that reduce accessibility to contraceptives, particularly long-acting reversible contraception.

We need to build a system of health in our public healthcare architecture that understands its different parts and roles and is less hazardous and traumatic to navigate. We ask that government untangle and make the system of referral and regulation consistent across PBS, TGA, state and federal systems, which has increased confusion and distress for women and for people with uteruses. We ask that government understand and be realistic about the cost burden that women bear for managing fertility and contraception, and be real that this responsibility is gendered. We know that the costs of contraceptives are a barrier to uptake. The upfront costs and ongoing appointments limit affordability. There are policies in our world to address this, such as in the UK, France, Sweden and New Zealand, where no-cost contraception is offered to people at a minimum age up to the age of 25 years.

We also ask the government to streamline the approval process for introduction of new contraceptives. We lag behind comparable settings such as the US and the UK. While we're on affordability of managing fertility, we need universal access to contraception and abortion for all women and people with uteruses. We need to address

the gap in knowledge and capacity of our medical and health workforce to enable access to reproductive health care. This will require investment in capacity and enabling services to be provided in primary care settings, implementing and scaling up nurse led models of care and incentivising our GP system to provide services like an abortion.

Finally, services must include ways of work that are culturally sensitive, trauma informed and grounded in an evidence base of inclusive and sex-positive health literacy. We must think of reproductive health care as not only as occurring in clinical settings but also as inclusive of health promotion to provide information and access on all of people's rights and responsibilities in relation to sex and consent. The evidence of what is needed and what works has been around for years. In fact, I know that you will have heard and read recommendations and views that I have shared here in other submissions at this hearing today. We fully support this hearing. We thank you for your work and your commitment to discussing we, and we look forward to seeing and supporting your outcomes.

CHAIR: Let's now go to Women's Health Tasmania. Ms Shannon, do you have an opening statement?

Ms Shannon: I do. I also want to say thanks to the committee for inviting Women's Health Tasmania to speak to you today, and also a big thank you to Ms McMahon for that first opening statement. I think there's a lot in what Ms McMahon has said that I would completely support and that we here at Women's Health Tasmania are thinking about and talking about every day as well.

Women's Health Tasmania is a health promotion organisation. We've been around, working in Tasmania, for over 30 years. We undertake research, policy and advocacy in Tasmania around women's health generally, and so, of course, we've done a lot of work in the reproductive health space. A lot of what I'll be drawing on today in this opening statement is based on research that we've done with people who have a lived experience of having an abortion in Tasmania in the last 10 years—that's the point from when it was decriminalised here, in 2013, and following a range of different access systems in Tasmania through that time. I want to paint a picture for you of what the lived experience of women and other people tells us about what's important when we think about universal access.

My first point is: who are we talking about when we say 'universal access'? I think often certain groups are getting left out of our 'universal access' conversation. There's definitely key areas where we see women and people get very different kinds of access. The first one that's especially pertinent to Tasmania is people that are living in remote and rural locations. So much of Tasmania is rural and remote, and many of the folk in these areas rely on locum GP services as their first port of call for health services. Often pharmacies in the area are very limited, and people are having to travel long distances to access the services that they need and they often have to travel multiple times. Because our system isn't responsive to the circumstances of people living in remote and rural areas, we are building in a lot of weaknesses and vulnerabilities for folk in terms of being able to access the care that they need in a timely fashion.

The other area I want to touch on is people who are in Australia on temporary visas. Usually these folk have to rely on insurance or paying full costs for services, and it's a huge barrier. I also want to talk about people who do not identify as women but still need access to terminations and long-acting contraception. Those are the particular areas that it's really worth us looking at in more detail. Generally, what we hear from health consumers in Tasmania is that reproductive health care is not affordable.

Tasmania is an interesting jurisdiction in that we've just in the last few years had some of the barriers around costs removed, and this is because of the decision of the state governments to change what's available to people at no cost. Now we have a system that is quite similar to South Australia in that SToPs are available through public hospitals on demand. Specific funding has been made available to people who are on low incomes or in financial crisis, and that patches up the gaps between what Medicare provides and what clinics and private practice charge for MToP services. Importantly, this financial support and public health support have been made available to people on temporary visas down here, but it was by no means a given. We saw many issues for people, including women, who were here on temporary visas because of the gaps around Medicare.

Lastly, we really need to talk about how we can equip the health workforce to enable people to have reproductive choice to access the choices that are right for them. The consumers we spoke to told us about a range of responses from primary healthcare workers that were really concerningly antithetical to person centred, choice focused care. People told us they had experienced judgement and dismissal by healthcare workers and even reproductive coercion in healthcare settings. Something that the Tasmanian experience shows is that the leadership in public provision of termination can be really transformative to a service landscape, but there's still a lot of work to be done on the how we design our services for the future and workforce readiness if we're going to give consumers access to choices in a way that is empathetic, accessible and person centred.

CHAIR: Thank you very much, Ms Shannon. Would the Australian Federation of Medical Women like to make an opening statement?

Prof. Simonis: To give you some background, I'm a general practitioner and the President of the Australian Federation of Medical Women. Dr Marjorie Cross is a general practitioner who works in rural Australia and Dr Catherine Duncan is a retired obstetrician gynaecologist who is now doing locums in areas of need, supporting colleagues who are overburdened and need time off. We come with a background of immense experience in women's health.

So who are we as individuals? I'm on the National Action Plan for Endometriosis. I have written education modules for primary care, general practice and nurse practitioners in endometriosis. I'm on the national strategy for the elimination of cervical cancer. I'm on the Safer Families Centre of Research Excellence at the University of Melbourne, which is the only dedicated primary care research centre in the area of family violence. I come with 30 years of general practice experience as a women's health expert. Alongside my colleagues, we are representing the voice of other medical women, including the Australian Federation of Medical Women, who work to amplify the advocacy of women's health needs in Australia through medical services and through our work in our own areas of expertise.

With this in mind, I look across the room and, here, we're all women. We represent 50 per cent of the population of Australia, and, in most countries in the world, we comprise 50 per cent of the population, and yet there are no men in this room. We are the vocal advocates here for sexual and reproductive health in Australia today after generations of having faced this same issue. Given that women are 50 per cent of the population, 30 per cent do not live in major cities and in rural and remote Australia. Therefore we are faced with issues around access, equity and fairness in terms of the availability of services across all areas of women's health and reproductive health services.

We believe that women across Australia should have access to clear, non-directive, non-judgmental information provided in their language and in a trauma informed way. Up to 50 per cent of unwanted pregnancies occur due to a failure of contraceptive devices. Some of that revolves around a lack of understanding around the function of the contraceptive device, but there is also an element of coercion, which may or may not be disclosed at the time of presentation. I think that any healthcare practitioner who deals with a woman who presents with an unplanned pregnancy needs to be asked about this. We need to be able to take this into consideration when we are advising them around these services.

Information that women should be able to then access is clinically appropriate means of abortion of their choice without being impeded by various barriers, which we've described in our document. One of the key issues here is that, with one in four women experiencing unintended pregnancy, the majority of these women are young women. In my practice, I'm surprised daily by the lack of understanding that young women have around the safety of basic things like the oral contraceptive pill. We have a huge responsibility as a community to improve the literacy of the community, not just of women, around the safety of contraceptive devices, their significance, and that withdrawal methods and condoms are not really safe forms of contraception, which, in social media platforms, are still being proposed as safe. We need to be aware of what's being espoused on these sites and counter that with adequate health information from a public health perspective.

People should also have a choice of provider. No-one should have to travel from a publicly funded hospital that provides maternity services to access abortion or even contraception. They should be able to access an abortion at any gestation from a publicly funded maternity service. I do shared care as an obstetric GP. I have had patients who, due to limitations of the region that they live in, have needed to go to, let's say, a mercy hospital or a Catholic based hospital. When they've requested a tubal ligation at the time of a caesarean section, this has been refused and they have not had their choice of contraception, such as Implanon or an IUCD, and they've had to go to another service to have this done. So they've had to spend more money, whilst recovering from a pregnancy, when they could have had it done at the same place. These are things that we're accepting. These are things in today's Australia and today's Victoria. These are conversations I have with patients which stun me to this day. I think we need to seriously consider how our public hospitals, which are funded by us, are resisting that kind of service to patients on a religious basis. This comes down to religious freedom certainly, but it should not impact healthcare delivery.

Then there are also issues around affordability and access gaps in Australia for abortion. The delivery of abortion services in Australia is very expensive, and women can't simply look online and find services that they can access that are within their reach and that provide affordable abortion services or even advice and follow-up appointments following the procedure, whether it be for contraceptives, for counselling or for complications.

The disparities across Australia are significant. They've only started to improve in our metropolitan regions. We have an incredibly impoverished supply of providers in our rural and remote areas. With that in mind we need to consider the significance of telemedicine and telehealth services for women's health services across the board but also for the provision of medical termination advice and surgical termination advice.

We also need to have a registry of termination services across Australia. We need to have a registry that is available in all languages, is easy to find and also protects the providers of these services, because we need to remember that this is also an area of medicine that has a fair amount of stigma associated with it. As we know, there is still strong representation in the community of people who conscientiously object, but conscientious objection should not equate to not providing healthcare services. They should be mandated to recommend services and to assist the women to access these services in a timely manner. With this in mind I will hand over to my colleagues to speak also.

CHAIR: Very briefly. We're running very short of time. We have got just over 15 minutes at this stage for questions, but your colleagues could make a really quick addition.

Dr Cross: I'm a GP who has been working in southern New South Wales for over a decade and providing non-directive pregnancy counselling and medical termination of pregnancy for the last three years. We provide it from a general practice location. We provide telehealth abortion services.

The most important thing I want to say is that we believe there is significant access and affordability gaps within Australia for termination/abortion. There are also various limitations with regard to accessing different forms of abortion. Everyone is aware of the WHO abortion care guidelines. Abortion should be available to pregnant people on demand. There are significant barriers to achieving universal access to sexual and reproductive health treatment and services, including lack of a national reproductive strategy; lack of data; lack of KPIs; lack of readily available clear, non-directive based information; lack of translated information; and lack of training of health services. I have a summary, but you wanted it brief.

CHAIR: Thank you very much. Let's move to questions. I'll start with you, Senator Tyrrell, because I presume you have some questions for Women's Health Tasmania, so let's kick off with you.

Senator TYRRELL: I do. Your submission sets out that Tassie is the state with the highest population of people with a disability, with the highest levels of smoking and obesity, with the highest preterm birth rate and with the lowest levels of literacy, educational attainment and income. Your submission also says we're well ahead of other jurisdictions in reproduction health care. What are the three most critical issues in Tasmania in the context of reproductive health care? And if you could pick three reproductive healthcare reforms in Tassie, what would they be?

Dr Cross: There are a few things. One of them is not Tasmania specific though. One is about Medicare rebates. I won't go into it in great detail because I'm sure you've received plenty of information about it, but the gap between what Medicare covers for a lot of these reproductive health procedures, like MToPs for example, is no longer anywhere near what it actually costs a GP or even a specialist clinic to provide. People are paying an out-of-pocket set fee in many cases for something that we think should be free or should cost a very minimal amount. That's not actually something that can change just in Tassie; that's something that needs to change at the federal level.

In Tasmania it would be fantastic to see the growth of other kinds of health practitioners being able to deliver MToP and other kinds of services, like long-acting contraceptive services, so that we could have a deeper spread of health workers across Tasmania, particularly in regional, remote and rural settings, who could be providing some of those services, some continuity of care, some navigation support for women and other people who are seeking an abortion or seeking support around a LARC.

Another one has kind of been hit on by some of our previous speakers. It's about reproductive health literacy in the community. This is something that we see all the time. When we've talked to people who've had terminations of pregnancy, they've spoken about layers of discrimination and stigma. They might encounter stigma at the level of the GP, who might not be a conscientious objector—they were assisting them to get an abortion, but it came with a healthy serving of shame and judgement. And then, when they returned to their community, they still felt that shame and judgement and that would stop them from actually reaching out for support from the people around them. This is a really difficult state of affairs, particularly when you consider that abortion is actually quite a common procedure and people shouldn't be feeling alone in that space. If we were able to build generally the community's understanding of reproductive health literacy, including an understanding that abortion is health care and that reproductive choice is a human right, if we had some interventions around that, that would make a big difference in the Tasmanian space.

Senator TYRRELL: Thank you so much. More broadly, though, maybe to the Australian Federation of Medical Women, listing all contraceptives on the PBS would be very costly, but would this lead to a reduced burden on medical practitioners and hospitals and end up costing the taxpayer less, do you think?

Prof. Simonis: My short answer to that is, yes. In the long run, we need to think in terms of reproductive healthcare provision not in just the cost to the taxpayer but also how the avoidance of burden costs to the taxpayers is saving taxpayers money. There are inherent costs in having—not all unplanned pregnancies end up in termination. A good number of them end up in full live delivery. And not all of those are adopted out. As we know, the adoption rates in Australia are still very, very low. Therefore, a lot of these children are raised in families which may have existing dysfunction, especially with a background of dysfunctional family reproductive coercion, family violence and so forth.

Also, failure of contraceptive success is more common in lower socioeconomic areas, so you're increasing a burden on an already burdened, socially disadvantaged group to begin with. So, in terms of the actual cost to the taxpayer, the costs would be redeemed in the long-term benefits. It also means that it empowers women to have the choice to be in the workforce and to time their children. So it's not that they're not going to have children down the track; it's that they will time their families to also suit their life, according to their relationship and their ability to provide for that.

Senator TYRRELL: We're not stupid people—any of us—in this life, and young people are highly intelligent in different ways, but does it seem strange to you that we still have this archaic perception of sexual health, sexual orientation and the things that we need to do sometimes to have a happy life?

Prof. Simonis: These are really, really good questions, because I think what this points to is the gendered inequality that exists in our community in terms of enculturation messages that young people still face and have around sexual choice, which is why we now have a whole conversation around consent and sexual consent for youth and school-age kids. There's this expectation that young women and also young men and young people feel around having to comply with sexual requests. What statistics have shown, unfortunately, is that up to 75 per cent of young males up to the age of 25 still consider it okay to slap or push a woman. So we're still living in a very gendered, biased society.

When we look at what young women are facing: they have to be sexy, they have to be brilliant at school, they have to have the career and they have to have the boyfriend or the partner. They also want to be liked. This is not about intelligence. It's about social pressure. Social messaging, with sexist advertising and the whole emphasis around what it is to be appealing and sexually attractive, is very gendered. It discriminates against women, and it makes women feel bad about themselves from birth all the way through. That message is perpetuated all the way through. Coming back to this: yes, it does surprise me. It surprises me that I see university-age students who are brilliant. Their ATARs are amazing, and they're engaging in activities that are painful or uncomfortable and are not taking their contraceptive because 'he hates the condoms' and so on and so forth.

I also need to express the significance of what we do as GPs, because this is not a 15-minute consultation. To address and come back to what was said earlier, it breaks my heart to hear that some women feel that they're not being listened to and that they're made to feel bad about themselves. It takes time in a rushed general practice, where patients are waiting outside and are already angry at their GP for running late. I'm apologising every day of my life, and I've given up trying to be on time—I say that to my patients openly. But most of us don't have that confidence, so it takes a lot of time to unpack that with patients and to re-educate, which is why my opening statement was really around education at a community level and the significance of knowing that you have choices and that you cannot be a free person unless you have sexual and reproductive health choices.

Dr Duncan: I'd like to just illustrate Magda's position there. In three weeks at Bendigo Health, as the obstetrician in charge of the labour ward, I have delivered babies for two 15-year-olds and one 16-year-old. We are trying to overcome an ignorance amongst younger women about contraceptive choices and their entitlement to contraceptive choices. The ignorance is profound, and we really need to concentrate on availability of and access to knowledge. Another point is about the lack of services provided by Catholic based hospitals, which also includes a lack of ability to do terminations, a lack of ability to provide contraceptive advice and also, in some cases, absolutely no engagement with fertility programs such as IVF.

Dr Cross: May I add to that answer? I would like the top recommendation to be to ensure that publicly funded hospitals that offer maternity services also offer abortion care, appropriate to their service level, as part of their funding requirement.

CHAIR: Thank you, Dr Cross. That's very powerful. Senator Smith?

Senator MARIELLE SMITH: We've got very limited time, so I just have one burning question to ask. I'm from South Australia, where, unlike many states on the east coast, we don't have the big regional centres in our regional areas. We're probably similar to Tasmania in that we have a lot of women from a very large geographic area trying to access services, particularly maternal health care services, to have their children near home, get support to have their children near home and have all the other healthcare services that are needed on that journey of having a baby.

In my state, in instances where services have been pulled back, such as obstetric care services and those sorts of things, and women have then had to travel hundreds of kilometres to have their babies, away from their family, support, other children and all of that, the pushback that comes is: 'We need to make sure that women can have their babies safely, so this is what we have to do.' It's not a satisfactory answer, to me. The alternative isn't satisfactory. I'll put this out to the panel: What do you think we can do at a policy level to make sure that when women have their babies across regional and remote areas, and in states like mine, we can keep those women close to home to have their babies and do that safely? What are the best things we can do, or could be doing, at the Commonwealth level to ensure that can happen?

Ms McMahon: The evidence and the strategies around that are—there's a lot of good evidence behind it—to utilise the GP network and invest in the workforce around nurse practitioner skills. I know you've got the midwives coming in soon, and they will be able to give you great strategies to strengthen the midwifery workforce. As a girl from rural Victoria, I know there's another barrier there if you're a woman and you want to have a healthy child and be healthy yourself. We need to embrace and understand the workforce issues. It costs a lot of money to skill yourself up, and that's more so if you are in rural areas. It's $2,000 to train yourself up to use an IUD, and that's not available, even to access, if you're a nurse practitioner. So there are real barriers in place to liberating the workforce and the skills needed. Also, the other opportunity there is to actually get the pharmacy system working for MToP and contraceptives as well. You need to liberate that whole system and the channels of dispensing the skill.

Dr Cross: I'll jump in there. Much of what I was going to say has just been said. There's a 'should' here: no woman should have to travel hundreds of miles for obstetric care when there is a maternity service closer by. I know there are barriers around what is available locally. It also comes back to some sort of national program to support patients accessing difficult-to-find reproductive health care. What the federal government might be able to do is actually have some sort of national phone hotline to support patients, to give them information right at the very start about contraception, IUD insertion, vasectomy and abortion care, including counselling and health support. That also goes to obstetric care—making it well known what's out there.

Dr Duncan: If I was going to add anything, I would mention the recent encounters I've had using the telephone interpreter service. When there are absolute language barriers in an emergency or an urgent care situation, strengthening the availability of the telephone interpreter service is going to be fairly crucial.

Dr Dorrington: I just wanted to add one point to that in terms of obstetric access in rural and remote areas. I actually, in one of my jobs, provide telehealth abortion, medical abortion. I spoke to someone yesterday in Queensland who didn't have medical as an option because of how far away they live from a service that could do an ultrasound and also a hospital that would be able to look after them, because we have a rule that we won't provide it to someone if they're more than 200 kilometres away from a hospital, which means they need to travel more than 500 kilometres to Brisbane to get a surgical termination due to the time frame of their pregnancy. It's not just deliveries in terms of rural and remote that obstetric services limit; if this person had a hospital closer by that had maternity services, they would have been able to access a medical abortion.

CHAIR: Thank you for that example.

Senator WATERS: Thank you, everyone. I loved everything you've said, and I've taken copious notes. I hope that we can collectively address some of these issues. They're long overdue.

Ms McMahon, in your opening statement you referred to the need to review the approval processes for new medicines including contraception. We've got the TGA coming up this afternoon. Do you have any suggestions for how the process should be improved for listing those new medications?

Ms McMahon: Our experience of these is that we believe the TGA has taken a very conservative and cautious approach towards new contraceptives, when there is evidence from across similar settings to us to support the distribution and approval of those contraceptives. We need to ask the TGA to consider the gendered impact of their decisions as well. The streamlining of the approval process for the introduction of new contraceptives is also about centring the lived experiences of professionals and practitioners like we've got in the room today. We also asked the TGA to do things like revisit its proposal to down schedule oral contraceptive pill, which might be a

conversation they're open to having at the moment, on the condition that that pill is prescribed. In the evidence they use, they need to understand the gendered impact of their decision but also the distribution of where those drugs are dispensed. I hope that answers your question.

Senator WATERS: It does. It's given me some suggestions for them.

CHAIR: Thank you all for your evidence today. It's been really useful for the committee. I'm sorry we have been rather short on time to cover everything that you wanted to cover. I'm not sure whether you took anything on notice, but, if you did, can you get it back to us by 5 May—or if there is extra information you feel you would really like to share with the committee. We're going to be reporting to the Senate on 11 May. The committee will now suspend.

Proceedings suspended from 13:33 to 14:16

COOMBE, Ms Brigid, RN, MN, Co-Convenor, South Australian Abortion Action Coalition [by audio link]

DAWSON, Professor Angela, Professor of Public Health, Public Health Association of Australia [by audio link]

HILL, Ms Dianne, Chief Executive Officer, Women's Health Victoria

MOGHARBEL, Ms Carolyn, 1800 My Options Manager, Women's Health Victoria

CHAIR: I now welcome representatives from the South Australia Abortion Action Coalition, Women's Health Victoria and the Public Health Association of Australia. I invite each organisation to make a brief opening statement. After that, the committee members will ask you some questions. Ms Hill, would you like to kick off?

Ms D Hill: Good afternoon, and thank you very much for the invitation to present today. I acknowledge and pay respect to the Wurundjeri people of the Woiwurrung nation as traditional custodians of the land on which we're meeting today, their culture and their elders, past and present, and any First Nations people who are here today. I'm the CEO of Women's Health Victoria. We're a statewide women's health service operating across Victoria for 30 years. Our work includes policy, advocacy, capacity building and direct services to support women's health and gender equality. We're part of the Victorian Women's Health Services network, and several of our colleagues will be presenting throughout the day.

One of our core areas is sexual and reproductive health, with a focus on reproductive rights, autonomy and justice. Over the last three decades, we've advocated for the rights of women to have access to safe and legal abortion and to be free from harassment through safe access zones, and we've supported the development of the first women's sexual and reproductive health strategy in Victoria. In 2018, we designed and began operating 1800 My Options, Victoria's first sexual and reproductive health navigation service. Working across the sexual and reproductive health service system and with women and gender diverse people, we have a unique insight into the experience of service providers and people seeking services, the barriers they face, what works and some of the system enablers. My colleague Carolyn will be able to tell you more about this through our experiences shortly.

We also manage the Women's Health Atlas, a geomap database with over 60 women's health and gender equality datasets disaggregated by sex—male and female—to every local government area. Using this data, we can often see demand, supply and service access and delivery gaps in critical service areas, including sexual and reproductive health. Just to give you a very small example of this, in one of the local government areas in the Grampians region, we know that, by patients—that is, by the number of people who've actually received a service—they have the third-lowest rates in Victoria out of 79 LGAs for medical abortion. We also know from the data that in that area there are no prescribers—that is, GPs providing a service or community health—and no pharmacies who are dispensing the services. We also know they have the highest rate of adolescent birth in the country and they have the eighth-lowest rate of contraceptive implants in the country.

The outcomes here are low rates of abortion and contraception and high rates of adolescent birth. This suggests that the abortion seeker has most likely had to travel to get the services they need or has perhaps used telehealth. What does this mean for people who don't have transport, are unable to take time away from caring or work, are unable to find services in another location or are isolated in a rural setting due to family violence or other circumstances? I think this is a very stark example of the access issues. In the interests of time, I'm very happy to provide you with more detail about the atlas. The data that we've mapped in Victoria is really helpful for thinking about how that could apply nationally.

These are small examples of much bigger issues when it comes to access, and I'm sure that you've heard a lot over the last few days and through the various submissions, so I'm not going to go into that. I'd just like to say that one of the key things that we think is really needed is an integrated service system where reproductive health care—and that's the full range of reproductive health care—is seen as part of mainstream health care. In the interests of time, I'm going to hand over to my colleague, Carolyn, to talk to you about our experiences of an integrated healthcare system in Victoria.

Ms Mogharbel: Thank you, everyone, for the opportunity to speak today. I want to talk to you about how 1800 My Options works and what we've learned from working within an integrated system in Victoria. The service is a free, confidential, pro-choice phone line for people looking for sexual and reproductive health services. Since we established in 2018, we've spoken to over 25,000 people, over 85 per cent of whom are seeking abortion services in Victoria. They call us because they don't know how else to find the abortion care that they need. These people come from all ages, backgrounds and experiences.

I know that you've already heard a lot about the barriers that abortion seekers face relating to cost, conscientious objection, stigma, distance et cetera, so I'm not going to go into that today. I want to talk to you

about the things that work when we're trying to address those barriers. Essentially, 1800 My Options is a service navigator. We speak to over 600 people a month about their needs. We speak to people who are pregnant. We speak to their partners, their families, their friends, their doctors, their nurses, their obstetricians to help them assess what they're looking for and provide them with evidence based information as well as pathways to the services that they actually need. We're a completely impartial service, so we provide pathways to, generally, at least three services that that person will be able to access to get the abortion or other sexual and reproductive health service that they're looking for. To do this, we have a database of sexual and reproductive healthcare providers across Victoria.

When we established the service in 2018, we had about 30 providers on that database—not many places to suggest to people to try for their abortion or sexual and reproductive health services. Now we've got over 650 providers of sexual and reproductive health care on that database all across Victoria. That includes not only clinical care and abortion care but also pregnancy options, counselling, pharmacies and ultrasound services that are pro-choice where we know people will get the service that they're looking for. The database is publicly accessible and searchable. You can search by the service you're looking for. You can search by your postcode or location. It also allows us to monitor in real time what service availability is doing and what it looks like.

We understand the ebbs and flows of service provision because we're in close contact with the services on our database and they let us know when they might have longer waiting lists or when there might be other barriers to access at that particular service, or when they've got a lot of appointments available as well. That enables 1800 My Options to manage supply and demand across the system and ensure that abortion and contraception seekers can find the services that will meet their needs. It also gives us insight into the barriers that the service providers are facing, and I know that you've heard a lot about them already—impacts of inadequate renumeration through the MBS, impacts of not enough training, impacts of stigma et cetera. You've heard a lot of evidence and have had a lot of submissions on this already.

We also know the thing that works for service providers, and that is a lot of support. You've heard from the Royal Women's Hospital already today. They deliver the clinical champions project, which has been absolutely integral in building the capacity of the sexual and reproductive health service sector to provide medical and surgical abortion, as well as long-acting reversible contraceptives. It's also been really integral in decentralising abortion, to make sure that people don't have to travel all the way to Melbourne to get the abortion services they need. It means that people can actually access them in their local community.

On that, I'd like to add to Di's points where she talked about an integrated service system. I also want to state that, in summary, we need a system that is funded appropriately through the PBS and MBS so that people can actually afford the services and that providers can be remunerated appropriately. We need extensive workforce training and a national plan to ensure that we've got a succession plan in place so that the providers that we have, who are absolute champions for reproductive rights, can have a break, can take leave, without impacting on service delivery. We would love to see free contraception and abortion care, both medical and surgical, across Australia so that people don't have to travel and don't have to go into debt to be able to have their reproductive health needs met. And we want to see the entire health system integrating sexual and reproductive health with a gendered lens that is able to recognise the intersections of gendered violence, mental health, stigma and discrimination and ensure that our services are culturally safe, culturally responsive and able to meet the health needs of our diverse population.

CHAIR: Thanks, Ms Mogharbel. Ms Coombe.

Ms Coombe: I am speaking today from Adelaide, on Kaurna Yarta, the unceded lands of the Kaurna people, and I pay my respects to elders. I am a nurse and recognise the role of the nursing profession in the oppression and denial of Aboriginal and Torres Strait Islander people's reproductive autonomy.

I'm pleased to speak directly to the committee today, at short notice, of the experience from the Australian state where abortion care has been provided in the public healthcare system since the law reform of 1969—that is in metropolitan and country hospitals—and then from 1992 also from the specialist service, the Pregnancy Advisory Centre. I am speaking to you today as the co-convener of the South Australian Abortion Action Coalition, but I worked with the Pregnancy Advisory Centre as a clinical nurse from shortly after its opening in 1994 and then as the director until 2012.

My personal experience and the experience of the coalition highlight the critical role of leadership by departments of health, hospital executives and clinical directors in ensuring that abortion services and the staff who do this work are appropriately supported. This requires a knowledgeable leadership that is pro-choice. We also have experience of the consequences when this leadership is not provided and demonstrated. Publicly provided services ensure universal access to abortion as a routine and specialist aspect of reproductive health care

and must include the provision of surgical and medical abortion in public hospitals by a skilled and willing multidisciplinary workforce.

CHAIR: Ms Coombe, we're having some problems understanding you. Are you on speakerphone? If you could get off speakerphone, that might help.

Ms Coombe: Am I better now?

CHAIR: Infinitely better. Thank you.

Ms Coombe: I can't really hear you, but I will continue. This workforce requires specialist skills to provide abortion care that is trauma-informed, culturally safe, non-discriminatory and informed by people with lived experience addressing the barriers that we know have been put before your committee in this process. The community experience is that, when the need for this very commonly required healthcare service arises, the public health system provides it. Public provision on this scale works to reduce stigma, develops expertise, facilitates research and is necessary to support education and training at all levels, and especially to develop the specialist skills required for complex presentations in the second and third trimester. The Pregnancy Advisory Centre has been able to demonstrate this with research, service innovation and long-term development and maintenance of the skilled workforce.

South Australian abortion legislation is no longer a barrier to the provision of early medical abortion by nurses and midwives. This is the most appropriate and affordable level of provision, and national regulatory barriers to this must be urgently removed. This must include the consideration of the role of Aboriginal and Torres Strait Islander health care providers as determined by the National Aboriginal Community Controlled Health Organisation.

Commonwealth funding should support public provision, a national information service, like the 1800 options that have been discussed, and a public telehealth service to early medical abortion that is nurse led and nurse provided when legislative and regulatory barriers are removed.

CHAIR: Thanks, Ms Coombe. Professor Dawson, do you have an opening statement?

Prof. Dawson: Thank you very much. The Public Health Association of Australia is the peak body of public health professionals in the country. I'm particularly aligned with the Women's Health Special Interest Group in the PHAA. I'd like first to acknowledge that I'm standing on Gadigal lands, the lands of the Eora nation, here in Sydney, Australia, and I'd like to acknowledge all the lands that we are meeting on today and acknowledge elders past and present.

I'd like to provide a public health perspective on this inquiry. Basically, a public health approach focuses on more than just the provision of health care—really, on strengthening our health system. If we want to make a difference to reproductive health at the population level as well as the individual level, we really need to focus more on universal access to reproductive health. We really need to be thinking about achieving universal coverage. This means we need to be concerned with how our health system is performing so that those who need reproductive health services can receive or have actually received them.

We know that our health system is not performing, and that's largely because out-of-pocket costs are one of the main barriers to accessing reproductive health care, particularly for people on low incomes. For example, 56 per cent of the cost of unintended pregnancies is shouldered by a woman, with the direct and indirect cost of each unintended pregnancy having been estimated at over $36,000 per unintended pregnancy. We know that service and commodity costs vary greatly across Australia. A women can pay over $700 for a surgical abortion in one area and over $300 for a progesterone IUD. It really depends on who you are and where you are.

There is massive inequity in Australia, and the burden, as I've said, is largely on women to pay for and identify these services. People have to locate the commodities and the medicines and the providers who are willing to insert an IUD, for example, or receive an abortion. It varies. In New South Wales, where it's largely in the private sector, it is particularly challenging but there are some really good models. In the ACT, for example, IUDs and abortions are now free under certain conditions, and in South Australia abortion has existed in the public system for over 50 years. Our ability to provide universal health coverage is adversely affected by complex and interrelated factors that create unpredictable and paradoxical conditions that affect our reproductive health outcomes. So change is urgently needed. Others have said today that change requires a focus not just on reproductive health but also on sexual health, because, if we do not integrate this approach, we risk continued fragmentation and siloing of services. Leadership is really needed, particularly in the public sector. From a public health perspective, we really need to focus on the range of health system interventions that can transform our sexual and reproductive health. These include leadership across policy, law and regulation, commodity and

medicine supply, health service delivery, human resources for health, health financing and our health information system.

I don't really want to really repeat everything that's come before me, but, if I were to give the top seven things that I would change, the Public Health Association of Australia would want to introduce properly funded public services, including medical-abortion-specific MBS numbers to accurately reflect the true cost and complexity of consultations; remove MBS restrictions, particularly on nurse practitioners and midwives, to prescribe medical abortions; have national referral pathways, curriculum and standards for sexual reproductive health; and allocate appropriate budgets so that we can achieve the key outcomes that we've set ourselves in the National Woman's Health Strategy. We really need to strengthen the collection of national data. We have very little reporting in this country in comparison with like countries, and we should have standard reporting frameworks and key performance indicators so services can actually meet adequate universal coverage. On all of this, we can't really move forward if we don't ensure the delivery of national comprehensive sexuality education in schools and evaluate this. I might leave that there. Thank you very much.

CHAIR: Thank you very much. I'll throw two questions, starting with Senator Waters.

Senator WATERS: Thanks very much for joining us online and in person and for your submissions and your time. Professor Dawson, you just called for more systemic data to inform the research, the funding and the workforce development. What are the current gaps in data nationally, and what do you think is needed to address them?

Prof. Dawson: There's no standardised national data collection—for example, an unplanned pregnancy and abortion in Australia—and different states have different laws and regulations, and there are different reporting mechanisms. The only state that does collect standard information is South Australia. I would say that national leadership is required in this space to set reporting frameworks and indicators, and these should be linked to our national women's strategy. For example, at the moment, we have a situation with contraception where we can only gather some data from the HILDA surveys from 2015; data from the PBS, which is not always helpful; and the Medicare items to process abortion. They're not used exclusively for abortion procedures. They could also be used to denote the treatment of miscarriage and other gynaecological procedures. We don't have an MBS number for medical abortion. That would help us collect some data. I think this is the time for leadership in this space. If we want to be able to plan our services properly and meet the needs of the reproductive health needs of people in Australia, then we absolutely need to collect standard national data in this space.

Senator WATERS: Thank you. I strongly agree. I will ask you now about conscientious objection. We've heard in previous hearings that there's no requirement to register or have some notation that you are, in fact a conscientious objector. What responsibility do you think healthcare providers should have to disclose that information?

Prof. Dawson: I think they should be disclosing it upfront. There are some good models that exist, for example, in Canada, where health providers have to openly declare their objection and provide women the opportunity not to proceed with the consultation. There should be a legal obligation to refer directly to a provider who will actually deliver that service.

Senator WATERS: Thank you. I will move now to some questions for Women's Health Vic? We've heard quite a lot about 1800 My Options in the course of this inquiry, and it seems to be universally feted, so congratulations. It certainly sounds incredibly useful. Thank you for running us through some of the key features in your opening statement. I'm interested in how readily that can be made a national phone service navigation line. It's certainly something that I'd like to see happen. What level of national coordination do you think would be necessary to operate a hotline in each jurisdiction? Do you envisage one national hotline or separate state and territory based hotlines? Based on having done it, what's the best kind of model?

Ms Mogharbel: It's a really good question. I know Di and I have a lot to say about this, but I think the key point is that the reason that 1800 My Options is successful is that we're so closely engaged with the Victorian sexual and reproductive healthcare system, the providers themselves. We'd strongly advocate for a national coordination of state based services. We know that there's Children by Choice in Queensland, which has a map that's modelled on the 1800 My Options one. Women's Health Tasmania have their own phone line as well. We know that each phone line needs to understand the local context, the local legislation and the local system. So it's something we definitely support, and we would be very enthusiastic to work with other jurisdictions to do that.

Senator WATERS: That makes sense. Should there be separate hotlines for practitioners and patients?

Ms Mogharbel: Sometimes practitioners need just as much education as their patients.

Senator WATERS: Exactly—and there's no shame in that. They're obviously expert in a whole range of areas. You can't be across everything all the time.

Ms Mogharbel: And we certainly speak to GP's, obstetricians, nurses et cetera very regularly, providing them with information on what their best course of action is in a non-clinical way, giving them guidance about how they can best support their patient to access the services that they need. I don't know that there's a need for separate lines.

Senator WATERS: So you'd do that through the one line.

Ms D Hill: Can I add to that? I agree with Carolyn that if you're looking for, say, secondary consultation or some information about how to navigate the service system—for example, you're a GP who doesn't provide those services, working in a rural area, and you want to understand who else might be around or how you can do referral pathways and things like that. There's probably, though, a need for support for sexual and reproductive health service system providers that's more about their clinical support, that's more about helping them continue to be upskilled and that's helping them to connect with each other. I would see those two things as quite different. We did talk about the Clinical Champions program earlier today. We know that we've got SPHERE. I think you've met with Danielle Mazza and Deb Bateson, who are providing support for GPs through AusCAPPS.

If you're talking about supporting them to do clinical practice and actually provide services, I think that's one thing. If you're talking about secondary referral, I think this is a great model, because we have 600 providers. If someone rings us up and says, 'I'm not quite sure if there's a pharmacy in the next town or somewhere close to me, but I can prescribe the MTOP,' for instance, or 'I'm looking for an ultrasound,' I think you don't need it for navigating the service system.

Senator WATERS: I understand. Thank you. What resources do you think would be useful to complement the hotline. You've already referenced C by C's map. I'm from Queensland and I'm a big fan of their work and that map in particular. Do you think we need a similar national map or, for example, information about conscientious objectors. Is there anything that you think could usefully sit alongside a nationally coordinated service navigation hotline?

Ms Mogharbel: I think a map is really crucial, because it increases visibility of services. Not everybody wants to phone a number, and a map equalises access and visibility. I think that's the key thing. In terms of other things we need structurally, it's about those structural elements that mean that, even if there is something in my neighbourhood or in the next town that provides the service, that service still needs to be accessible. Just because it's there doesn't mean it's accessible. It's things around the cost of services that are really crucial. That can be managed through the MBS and the PBS under some circumstances to make it more accessible because providers and patients are both remunerated more appropriately. Those broader access issues need to be really key in it.

Senator WATERS: We've taken a lot of evidence about various MBS and PBS changes that would be more conducive to universal access to reproductive health care; there is strong support from me on that. What sort of quantum of funding do you think would be needed for a nationally coordinated hotline staffed at such a level that demand could actually be met?

Ms D Hill: That's a very interesting question.

Senator WATERS: We won't hold you to the estimate. If you've got a ballpark sense, that would be helpful.

Ms D Hill: Are we talking about the quantum for state based services as well as a national phone line?

Senator WATERS: Yes.

Ms D Hill: We have several states and territories. You would need several million dollars every year, because this is about making it the most comprehensive service it can be.

Senator WATERS: It sounds like a small amount compared to the healthcare spend overall.

Ms D Hill: Exactly.

Senator WATERS: Is it your view that laws relating to abortion access should be harmonised?

Ms D Hill: I think it would be amazing if, across the country, we could harmonise laws for abortion, for the nurse led models, for all those things that might enhance the service system. I think, though, we would want to see Victoria as the benchmark, because Victoria has the longest gestation periods. If we're going to harmonise, we'd want to say, 'Let's harmonise up and go for the very best that we can.'

Senator WATERS: Thank you.

Senator MARIELLE SMITH: Ms Coombe, in your submission you mentioned the experience in South Australia and that this might provide an indication of best practice in terms of what other states can be doing

around the regulatory framework and access. I was wondering if you could speak to that part of your submission and recommendation.

Ms Coombe: Legislation that doesn't limit provision to doctors—is that the bit you're talking about?

Senator MARIELLE SMITH: Yes. Your submission speaks about the experience in South Australia and the advocacy which led up to the change in legislation and the current model being—I'm trying to find the exact words you used in your submission, but there was an indication that it presented a model which would be worthy of consideration of the other states and territories.

Ms Coombe: Yes, it is a model, as is Victoria, where abortion is considered legislatively as a healthcare procedure. The important thing for services to do is to do that in a framework that's not limited by laws. That's what I think has been the work in South Australia—to develop a workforce, including a nursing workforce, so we can move towards nurse provision, supporting medical provision.

Senator MARIELLE SMITH: In your submission, one of your recommendations refers to the 1800 My Options resources. Is there something similar in South Australia?

Ms Coombe: We do not have anything like that in South Australia. The consequence of that is it can be very hard for people to find an abortion service, and, also, people can experience hostilities. I'm sure these barriers have been spoken about to you before, including blockages in making phone calls to get services. It also means, we find, that people often will book at more than one service because of waiting times being quite long, and then that contributes to long delays. So what we're advocating here, in addition to the 1800 options, is also a central booking service, which we think may be, for South Australia, an important way of reducing those barriers of waiting times caused by limited access.

Senator MARIELLE SMITH: How do you think such a service should be provided? Who should provide it? How should it be funded?

Ms Coombe: I think it should be publicly funded. I think it should be something that's funded by the department. We have local health networks in South Australia, so, if I were looking at a local context, that would be the way that it would be provided with leadership. We have a local health network which has responsibility for women's health services, and that's where the responsibility should lie. It would then articulate out to other services, but the responsibility would be with that service, which is, of course, the place where all reproductive and sexual healthcare services should be supported from.

Senator MARIELLE SMITH: Okay. Ms Mogharbel, can I just confirm: is your service state government—

Ms Coombe: Funded.

Senator MARIELLE SMITH: You do receive funding from other sources?

Ms Coombe: Yes. I can't really hear very well, but yes. That's right.

Senator MARIELLE SMITH: Sorry about our connectivity issues. We can hear you much better now. Anyway, I'll persist. I just had one more question for you. Your submission refers to the potential role of Primary Health Networks in providing access to information in multiple languages. I was just interested in your perspective on the availability of translation services in South Australia at the moment and where you see the issue or the deficiency in the provision of those services?

Ms Coombe: I think the problem in South Australia has been that there's a disconnect between the Primary Health Networks and the acute networks. Whilst that work is done, and Primary Health Networks do have responsibility and funding for translation services and interpreter services, they don't have a focus on the provision of abortion or sexual and reproductive health care. So their healthcare pathways are certainly a way that that work can be supported.

Senator MARIELLE SMITH: Thank you. Ms Mogharbel, you referred to there having been 30 or so services when you started and there now being over 600. What explains that? Was that just sort of—

Ms Coombe: No, that's Victoria.

Senator MARIELLE SMITH: Oh, yes. Sorry.

Ms Coombe: I wish I could say that.

Senator MARIELLE SMITH: Apologies. I was actually directing that to Ms Mogharbel. It's a difficulty when we've got some witnesses in the room and on the phone.

Ms Mogharbel: I can speak to that. I think what we found as the service was developed was that, as more services became visible, it emboldened other services to register on our database. We have an option for our services to be either privately listed, where they're only visible to our phone line workers and provided over the

phone, or publicly listed. When we first launched, around 70 per cent were publicly listed. Now we're up to 85 per cent publicly listed. We've had a number of services choose to become publicly listed when they were previously privately listed because they've seen the benefits that come from a visible and accessible abortion and sexual and reproductive healthcare system. We've done a lot of work with those providers as well to build their trust. We had an evaluation of the 1800 My Options service in 2020, and that showed that there were no detrimental outcomes for services that chose to list publicly. That definitely gave a lot of the healthcare providers confidence that this was something that would be suitable for them and their patients.

CHAIR: Senator Tyrrell?

Senator TYRRELL: Unlike a lot of other organisations, you don't explicitly recommend free contraception or free termination services in your submission. Is there a reason?

Ms D Hill: We didn't put it in the submission, but we would advocate for free services. We were going for something more pragmatic, but we absolutely would advocate for free contraception and free abortion as widely as possible because that would fundamentally improve access, improve outcomes and also support gender equality. We absolutely support that.

Ms Mogharbel: It's worth noting that we did endorse the Victorian Women's Health Services Network's submission, which specifically speaks to that.

Ms D Hill: We didn't want to repeat that. We thought we'd add value with our submission.

Senator TYRRELL: I appreciate that. Because I am Tasmanian based I'm asking a lot of Tasmanian questions. Because you've got a 1800 number, do you find that you get a lot of calls from outside of Victoria?

Ms Mogharbel: Around two to three per cent of our callers are interstate, so there are callers from Tasmania and there are also callers from across the border. Often in border towns it's a little bit confusing because people may access it in Victoria, South Australia and New South Wales border towns, for example. There are also callers from across the country who are looking for services because they cannot find how to access services like we can in Victoria, so they call us asking: who do I call in Western Australia? Who do I call in South Australia or Queensland?

Senator TYRRELL: You're setting a really good standard, I hear. Professor Dawson, are you still there?

Prof. Dawson: Yes, I am.

Senator TYRRELL: In your submission you advocate for a number of free services and products like free menstrual products and emergency IUD contraception. I don't disagree with this, so don't take this the wrong way, but I'm wondering if you know what the cost would be if we were to implement all of these recommendations.

Prof. Dawson: There is certainly evidence as well as costings from the UK. Scotland, for example, provides free access to menstrual products. I would have to get back to you on that with a cost-benefit analysis and some figures. In terms of the provision of IUDs, you would need to look at a package of funding because currently the burden is on the woman or person to source the commodity. That might be available at the service or it may not be meaning payment for two consultations, so there are out-of-pocket fees associated with that. And then pay for the cost of insertion or the cost of removal.

If one was to think of packaging that together in terms of costing, that would properly reflect the true cost rather than the way it's currently sliced. Progesterone-only pills are freely available over the counter in the UK, for example, at a subsidised cost. These are the sorts of costs one needs to factor in. Not having these freely available also has ramifications linked to productivity and unintended pregnancies. There are some costings available that I could supply if you need it.

Senator TYRRELL: Would it generally be a preventative investment then?

Prof. Dawson: Absolutely. That would be primary prevention number one, which would deliver great benefits to Australia.

Senator TYRRELL: In your submission you say that the skills and human resource shortages within the health workforce are major challenges affecting the entire healthcare industry. You also say that this is worse in regional and rural areas. Can you discuss what you are hearing from your members, specifically in Tasmania but I understand that it's a broad topic.

Prof. Dawson: There's an acute health workforce shortage, so we really need to consider the potential of task sharing in this space. This is on the point about removing MBS restrictions on nurse practitioners and eligible midwives so that they can, for example, prescribe MToP and can conduct pelvic ultrasounds if needed, which is very much in line with their scope of practice, including the provision of Medicare funding and better MBS benefits for non-GPs—nurses, midwives—to provide abortion telemedicine as well. It's been clearly demonstrated

in a number of other high-incomes countries, including the UK and Canada, that it's really safe for nurses and midwives to provide MToP and contraception efficiently, and that would reduce the burden on general practitioners.

Senator TYRRELL: Thank you so much for your time, I appreciate it.

Prof. Dawson: Thank you for inviting me to give evidence.

CHAIR: Thank you very much for your evidence today. If you took any questions on notice or if there is material that you think the committee absolutely has to have, please provide it to us by 5 May as we are going to be reporting to the Senate on 11 May.

BRADFIELD, Dr Zoe, Vice President, Australian College of Midwives

DAVIDSON, Mrs Linda, National Director Professional Practice, Australian College of Nursing

WARD, Adjunct Professor Kylie, Chief Executive Officer, Australian College of Nursing

WHITE, Ms Helen, Chief Executive Officer, Australian College of Midwives

WILKES, Ms Elizabeth, Vice President, Midwives Australia

[15:02]

CHAIR: I welcome representatives of the Australian College of Nursing, the Australian College of Midwives and Midwives Australia. I invite each organisation to make a brief opening statement.

Ms Ward: As the peak professional body and leader of the nursing profession, the Australian College of Nursing is committed to our mission of shaping health and advancing nursing. We support nurses to uphold the highest possible standards of integrity, clinical expertise, ethical conduct and professionalism through our advocacy, membership, leadership and policy work. Linda Davidson and I are both fellows of the Australian College of Nursing. I'm a registered nurse, and Linda is a registered nurse and a registered midwife. She has 49 years of experience, and I've got a decade or two fewer.

The Australian College of Nursing is a member based organisation with corporate and individual membership reach of offer 150,000 nurses in all states and territories. Our membership consists of clinical nurse experts, organisational leaders, academics, educators and researchers, as well as early- and mid-career nurses looking to move into leadership roles within the profession. We are also an accredited higher education provider and registered training organisation, graduating over 100,000 nurses in the past 15 years with postgraduate qualifications. And we have provided hundreds of thousands of clinicians with clinical professional development training in all settings, including immunisation and vaccination, just as some examples.

I would like to thank the Senate Community Affairs References Committee, including you, Chair—Senator Janet Rice—and all senators—Marielle Smith, Wendy Askew, Slade Brockman, Jacinta Nampijinpa Price and Louise Pratt in particular—for this opportunity to provide an opening statement in relation to the inquiry as well as to answer any questions from the perspective of the Australian College of Nursing.

In a nutshell, I'd like to highlight key concerns from our members, including access and the limitations, particularly of those living in rural and remote areas. The nursing profession, with appropriate education are adept at providing holistic care, including safe abortion care We're the largest clinical profession group, with over 400,000 registered nurses, and are the most geographically dispersed profession, meaning nurses already live in the communities they serve and have trusting and therapeutic relationships with consumers of all ages and demographics.

Access to reproductive healthcare models in regional, rural and isolated communities is insufficient and does not meet the sensitivities of a person living in the community and accessing reproductive care. In particular, evidence from the WHO shows that nurse and midwife led abortion care models are clinically safe, effective and acceptable to pregnant women. This is only one consideration for access and equity in relation to universal access to reproductive health care. I believe an investment in education resources for all nurses would make a significant impact to vulnerable, marginalised and disadvantaged consumers in a way that is values based, accessible and the best use of taxpayers' dollars. We welcome the opportunity to answer your questions.

CHAIR: Thank you, Professor Ward. Let's hear from the College of Midwives.

Ms White: I'd like to begin by acknowledging the traditional owners of the lands on which we meet today and pay my respects to elders past and present and any Aboriginal and Torres Strait Islander peoples here today. The Australian College of Midwives is the peak professional body representing midwives in Australia. Midwives are primary maternity care providers whose scope includes the provision of women's health support, education and advice before conception, during pregnancy, labour and birth and in the postnatal period. Midwives are also experts in sexual and reproductive health. This means that midwives' scope of practice holistically encompasses the needs of childbearing women and their families through the life course. However, current structural and legislative barriers prevent midwives from working to full scope. This is a significant missed opportunity for the midwifery profession, for government and, most importantly, for women and their families, particularly in rural and remote areas, which I know has been heard throughout the whole of this hearing.

The college's pre-budget submission and the Senate inquiry submission provide realistic solutions to address sexual and reproductive health inequities in this country by removing structural barriers for endorsed midwives and ensuring the midwifery profession as a whole can work to its full scope. These low-risk and low-cost

recommendations can only have a long-term positive impact on women and their families, the healthcare system and, importantly, the recruitment and retention of the midwifery workforce.

Dr Bradfield: Our key recommendations include equity for midwife prescribers and medical prescribers through legislative change to access the PBS and expansion of the MBS for full-scope sexual and reproductive health care and contraception and, more specifically, for the long-acting reversible contraceptives, or LARCs, that you would have heard much about. The reality is that the current MBS funding is restricted for endorsed midwives to access only pregnant women and women up to six weeks postpartum. Having such restrictions around MBS access is a missed opportunity and an untapped potential in this scope for field workforce to be able to provide this expertise around sexual and reproductive health.

We'd seek removal of legislative barriers preventing endorsed midwives from registering as medical abortion providers and the provision of funding for training. We'd seek the removal of collaborative arrangements legislation, enabling direct access for women to engage with endorsed midwives, and Commonwealth prioritisation and jurisdictional implementation of evidence based continuity-of-midwifery-care models as the primary and default reproductive and maternity models of care in Australia, particularly in rural and remote areas for priority populations such as birthing on country and the Aboriginal community controlled health organisation models.

We know that continuity of care with a known midwife results in less unnecessary intervention. It improves maternal and neonatal outcomes. It is a culturally secure form of maternity care. It results in retention of a skilled and scoped workforce and it is 20 per cent cheaper than standard, fragmented public care. Given the recognition of midwives expertise in primary, sexual and reproductive health care and maternity care, we would seek compulsory inclusion of midwives in all primary healthcare networks across Australia. With continued inequities, such as limited access to counselling, education, LARCs and medical and surgical abortion, an increase in some STIs, it is timely to prioritise the role of midwives and endorsed midwives for maternity and sexual and reproductive health care in Australia.

The National Health Reform Agreement principle 4 states: 'All Australians should have equitable access to high-quality healthcare, including those living in regional and rural areas.' For all women and their families, midwives provide a ready solution to the provision of universal access to high-quality sexual and reproductive health care. On behalf of the Australian College of Midwives, we would like to thank the committee for the opportunity to appear today and we welcome your questions.

CHAIR: Thanks very much, Dr Bradfield.

Ms Wilkes: I would also like to acknowledge the lands on which we're meeting today and pay my respects to elders past and present, and I extend that to any First Nations people here today. I would like to begin by thanking the committee for the opportunity to expand on our submission. I'm representing Midwives Australia. We are a small organisation representing endorsed midwives in Australia. I have heard endorsed midwives described by different titles throughout this hearing, including 'eligible' midwife', 'participating midwife' and a range of other expressions, which are part of the problem. The nomenclature is, sort of, a difficulty.

I am an endorsed midwife. I was one of the first Medicare providers as a midwife in Australia in 2010. We have strong relationships in the sector, particularly with the Australian College of Midwives, who are presenting here today. I would also like to acknowledge their submission and the submissions of our colleagues within the ANMF and QNMU, who also represent a number of our members. Endorsed midwives are midwives who have undertaken their undergraduate qualifications in midwifery, registered as a midwife and then have undertaken further postgraduate studies in prescribing. We also participate in and complete 5,000 hours of clinical practice before we can gain an endorsement for scheduled medicines. Once endorsed, we are able to obtain a Medicare provider number, which means that we can also prescribe and access the PBS or scans and blood tests, refer directly to obstetricians and paediatricians, and admit women to public hospitals. Endorsed midwives work within primary care. We work within midwifery practices of our own undertaking in multidisciplinary teams within team based practices and in the Aboriginal community controlled health sector. Endorsed midwives also, importantly, have a role in providing midwifery continuity of care to women outside of the hospital system, specifically those seeking home birth, particularly in areas where publicly funded home birth is not available.

The scope of all midwives includes sexual and reproductive health. The skill set of endorsed midwives lends itself to the provision of this care across the primary healthcare sector nationally. This is most relevant as it is available in the areas where there is greatest need; for example, in rural and remote locations and in the NACCHO sector. An example of this is the 'birthing in our community' model in Brisbane, which is a wraparound service for First Nations Australians providing midwifery continuity of care and demonstrating fantastic outcomes for

women, babies and families. In the North Brisbane BiOC model, endorsed midwives have admitting rights and admit First Nations women to hospital for their birth care.

Whilst the issues surrounding equity and access for sexual and reproductive health care are complex for many Australians, this is not an area where there is little hope. Opportunities are available, and many solutions exist. Midwives Australia believe that endorsed midwives provide an existing opportunity to resolve many of the issues around equity of choice, access and cost for women and families. We seek to try and reflect the imbalances that we are also experiencing as midwives. It is true that there are a range of barriers that remain, and we highlighted these in our submission. I'm more than happy to comment on the possibilities and solutions through the course of this visit.

Senator MARIELLE SMITH: I'm so excited to have a panel of midwives in front of us. I want to go to our terms of reference, which look at pregnancy care, and ask about continuity of care models in midwifery practice. I'm from South Australia where it is an option, but many women are missing out on these models. The evidence I've received from women and also from many midwives is that they love being part of these models and they do lead to better outcomes of care. I'm happy to put it out there to the panel for your perspectives on these models of care and what you think the sticking points are which are meaning that these aren't being expanded and provided more universally.

Dr Bradfield: Thank you for your enthusiasm and your warm welcome, particularly towards the end of the day. I appreciate you having us The reality is the jurisdictions run the way that maternity care is provided, largely, in these types of formalised systems outside of endorsed midwives, who offer private care. I'll speak to how the jurisdictions run and then maybe it might be useful for you to augment that with private care. From a jurisdictional perspective, you're right: there has been this expansion of access to continuity of midwifery care and it has been well received, but the demand far outstrips supply and that's nationwide. That's not a jurisdictional issue. What it really needs is bravery on behalf of our health service leads to default to exactly what we've put in our submission—that is, continuity of midwifery care must be the default model and not for any other reason than the evidence supports it so comprehensively.

We then have consumer demand as well. The outcomes are significantly improved when the woman who is pregnant is cared for by a known midwife. We see those outcomes; we can list them as long as our arms. We get reduced neonatal admissions, reduced unnecessary intervention, lower caesarean section rates. We have lower stillbirth rates. We have lower preterm birth rates, which is a significant predictor for neonatal or foetal morbidity. We have all of these positive outcomes. Then we look at the fact that we're in the middle of a workforce crisis, and continuity of midwifery care is the model where our workforce wants to work most. It results in a skilled and capable workforce because people are working to the peak of their capacity. It's an autonomous workforce. We retain them. It's culturally secure. As if we needed another piece of evidence, it's 20 per cent cheaper than the standard public fragmented model that we're currently working on, and that modelling has been comprehensively done through Professor Emily Lancsar's work. She's based out of UTS now. The economic modelling really is the final piece where we should be defending now why we're not having that as the default model of maternity care rather than why are we. Why is that not the default, because the outcomes are better, women want it, workforce stay in it and it's cheaper?

Senator MARIELLE SMITH: What kinds of recommendations would you like to see from our committee that could help drive an expansion of these models around the country?

Dr Bradfield: Obviously, we've outlined some of those in our submission but clearly we'd like to see a questioning from within the jurisdictions about why there isn't this expansion. Having worked in the health system for more than 25 years, I understand that big ships turn slowly and that is true about bureaucratic systems. But the reality is we have just come through COVID and have demonstrated to ourselves beyond a shadow of a doubt that we can turn it like this. Systems, policies, guidelines and procedures that once would have taken a year to get through a hospital or a health service board suite of committees, we can now change in an hour. So it's actually really encouraging to me, as someone who's worked in the health sector for so long that, yes, we do have to do due diligence about this but we actually don't need any more evidence in order to pivot our systems. You could actually start to say, 'Is it unethical to continue to commit funds to generating more evidence around the benefits of continuity of care? We have it comprehensively within Australia and around the world. It's undeniable that continuity of midwifery care is the evidence based way to provide care for all women who are pregnant.

Ms Wilkes: I'm living proof that the Commonwealth can have an impact on this sector. I definitely want to say that, as endorsed midwives, we are the living proof that the Commonwealth can actually expand continuity of care to midwives by expanding access to this model. The number of endorsed midwives has doubled in the last two years to a thousand midwives. If we continue to double at this rate, in two years time we will be at the same

level as nurse practitioners are currently. It's not an area where we need to be concerned that we're not going to get the numbers. We're getting them. Midwives are working with their feet. Women are demanding this option, and we're certainly having a significant amount of growth.

There is an absence of endorsed midwives and an absence of midwives in general in government policy to some extent. I think that any recommendations that come out of this committee need to reflect the fact that we need to be more visible, that we need to be listened to, and that there are small changes that can be made, such as around insurance. We've talked previously in our submission about professional indemnity insurance, but some of the barriers of access to equity in the PBS is another area that could be expanded upon. And, certainly, what's available in MBS funding is another area. But even just looking to the sector and providing more health literacy and education for women as to what's available and for midwives about how to move into this model is something that is definitely within the Commonwealth's remit.

Ms White: Just on that note, the Innovative Models of Care funding, for which the government have $100 million, does not currently include the maternity space. I think that's really a recommendation that could be provided to government. We need to be front and centre in that space if we want to grow midwifery models of care.

Senator MARIELLE SMITH: Thank you. If no-one else has got anything to add on that, my second question goes to the challenges we see in remote and regional parts of Australia when it comes to access to maternal health care. As I was explaining to previous witnesses, I'm from South Australia. We do not have big regional centres like other states and territories do, where you may be one or two hours from a big hospital. If an obstetrics service or a maternity healthcare service leaves a town, you're up to a four- to six-hour drive to the next hospital which might have these services. I'm interested in the role you think midwifery might play in solving some of these challenges and how that rubs up against your current scope of practice, full use of scope of practice or potential extensions of scope of practice.

Ms Wilkes: Certainly, endorsed midwives sit really well in this space. There's the ability to work in those hub-and-spoke models. We already, obviously, have access to MBS prescribing. We can do ultrasound. We've got all sorts of different abilities within our scope, and that gives us the ability to work in very remote areas and then either work by pathways of referral or by actually travelling with women to be able to provide additional services into those centralised hubs. There are many models where this is already working, and I think that it's really incumbent that people start to look to the models where it's working and start growing those models.

Obviously, the funding that government has that Helen was just referring to is the sort of thing that could be expanded to include areas of maternity care. I've sat on several committees where there hasn't even been a discussion around maternity care, because they've said, 'Well, there aren't any maternity services in these areas, so women have to just travel.' We can bring birth back, or we can even bring some form of maternity care back to those more remote areas, if we actually look to ensuring that midwives can work to full scope and that that's supported by funding.

Dr Bradfield: And even outside of the remote areas, we have relatively major rural and regional centres that have lost their maternity services, and that's completely unacceptable. When we look at the national maternity strategy around access, there really needs to be a mandate offered that we need to have maternity for these services to continue. When maternity care is embedded within a town, it does other things outside of just provide health care for the town. It also provides extended support services and the like.

The other thing is that endorsed midwives, as Liz has already spoken about, are often living in the areas where these rural, regional and remote areas are anyway, so they're able to provide that. Birthing is just one part of maternity care. There's a whole lot of antenatal care, postnatal care, interconception care and preconception care that midwives are fully scoped to be able to provide, but currently they are unable to access MBS funding outside of seeing a pregnant woman.

Senator MARIELLE SMITH: I apologise; I have to leave early to catch a flight. I'm really excited about the role that you can all play and some of the challenges we're looking at. Thank you so much for your evidence.

Mrs Davidson: Can I just add one bit before you go. I acknowledge what my colleagues have said, but there are areas where there aren't midwives, and I think there needs to be recognition that there are nurses working there in advanced practice that do need that support, education and skills in that place. They are providing it and not getting the recognition. They also don't get access and they don't have RN prescribing. But nurses are everywhere.

Senator MARIELLE SMITH: Yes, that's a really important point. Thank you.

CHAIR: Senator Waters.

Senator WATERS: Likewise, I'm thrilled to have a panel of nurses and midwives at the table. I was fortunate to deliver both of my girls at the Birth Centre at the Royal Brisbane—so, massive support and a shout-out to the midwives and nurses doing wonderful work to support women through birth, and before and after. I had great antenatal care. Anyway, enough about me.

You've talked quite persuasively about the expansion of the things that you could do and the fact that we need Commonwealth funding to properly recognise that so that we can fill the gaps in the existing health workforce by using the skills that you already have but you're just not paid to deliver. It makes perfect sense to me. Could you contrast what you're able to do in Australia with, for example, New Zealand? I think you mentioned there was a good point of distinction there.

Ms Wilkes: Yes, certainly. We still are able to do similar things, but we are funded extremely differently. The model of care in New Zealand is funded on an episodic level of payment so that a person is able to access whichever lead maternity care they choose, and they receive a payment for the antenatal component in trimesters, birth care and then postnatal care. This enables them to seek the care that they want over the continuity experience. But we are not funded anything like that in Australia. It's very much still a fee-for-service model under Medicare for endorsed midwives. Then obviously, in the private sector, it's completely different again, and in the public sector they're accessing that through hospital systems, often in a fairly fragmented way.

So, whilst the scope is fairly similar in the maternity space, it is different in things like access to medical abortion and access to prescribing. There's a much broader scope of drugs that midwives are able to prescribe in New Zealand compared to what they're able to do in Australia. Access to things like ultrasounds and technology is fairly universal in New Zealand, whereas in Australia you have to do an additional credentialling course to be able to provide ultrasound services.

Senator WATERS: Okay. We've had a lot of evidence so far, not just today but in other hearings as well, about the fact that both nurse practitioners and midwives could readily deliver not just maternity and antenatal and postnatal services but contraception and pregnancy termination services. Is that something that you support and would like to be funded to do?

Dr Bradfield: Midwives have scope to provide care from menarche to menopause and everywhere in between, and currently, certainly from a Commonwealth perspective, we are restricted to providing care only once a person is pregnant and then up to six weeks postnatally. The women of Australia deserve access to the high-quality evidence-based levels of care that Australian midwives and nurses provide. Yes, we would absolutely seek an expansion of MBS access—but also that recognition that flows down into jurisdictional based care as well.

Ms Ward: Can I add for the Australian College of Nursing that even nursing practitioners are limited, as no doubt our colleagues are, with MBS and PBS limitations. As we've just heard from the National Cabinet this afternoon, people working to the top of scope, registered nurses, should be given the education and support to have prescribing rights. That would make a tremendous difference. For example, if we look at pregnancy or even the consideration of termination, registered nurses generally complete the initial consultation and do the paperwork, but, when it comes to being able to request a bulk-billed pelvic ultrasound or prescribe the MS-2 Step, there's no opportunity, and then you've got to redirect around if there's no doctor, and there's the time that's taken to get that access. For us, it's not the best use of highly educated professionals. It's certainly distressing to consumers waiting for outcomes, and it just puts another roadblock in the system. It's a bureaucratic process that just needs to be lifted. All of us have access to be able to deliver the care we are trained to do and want to give.

Senator WATERS: Yes. You've already the skills, there's just this arbitrary obstacle in the way.

Ms Ward: Correct. If not, we can put the training in. One of the things we've said is: 'Fund some education. We'll develop it and deliver it nationally for free to every nurse or whoever.' We can do that as a higher education and registered training authority. I would just quickly like to acknowledge Senator Waters, Senator Tyrell and committee secretary Ms Youhorn. I'm sorry I didn't have you in my initial welcome of who I thought was—

CHAIR: And we've got Senator Payman, who's just joined us online.

Ms Ward: Okay. It's a mystery, but I'm open to it.

Senator WATERS: It's very gracious of you to acknowledge any of us.

Mrs Davidson: Can I just add, we've recently been to the rural health summit with Anne Webster. There were many stories there, but, in particular, there were nurses that are dealing in women's health and working in the bush with collaborative arrangements, where they've got it already to go, but the GP or the doctor is not available, so the woman has to travel another 60 kilometres to go and get the care that they've just had.

Ms Wilkes: I had an example from my colleague Mel Briggs, who's at Waminda. I've heard Waminda mentioned numerous times. They're an Aboriginal community controlled health service that we're doing a lot of consultancy work with. She was explaining an exact example of that. She is an endorsed midwife. They had a woman present for a six-month infant check, and she was pregnant again. She asked to speak to the midwife, because she'd obviously had care from her previously. The midwife, as an endorsed midwife, was able to order the blood tests and order the scans but then couldn't go on to order the termination that the patient was seeking. Then she's had to go to someone that she didn't know, to try and seek services in another area. as Mel said, they're expanding everything that they can do within their service, but they're not able to actually prescribe medical terminations.

Dr Bradfield: That's just the prescription, then you've got to find the pharmacy that will actually dispense it. For rural and remote women, having scope for field workforce is one piece of the puzzle. We're already scoped and we're able to provide it. There are legislative barriers, but they could be removed, so we could write the prescription. But then I have a woman in front of me that I've given a prescription to, and I know that she can't get the medication in time to have a medical abortion.

Senator WATERS: The TGA are up next, and I'm going to ask them. They're currently reviewing the dispensing rules, so that's definitely on our radar. Sticking with the College of Midwives and Midwives Australia, what are the outstanding recommendations of the Participating Midwife Reference Group of the MBS review? How would implementing those recommendations help improve sexual, maternity and reproductive health care?

Ms Wilkes: I can definitely speak to that. I was a member of the Participating Midwife Reference Group. What's on the public record and what we can see now is that the only recommendations that have been implemented are those that impacted intrapartum care. There are four recommendations. All of the recommendations around antenatal and post-natal care have not been implemented. Out of the 10 that were endorsed by the MBS task force, six of them have not been implemented at all, and some of them were considered outside of scope. There are areas outside of pregnancy—so the extension past that six-week mark—that were considered by the Participating Midwife Reference Group that weren't actually considered by the task force. That's a really important gap because women are not necessarily thinking about contraception at six weeks—they probably are thinking about it a little bit later along the journey than that—and midwives are still in the space to be able to provide that support. It's certainly within our scope, but we haven't got any Medicare items that are available for that. That needs to be considered as well.

Senator WATERS: Thank you. Can I come now to the College of Nursing, noting that I will have to share the call soon. We've already covered expanding the scope of practice for nurse practitioners and advanced practice nurses. You've noted that's within your skill set as well and that it's those arbitrary bureaucratic barriers that are stopping it. In your submission, you call for the expansion of mobile reproductive health services. Do you have any good models for that? I'm asking because I met with True in Queensland last week. They have a plan for a mobile bus, which actually sounds amazing. Can you tell me about any good models for mobile reproductive health services?

Ms Ward: I'll hand over to Linda to give you an example. We can also put a shout-out to our membership and take that on notice and get back to you.

Mrs Davidson: It is a Queensland model. It's been a very successful model, and it's expanding more and more as we go—that is, the mobile women's health nurses.

Ms Ward: These are really easy solutions if people are empowered to actually make decisions—get in and drive out, have a therapeutic relationship and meet the community.

Senator WATERS: Yes.

Ms Ward: We'll get any others to you.

Senator WATERS: Thank you. I'll look forward to those.

Ms Wilkes: The other thing is that there has been no ability for nurses and midwives to apply for a lot of the funding. There's funding that's going through with PHNs and there are other opportunities for allied health and GPs, but nurses and midwives are totally falling through the gaps in terms of being able to apply for funding for these types of innovative models. Every time a funding round comes out, we look to it. I'm sure the nurses are the same. And we're—

Senator WATERS: And you're not eligible to apply. That must be enraging.

Ms Ward: In fact, in other examples, they're almost crowdsourcing or going to corporates to fund, which is unacceptable for the marginalised and vulnerable groups that they support.

Senator WATERS: We're meant to have a public healthcare system for the country.

Ms Ward: Correct.

Senator WATERS: Lastly—and because you've raised it already and because I've been to the service in Salisbury, if geography serves me correctly—can you talk me through the benefits of supporting First Nations people to stay on country for maternity care and birthing and what we can do to better facilitate that? I'm happy to hear everyone's views on this.

Ms Ward: The Birthing in Our Community model, which you're referring to, has a number of hubs now in Brisbane. It's been published in the *Lancet*. It has reduced preterm birth by 50 per cent, closing the gap—smashing the gap, really. There has also been an improvement in stillbirth rates. There has been a reduction in the removal of children, which is another massive area, which is obviously not necessarily particularly relevant to this committee, but, as a social health impact, it's huge. There has been an increase in breastfeeding, improvements to caesarean section rates, an increase in attendance in antenatal visits and a reduction in low birth rate babies. The list goes on and on. They're basically trying to expand that model across all of Brisbane and into rural areas in Queensland and looking at that as being the outline for other birthing-on-country models that could roll out through Australia.

CHAIR: It shows we've got some solutions.

Ms Ward: We've got the solutions. That's why I said that we've got hope. We've got solutions that are actually existing; we just need to be looking at them and maximising how we can roll them out.

Dr Bradfield: Having midwives on primary healthcare networks really is the linchpin of all of it. It helps that communication. Where I work professionally in Western Australia, there are still many community settings that aren't aware of these types of models. Then they might be aware of them peripherally, but how do I actually stand that up? What are the funding models? How can I make it happen? It's just those really pragmatic kind of solutions when we know that the model works.

Ms White: Midwives are also slipping through the net with regard to funding. For example, there's no HECS debt relief for midwives in rural and remote areas, whereas there is for nurse practitioners and GPs. Midwives are not in the Workforce Incentive Program; they're not in the practice incentive program. Midwives also need to improve their data in regional and rural areas. I think that whole space of funding is really important to consider as well.

Senator TYRRELL: I have a question about incentivising, and you mentioned HECS, which I think would be amazing. What other measures do you think would attract midwives to regional, remote or rural settings?

Dr Bradfield: Something the Commonwealth could action relatively easily is a support package similar to that which is afforded to the GPs in rural, regional and remote areas. It makes sense that, when you've got practitioners that are able to fill similar scopes within their specific areas, you afford them the same incentives that the medical workforce gets. Supported return to metropolitan base for professional development and looking at support online and professional development leave—the whole raft of measures that are available to GPs should be available to all midwives working in rural and remotes as well.

Senator TYRRELL: It's alleviating their workload.

Dr Bradfield: Yes, and it's supporting them. It's saying: 'We care. Your investment really matters. We want you to stay and keep doing the good work that you're doing. Let us come and help you—give you some relief, give you some development and keep you fresh, invested, motivated, interested and willing to stay where you are and keep doing the good work you're doing.'

Senator TYRRELL: I love that. College of Nursing, you had some recommendations about travel subsidies for people as well. How would that look for people who are not close to a hospital? How far away would the subsidy kick in? In Tasmania you can be half an hour away from a hospital but that's over the hill and far way and there's no public transport et cetera.

Ms Ward: That's not something within our remit that we've scoped, Senator, because access means different things to different people and there's the equity around that. The geography of kilometres might actually mean that there's no public transport. But one important thing that we tied in our submission was confidentiality. Linda had a great example of when a GP went on leave and a locum came in.

Mrs Davidson: One of our members gave that example. The locum came in so of course all the women who worked in the hospital actually thought, 'Right. The locals aren't there, because we work with them day to day'—

Ms Ward: Your Pap smear and your whole health—

Senator TYRRELL: They get all those things.

Mrs Davidson: Yes. However, they knew that they would be wanting one of the woman's investigations done so they prepared themselves so that it didn't happen, but this one was a bit of a wily person and had them in front. They actually had to get it done while they were there. It is just an example, having worked in a rural environment, how desperate even the caregivers are to make sure that it's sensitive, confidential and accessible.

Ms Ward: Even if we respect all of our colleagues, sometimes you want a bit of anonymity. What we're suggesting is not only around affordability, particularly for Aboriginal and Torres Strait Islander people and those that are affected by social determinants of health—how can you afford to get access? The other side of that is confidentiality.

Senator TYRRELL: Yes.

Mrs Davidson: We talked about our colleagues with midwifery. There is that preterm and the distance. Some of that takes in that distance to go. They have to come to the major centre not the day of but weeks in advance, leaving their families. There's a cost impost there. They want to get back as quickly as possible. There may not be the expert available there, but that's the desperation.

Dr Bradfield: And we see more and more people playing roulette on the highway—'I'm on my third baby. I know how this goes. I'm unwilling to relocate two weeks before. My partner is a farmer. We run our business from our home. I can't leave my two children. I have no-one else to support me.' Never mind those who are from refugee backgrounds and those who are from non-English-speaking backgrounds living in those rural areas—

Ms Ward: Who don't have a partner.

Dr Bradfield: who don't have a partner or any other extended support. There is just the economic impost of relocating hundreds of kilometres away for weeks at a time. If you end up with a caesarean section, which 38 per cent of people in this country do, then your stay is going to need to be longer and so you are apart longer. When you return, you need further repatriation and recovery time. These are significant issues.

Senator TYRRELL: Beautiful. I have one more and then I'm out. In the Midwives Australia submission you say that in Australia the role and potential of the midwife is not fully realised. I'd really like to hear from you what the situation is like in rural and regional areas. I'm from Tassie. They're alone a lot. They're remote. How does it impact on them and how they do their job?

Ms Wilkes: The thing is that when they're able to work to their maximum scope they actually do that really well and they link in really well with other colleagues in larger centres. They're able to do that where they are given permission. Inside the hospital system, as Zoe mentioned earlier, it can depend on the local hospital as to what's available to them. Outside of the hospital system in primary care—in GP world or in midwifery private practices—we take the lead ourselves. We develop those models. We get them up and running. In regional and remote areas, it works so well because we're able to then just step into our space, control our scope, work to the maximum of the scope and do that really effectively. More than half of our members are working in that space outside of the urban areas. They are the midwives that have stepped up and become endorsed so that they can work, prescribe, do all the extra things that they want to be able to do and access the MBS and PBS effectively. I think that we take the lead because we know what we can do, where we're able to. I think that's a really important factor.

Senator TYRRELL: Because you know what's going on.

Ms Wilkes: We do know what's going on. Tassie has one of the most amazing birth centres, at Launceston. The midwife there, Jaimee, is amazing. The birth centre has been in existence for quite some time, but she became endorsed so that she could then extend what she's doing. I think it just works so amazingly well for women accessing continuity of midwifery care.

Senator TYRRELL: I don't think anybody in their right mind would take a midwife or a nurse on!

Mrs Davidson: Can I just give you an example of another versatility and the advantageous employment of a nurse-midwife in a rural community? I've got an example of a midwife doing her rounds and ringing the local farmer to say that his cow was calving in the paddock.

Senator TYRRELL: And does he need help!

Mrs Davidson: Yes. So that was very advantageous for that farmer. He thought that that was taking birthing to the nth degree.

CHAIR: The usefulness of midwives!

Senator TYRRELL: The first calf that has ever had its umbilical cord clamped!

CHAIR: Thank you very much for your evidence today. It's been really valuable for the committee. Thank you for appearing. I don't think any of you took questions on notice. We're going to be reporting to the Senate on 11 May. Thanks for your contribution to our inquiry.

Proceedings suspended from 15:46 to 16:04

DUFFY, Ms Tracey, Acting Deputy Secretary, Health Products Regulation Group, Department of Health and Aged Care [by audio link]

LANGHAM, Adjunct Professor Robyn, AM, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care

CHAIR: I now welcome representatives in person and by teleconference from the Therapeutic Goods Administration. Thank you for appearing before the committee today. Do you wish to make an opening statement?

Dr Langham: The Therapeutic Goods Administration, or the TGA, was established to enhance the health of the Australian community through the effective and timely regulation of therapeutic goods. Part of the Commonwealth department of health, the TGA regulates all therapeutic goods in Australia by evaluating them before they're marketed and by monitoring products once they're on the market. The TGA focuses on safety, efficacy and quality in both evaluation and monitoring, and it works closely with consumers, health professionals, industry and international counterparts. The TGA undertakes these tasks through administration of the Therapeutic Goods Act 1989, setting requirements for the entry of products in the Australian Register of Therapeutic Goods, or the ARTG.

Very importantly, registration or approval under the ARTG is a critical requirement for any sponsor who wishes to supply a product to the Australian community. Importantly, the TGA cannot compel a sponsor to make an application for registration. The TGA does not have the legal ability to grant approval or initiate evaluation of a product in the absence of a formal application by a sponsor.

Of interest to this inquiry, we regulate two main categories of therapeutic goods—medicines and medical devices. There are standard evaluation pathways that do include time limits taken to complete evaluation and also allow for expert independent advice through one of our eight statutory advisory committees. There are also pathways that allow for a more expediated review. On the one hand, we have priority pathways for products that meet certain criteria, but there is also the opportunity for a sponsor to seek parallel approvals, halving their time, for both the TGA approval and consideration under the PBS at the same time.

There are TGA supported pathways for consumers to access certain unapproved products as well, things that have not been assessed by the TGA. These are the special access scheme, the authorised prescriber scheme and also clinical trials. Unapproved medicines that are accessed through these pathways have not been evaluated by the TGA for safety, quality and efficacy.

In acknowledgement of the importance of women's health, the TGA established the Women's Health Products Working Group in June 2022. The working group brings together the TGA, health professionals, academics and patient groups as a collaborative forum, examining questions relating to the clinical evidence and policy that support the safety, quality and efficacy of health products and women's health. The issue of access to medical abortion was discussed in depth that our meeting in October last year, providing very clear messages on the imperative to amend and revise current barriers to health for greater access.

In summary, the TGA's robust regulatory processes do strike a balance that ensure consumer safety with timely regulatory availability.

CHAIR: Questions.

Senator WATERS: I have lots. Thanks very much for being here, Professor Langham and Ms Duffy. Can I just start off with the last reference you made, Professor Langham, to the women's health product advisory group, which, if I heard you correctly—and I'm not hearing very well today—you said was established in June of last year and had a meeting in October of last year discussing abortion access. Can you tell us a little bit more, if you're permitted to, about what was discussed and what the results of that discussion were?

Dr Langham: What was discussed was just that: the barriers to access, and also the data that was presented to the group was the paucity of availability that was, in part, from the very low numbers of general practitioners which were registered to prescribe and also the low number of pharmacists that were registered to dispense. There were a number of other factors that were identified, and most of these were barriers that were put in place when the drug was first registered in Australia about a decade ago, and that was, in part, through a risk management plan and, in part, through the actual regulatory documents that sit around the registration—the product information document. It was universally agreed that what was put in place 10 years ago was no longer relevant. It was really out of step with current international guidelines and it certainly was not meeting the needs of the Australian community in what it did. We discussed several options as to how this could be remedied. Along with my earlier statement that the TGA is not able to evaluate or monitor a drug that's not been presented to us by a

sponsor, we're also unable to make any changes to risk management plans or product information without an approach from the relevant sponsor. In Australia, there's just the one sponsor, and that's MS Health. We talked about where others might be able to make approaches, where other options might be moving forward. It was a few weeks after that I think that MS Health came to the TGA with their application to ease some of the restrictions in the risk management plan and in the prescriber information, namely that there wasn't going to be a requirement for pharmacists to register but also that there was going to be a removal of the specific word 'doctor', opening up potentially to all healthcare practitioners, including nurses and midwives, and that after registration healthcare practitioners would not be required to do annual certification programs. Because of the clear messaging that had come out of the working group, I was able to then go to the sponsor and say: 'We thank you for doing this. We think this is a great step forward, but there's certainly a lot of very strong sentiment in the community and in the relevant stakeholder groups that you need to go further.' So we had a discussion trying to share the thoughts of the group with the sponsors, and it was after that that the application to amend the current risk management plan and the PI was expanded further so that their application that's currently sitting with the TGA, which is being dealt with in an expedited fashion, includes dropping the requirement for doctors to register with the company altogether. I would anticipate that without this requirement the stigma that might be attached to prescribers having to register with the only company in Australia that provides medical abortion will certainly allow for a greater access and a greater uptake.

Senator WATERS: Thank you. That's a great run through. I appreciate that. What time frame are you now working to to assess that revised application?

Dr Langham: At the moment we're talking a couple of weeks. As is part of our process, I mentioned our external independent clinical advisory committees, and we have one specifically for the evaluation of medicines. That's our Advisory Committee on Medicines. I understand that the evaluators that are currently working with the proposal are planning to take that to the Advisory Committee of Medicine for further comment, and, if that's going to happen in too long a time, then certainly an out-of-session consideration could be managed.

Senator WATERS: What further steps are there after that, before such time as hopefully those reforms would then become reality?

Dr Langham: That's it, once the TGA approves the amended applications.

Senator WATERS: There's no further delay? That just changes like that. You mentioned a couple of weeks, but then you also said waiting for the special Advisory Committee on Medicines. What's the longest you think it could be?

Dr Langham: That's a single meeting, and it really has to do with the calendar for the meetings to which they sit. I'm not sure of when their next sitting is. They generally happen every couple of months. If it's too far away, then we could certainly have an out-of-session consideration for something like this.

Senator WATERS: That sounds really positive, and that's following on from when we previously spoke in estimates as well. With the proposed removal of the restriction for doctors to register and the removal of the term doctor, will that mean that nurses and midwives—notwithstanding that the PBS won't change or may not change—will be able to prescribe both medicines?

Dr Langham: Senator, you've hit upon one of the interesting vagaries of our country, and that is that not all federal law applies on a state basis. Certainly the states and territories have their own powers, and allowing prescription of certain drugs and medicines by nurse practitioners is really on a state-by-state basis.

Senator WATERS: I see. So even if—

Dr Langham: We can make it allowable, but still the states have then got to decide for themselves. You've probably heard already that there are some states that are very active in promoting nurse practitioner activity and prescribing and even clinical activity, and some are less so.

Senator WATERS: Thank you. Just sticking with MS-2 Step, the World Health Organization has recommended that it be available up to 10 weeks through nurses and midwives and 12 weeks through GPs and also that an ultrasound should not be a prerequisite for dating the pregnancy. The risk management plan that you've already referenced is at the moment far more restrictive. Are those restrictions under review?

Dr Langham: Again, this is reliant upon the sponsor coming to us with those requests, and my understanding is that MS Health is not at this stage willing to reduce the gestation time. I understand it's from a risk management perspective: risks increase as gestation increases. On the ultrasound itself, the wording in the product information doesn't mandate an ultrasound; it recommends. So I don't see that necessarily—

Senator WATERS: You think that's not a problem?

Dr Langham: as a huge barrier. I certainly think that, where an ultrasound could not be obtained, sense and pragmatic, practical behaviour would prevail.

Senator WATERS: It wouldn't be a barrier. Okay, thank you. That risk management plan also mandates a follow-up appointment after two weeks, and we've heard that this can be expensive, inconvenient or impossible, depending on where you live, if you've got to travel for that care. Is the need for that follow-up appointment under review?

Dr Langham: Again, that has not come to us as a particular instance—bearing in mind that what the product does is that it brings about a miscarriage and women have miscarriages all the time, sadly, in a lot of cases. It would normally be a clinical recommendation that women see medical practitioners for follow-up after that incident at any rate.

Senator WATERS: Thank you. We've taken a lot of evidence so far about the limited range of contraceptives that are available on the PBS. Can you explain for me what role the TGA has in recommending to the Pharmaceutical Benefits Advisory Committee about whether medicines and devices be added to the PBS? Can you tell me who does what in the zoo?

Dr Langham: The zoo is very independent in that regard. We sit very much in different cages. Sorry, tell me if I'm using too many analogies. The TGA's role is to evaluate and approve and monitor. Our role really does not move into the economic affordability or otherwise at all, so we have no responsibility.

Senator WATERS: You don't make any recommendations to PBAC in that regard?

Dr Langham: We make no recommendations. Our role is purely based on quality, safety and efficacy according to the dossier that's been presented to us. Some of the paucity of drugs that are available is really due to the fact that not all of the sponsors that supply product internationally wish to have those drugs registered in Australia. We can't register a drug where a sponsor has not come to us.

Senator WATERS: And the government can't do that either, and that's your job anyway, not theirs?

Dr Langham: Absolutely, yes. By law, we cannot do it and the government cannot do it.

Senator WATERS: Can we change that law? Which law is that?

Dr Langham: It is certainly possible to change the legislation. The legislation gets changed every one or two years as the world of medicine and science changes around us. For example, the medical abortion drug could not be registered by the TGA at all up until the time it was registered, because an act of parliament removed it from our purview. So that was not a drug that was available in Australia at all. That's an example of how the government can change legislation, if you like, in order to change the way the TGA regulates product.

Senator WATERS: Sorry to belabour this, but—just for my own understanding—if the government were persuaded by the weight of evidence that this inquiry has taken and wanted to list additional medications related to reproductive health on the PBS, could it change the law and then unilaterally make that listing?

Dr Langham: I'm not a lawyer and am certainly not experienced in this. If it were to be done—if the government would want to make a decision on any product, independent of the TGA—then it would be done, I would imagine, without consideration of quality and safety and efficacy.

Ms Duffy: I would just add that we need to be very clear about the delineation of roles and responsibilities. As Professor Langham has said, any consideration for listing of a medicine on the PBS is not the domain of the TGA; it's different legislation and different requirements, and we have no part to play in that. For devices, it goes to the Prostheses List Advisory Committee, so it doesn't go through the PBAC process.

Senator WATERS: Thank you for clarifying that. I'm sure the government can do exactly what it likes, but I understand that the PBS listing is not within the TGA's purview.

Dr Langham: As I understand it, the PBS can only approve a drug that's listed on the ARTG.

Senator WATERS: And that is something that the TGA is responsible for?

Dr Langham: That's what we do, yes.

Senator WATERS: I understand.

Dr Langham: But it is possible now, to improve process and timeliness, that this can be done in a parallel fashion. So, as the TGA is assessing and evaluating a drug for safety and efficacy, the PBS can also be evaluating that drug for economic benefit.

Senator WATERS: Yes, and you mentioned that at the outset—that those two processes can be concurrent.

Dr Langham: Exactly.

Senator WATERS: We've taken some evidence previously about the plethora of newer pills—whether they're progesterone only, or whether they have fewer side effects or are just medically more appropriate for people—that are not on the PBS. I think maybe 20 of the 41 fall into that category. Just for my clarity: are they medicines that the TGA has assessed and the PBS simply hasn't done its part to list them and make them more affordable, or are they medicines where the TGA has also yet to give them its imprimatur?

Dr Langham: If there's a drug that is not on the ARTG, it is because, most likely, the sponsor has not come to us with a dossier asking for it to be registered. We are not allowed to give an imprimatur to a new drug that's available in the US but has not been presented to the TGA for registration—and that is the most likely case, I would imagine. Once a sponsor has a drug on the ARTG, it's then their decision whether or not they want to submit it to PBAC for approval under the PBS. There are some cases where a sponsor may not choose to do that because of the cost and the economic impact to them, or because they are still trying to settle into the Australian environment and that's still some time down the track. So you've either got drugs that have not been presented to the TGA for registration and are not on the ARTG, so the PBS is not able to review them, or you've got drugs that are on the ARTG and have been approved by the TGA and the company has not taken that to the PBS, or you've got the current situation where we have the drugs that are available. But certainly, wherever we get asked for approval and the drug is safe and efficacious and all the rest of it, we are able to approve a drug and place that on the ARTG.

Senator WATERS: So can you tell me where those newer pills sit in that spectrum of those three categories? Is it the first or the second?

Dr Langham: You'd have to give me a list—

Senator WATERS: We do have a list somewhere; I just don't have it to hand.

Dr Langham: As do I!

Senator WATERS: There's a progesterone-only one that has been referenced quite frequently. It's able to be purchased; ergo, it must be TGA-approved, but it's not PBS listed?

Dr Langham: Correct—

Senator WATERS: Okay. I will come back to you with more questions—

Dr Langham: which means the company probably has not taken that drug to the PBS for approval. It's not an automatic process where we approve a drug and then we send it off to PBAC for approval.

Senator WATERS: I'm just still struggling with the fact that people are missing out on the best quality medicine—

Dr Langham: I agree.

Senator WATERS: because some multinational person—company—wants to make more money. I find that a bit hard to fathom. But I'll just deal with that in my own way.

Can I come now to the trial of the over-the-counter pills in Queensland and New South Wales. Have you been consulted around the parameters of those trials, and is there a plan for the TGA to revisit its earlier decision to not allow over-the-counter pill scripts?

Dr Langham: The TGA has not been consulted. This, again, is one of those other state based decisions that happens independent of any TGA processes. At the moment, oral contraceptive pills are listed as schedule 4 on the poison schedule, which is prescription-only. The question of whether that could be down-scheduled from schedule 4 to schedule 3, which is behind-the-counter pharmacist consultation, not over-the-counter 'help yourself' in the pharmacy—that's schedule 2—was brought to the scheduling committee of the TGA about 18 months ago. Scheduling change processes are quite clearly regulated: the question is evaluated by a delegate; there's a broad consultation process; there's a speciality committee that also looks and gives advice on scheduling; and there's an interim decision, another broad consultation process and then a further final decision.

There was a decision made back in December 2021, and the delegate considered that the complex risks that changed with age—albeit they're very low—were such that involvement of a medical practitioner was required. There was also concern that, by having oral contraceptive pills available over the counter, there would be a bias in contraceptive opportunities towards oral contraceptive pills and not some other device, perhaps, that might actually be better suited for the woman than the pill. It was decided that having that overarching discussion and care of a woman's entire reproductive health was better placed in the hands of the medical practitioner.

I think there was a lot of concern at the time that women had to go and see their GP on a regular basis, and there was a comment made that an easier way to ensure that women were unencumbered by the need to go and see their GP was to change the prescribing length, rather than taking it out of the hands of the medical

practitioner. I think the feeling at the time was that a 12-month visit to a GP for your overall health when you are taking an oral contraceptive pill, with all of the potential risks involved, was not considered excessive.

Senator PAYMAN: My first question is: how does the approach by the TGA in Australia with regard to the approval of new contraceptives differ from the approach taken by its counterparts in comparable countries?

Dr Langham: Our processes are largely aligned with our international counterparts. As the case would be anywhere else, no regulatory agency would really be able to commence an evaluation of a drug without a request made by the sponsor. So, from the pharmaceutical company's perspective, they are likely to have a differing effect on where, from a commercial perspective, they want to have their drug evaluated and then currently registered and dispensed.

Senator PAYMAN: Does that include the generic brands of contraceptive pills as well?

Dr Langham: Generic brands are also presented to any regulatory environment by a company, so there must always be a commercial company or sponsor that sits behind the drug itself, be it a brand new one or a generic one. The requirements are not just to present the drug for evaluation but also to agree to provide oversight and care of the drug, if you like, after it's been approved in the post-marketing phase. So, if there are problems with side effects, signals or supply, then, as well as being given approval to register a drug, there is an expectation on the company to provide oversight and input and keep us informed of any other problems that might be arising after a drug has been registered.

Senator PAYMAN: Great. I think you mentioned this earlier, but I want to know how the TGA works with other advisory groups as part of this process of approval or assessing different medications—whether they're the new brands or the generic brands—and not just contraceptives.

Dr Langham: The TGA is responsible for evaluating and monitoring all registered drugs, devices and biologicals that are in Australia. Whether it's contraceptive pills, IUDs, antihypertensives or pacemakers, the TGA is involved in the process of evaluating and monitoring it all. The TGA itself is divided into several divisions that cover off each different area. There's a group that looks at medicines, there's a group that looks at medical devices, there's a group that looks at biologicals, there's a group involved with pharmacovigilance and there's a group involved with international interactions. Anything that is registered, provided and supplied in Australia—and that's considered a therapeutic good—is covered off by the TGA.

Senator PAYMAN: In terms of how you collaborate with the advisory groups and what that process looks like, how often do you guys come together? I think that's what I was trying to get at.

Dr Langham: Each of our statutory advisory committees will work with a specific part of the TGA's remit. We have an advisory committee on medicines; we have one on complementary medicines, one on medical devices and one on vaccines. The advisory committee's advice is sought once a product has been formally evaluated and the evaluator has some questions, concerns or queries for the specific specialists in that area. So the interaction with the advisory committee is always towards the end of the process of evaluation and just before the decision is made to register or not register. That advice is often incorporated into the—I want to say 'paperwork', but it's all electronic—advice and the detailing of the process that's listed on the TGA website. It's often incorporated and can also result in changes to the indication, the sorts of materials that sit in the risk management plan or the sorts of materials that sit in the product information. The advisory committees can be asked a really broad range of questions pertaining to how that drug will ultimately be registered and regulated in Australia—but very much towards the end of the process. I should say, having been on the advisory committee of medicines for some years, our advice is not always included, but it's always sought.

Senator PAYMAN: Thank you so much for that.

Senator TYRRELL: I'm know we're at the time, but I do have a few questions. I'll put most of them on notice, if that's okay, because I don't want to hold us all up. In regard to requiring a pharmacist to be registered for whatever tier of dispensary, particularly the MS-2, is it required, if they're registered, to do drug treatment programs and things for other higher level medications, such as for cancer?

Dr Langham: I think that was a specific drug-by-drug situation that arose at that time, and part of the risk management plan was for the pharmacist to be registered with the company. My understanding is that it was part of the company's suggestion to help manage the risk. In my recent years of working with the TGA I know of no other example where that may or may not have happened. To be honest, it's a similar situation for medical practitioners. We might, for example, with a very complex kidney drug, ask that only kidney doctors prescribe it. But, generally speaking, the pharmacists, as you say, are registered with AHPRA and have ongoing professional development themselves. There are requirements to show that they've got currency in terms of their practice. So, yes, I'm not surprised it was one of the first things that was asked to be removed from the risk management plan.

Senator TYRRELL: In that instance—you used the kidney drug as an example, prescribed only by a kidney specialist—would that be able to be issued through only a hospital pharmacy rather than a generalised pharmacy?

Dr Langham: That's often a commercial decision. You've got the situation where you've got a lot of oncology drugs which are only intravenous. They would probably only sit in a hospital pharmacy. I am a kidney doctor and I know that all the complex kidney drugs that I prescribe are now pretty much available through community pharmacies. But I do warn my patients, if I'm going to prescribe them a particularly curly, rare, expensive one, that they might actually wait a few days while their pharmacist purchases the drug and gets it in for them. There are very rare examples, and I'm trying to think of any—Tracey, you might be able to help me—which pharmacists themselves would not be able to dispense without other requirements.

Senator TYRRELL: But in the bigger scheme of things, the MS-2s really aren't—

Dr Langham: They're not unusual. It's a well-known drug and it's more than time that these restrictions were being removed.

Senator TYRRELL: Has the TGA done any analysis of GP locations where these drugs would not be available?

Dr Langham: The TGA hasn't. Our remit is not so much to regulate GP practice—

Senator TYRRELL: That's what I was thinking from what you were saying before.

Dr Langham: There's been a lot of work done by other academics in the area, certainly, and I'm sure those teams would love to be here with you today to tell you about their work and their evidence. They presented to us at our working group back in October and really informed the whole group that was there of the 'deserts of medical abortion access', which is what it's termed. And it's not just right in the middle of Australia either; it's the north coast of New South Wales, where you have neither GP nor pharmacist, or you have one but not the other, which is just as useless.

Senator TYRRELL: Thank you. I'll put the rest of my questions on notice.

CHAIR: Senator Waters?

Senator WATERS: I have two short questions of clarification. Your evidence has been very helpful so far. I appreciate that. Why is the copper IUD not on the PBS? What role does the TGA have in fixing that, if any?

Ms Duffy: An IUD is a device and PBS is about pharmaceutical medicines. We don't have an equivalent list for devices, other than the devices that are on the Prostheses List for the purpose of private health insurance. So there's no equivalent PBS for devices.

CHAIR: So it has to be a pharmaceutical.

Senator WATERS: So, because it's not hormonal—

Dr Langham: Because it's a device.

Senator WATERS: which is precisely why some people wish to access it, it can't be PBS listed. A special category can be created. We'll work on creating one.

Can you clarify whether a drug can be added to the PBS only if the drug is more efficacious than an existing PBS listed drug, as opposed to if it's just got fewer side effects?

Dr Langham: You're asking me about the PBS and I have very little experience with the PBS.

Senator WATERS: The second part of the question is: if so, what role does the TGA have in making a determination as to efficacy?

Dr Langham: It's a really interesting question. I know that there are often parallel and duplicative processes that run within the two. The PBS often don't just do an evaluation of cost alone, but do have their own almost parallel assessment of efficacy and safety.

Senator WATERS: Do you not have a role in that at all?

Dr Langham: Our role is really just with registration. It does raise possibilities of whether there could be more harmonisation between the two groups—a little bit of duplication might be saved—but that's for people other than me to decide.

CHAIR: Thank you very much for your evidence today. For questions on notice—and it sounds like you're going to be getting some—please get answers to us by the close of business on 5 May. That's quite a short time, but we are reporting to the Senate on 11 May, hence the time line.

Dr Langham: Happy to. Thank you very much.

CHAIR: Thank you.

HILL, Ms Shannon, Sexual Health Advisor, Women's Health Grampians; and Representative, Victorian Women's Health Services Network

MILLAR, Dr Erica, Private capacity

TAYLOR, Ms Elly, Chief Executive Officer, Women's Health East; and Representative, Victorian Women's Health Services Network

[16:40]

CHAIR: Welcome, and thank you for appearing before the committee today. Is there anything you would like to add to the capacity in which you appear today?

Ms Taylor: I'm the CEO of Women's Health East, and I'm representing the Victorian Women's Health Services Network.

Ms S Hill: I'm a sexual health adviser for Women's Health Grampians, and I'm also representing Victorian Women's Health Services Network.

Dr Millar: I'm an academic based at La Trobe University, and I'm an interdisciplinary abortion researcher in the School of Humanities and Social Sciences.

CHAIR: I now invite you to make some opening statements, starting with Victorian Women's Health Services Network, and then we'll ask you some questions.

Ms Taylor: Thank you for the opportunity to speak to our submission and thank you for your leadership on this very important inquiry. I'd like to begin by acknowledging the traditional owners of the land on which we meet, the Wurundjeri Woiwurrung people of the mighty Kulin nation, and pay our respects to elders past, present and emerging. My colleague Shannon Hill and I are presenting on behalf of the Victorian Women's Health Services Network, which includes nine regional and three statewide services.

Victoria is unique. It is the only state or territory with a funded women's health program. Our services are feminist, pro-choice organisations. Over the past 30 years our sector has played a critical leadership and partnership role in supporting sexual and reproductive health needs assessments, training and capacity building. Women's health services lead regional sexual and reproductive health strategies, integrated health promotion planning and delivery, and place based approaches to ensure that women and girls sexual and reproductive health needs are addressed within their local communities.

Our sector is particularly skilled in navigating complex service systems and building partnerships to improve access to services for women and collaborating on statewide campaigns, policy, advocacy and law reform initiatives. Our work is informed by the social determinants of health and takes a primary prevention approach. Women's health services respond to several areas of women's health that intersect with sexual and reproductive health, including prevention of violence against women, mental health and wellbeing, and gender equality. These are critical elements of prevention that we must invest in in order to prevent sexual and reproductive ill health occurring in the first place.

Reproductive health care, as we know, is highly gendered and stigmatised and is not viewed as part of mainstream health care. Our submission calls for universal public access to sexual and reproductive health care and strong investment in prevention and early intervention across the life course. We believe our health system needs to be patient centred, consumer led, culturally safe and inclusive. We deem this critical to supporting people's ability to exercise their sexual and reproductive health rights. Thank you.

Ms S Hill: I've been working to improve reproductive health care in a rural and regional context in Victoria for the last 11 years. I'm driven to continue this work because the system is not meeting need, so it's not meeting population health need, and the consequences of that are significant. And it's not only on the women or people seeking care, it's on the providers who, in many cases, are trying to hold that system together.

Urgent reform is needed to overcome these persistent systemic barriers, so we really welcome you leading this national conversation. It's our great hope that a clear national direction and task force mandated to achieve universal access to reproductive health care could really move us on from where we are now. We need to enhance our public health system to address the needs across the lifespan, so all the things that you know—services that are accessible; a workplace that is strong, well-equipped, sustainable and measurable—and that service users from all backgrounds and life experience are respected, supported and empowered as experts in their own bodies. So, it's not only good for sexual and reproductive health, but also for everyone's health and wellbeing and for gender equality. Thank you.

CHAIR: Thanks, Ms Hill. Dr Millar.

Dr Millar: I acknowledge the Wurundjeri people on whose stolen and unceded land we meet today and acknowledge that racial violence within health, prison and child welfare systems causes ongoing reproductive injustices for Aboriginal people. Abortion is life giving for people who are pregnant unwillingly. Abortion law was liberalised, then decriminalised, without the accompanying commitment to ensuring access. When it fully funds maternity care but relegates abortion to the private sector, the state makes a value judgement about which reproductive decisions it deems normal and acceptable. In Australia, reproductive autonomy is a privilege enjoyed more freely by people who live in places where abortion is fully covered under Medicare, such as in South Australia and the Northern Territory, and those with the health, literacy and economic resources to access and pay for their abortion care themselves. An abortion provider based in rural Victoria said to me the other day, 'There's really nothing sadder than someone having a baby they didn't want to have, just because it was too hard to access abortion.' I think that's tragic, but it definitely happens.

Five changes would help correct the historical legacy of inequitable abortion access: (1) Commonwealth funding for hospitals should be tied to abortion provision to ensure public access and training opportunities for the future workforce, as state funded services such as the Pregnancy Advisory Centre in Adelaide, which does fabulous work, already exist but are generally overburdened with long waiting lists; (2) the government must increase Medicare rebates for early medical abortion to make it a viable primary healthcare service; (3) there needs to be greater provision of second- and third-trimester abortion services, especially surgical abortion services, which involves law reform, support for training and compelling hospitals to offer this service; (4) the government needs to support and lead law and regulatory change to enable nurse, midwife and ATSI health worker provision of early surgical and medical abortion; and (5) the government should follow New Zealand and establish a nurse and midwife led abortion referral and telehealth abortion service.

Senator WATERS: I just jotted down your five suggestions. I like them all, and they're very consistent with the evidence we've taken so far. Honestly, the message could not be louder or clearer. Let's hope it is heard. You call for removing standalone abortion legislation and simply treating abortion care like any other health care. Why do you think abortion has been treated separately, and what are the benefits of removing that distinction?

Dr Millar: It's the historical legacy, isn't it, and it's a complicated question as to why abortion was criminalised in the first place. Obviously, it's a colonial law inherited from Britain. If you look at the 19th century, which I've done, all the debates at the time were about increasing the white birth rate and getting white women to do their duty by the nation and reproduce—so, a heavily racialised discourse. There were multipronged reasons. But we can't remove abortion law from our colonial history, so there's a historical legacy of criminalisation. In the 1960s and 70s, when we liberalised our law, as you would know, it continued to be criminalised. There was an exception allowing doctors to decide on a pregnant person's behalf whether or not they should have an abortion, and that was our legislative framework until now. Because it was criminalised and then really exceptionalised in law, it's never been integrated into medical schools, for example. Integral to this is that, when abortion law was liberalised in the sixties and seventies, public hospitals who were providing after-abortion care for all these unsafe abortions just said, 'No, we're not going to do that.' With the Northern Territory and South Australia as exceptions, hospitals just didn't take on that load, so it was relegated to the private sector from the get-go.

Senator WATERS: As a change of pace here, can you talk us through how Australia's approach to MTOP differs from World Health Organization guidelines and what's needed to change that?

Dr Millar: The WHO guidelines that it released last year, compared to the Australian landscape, were incredibly radical. If you read them, they would allow you just to rock up to a pharmacist and say, 'Hey, I want an early medical abortion,' and the pharmacist would be able to say okay, under nine weeks, I think, then GPs would be able to prescribe to 12 weeks. I don't think we're going to get there just yet.

Senator WATERS: Shame; sounds great.

Dr Millar: To me it sounds great. More radical still, some colleagues of mine say it should be in toilets and vending machines, because we know medical abortion is very safe. Misoprostol was available over the counter until they discovered it could be used for abortion, and that's when all the regulation came in. The other thing holding up provision that's critical is obviously we need midwives, nurses and ATSI health workers to be able to prescribe. The World Health Organization said these people should also be able to perform surgical abortions, because in the first trimester it's quite a straightforward procedure that nurses and midwives can certainly be trained to do. I can think of two other critical things in the Australian context. The first is the mandatory ultrasounds. WHO says that's unnecessary. It's unnecessary. Instead of trusting the pregnant person's account of when they had their last menstrual period, they're sent off to do this ultrasound, which is often a transvaginal ultrasound. It's uncomfortable, and it's unpleasant.

Senator WATERS: And expensive.

Dr Millar: It's expensive, and the user pays. I was interested to hear the TGA said that was a recommendation. But the thing is, when they recommend something, because of the nature of abortion, it's very sensitive and there's a tendency to overregulate, so what a recommendation will do is actually in effect cause a mandate. I don't know anyone who provides early medical abortion without that ultrasound. There are great places like Family Planning Tasmania who do bedside ultrasounds. You just go into the GP. They do the ultrasound and get everything done there. But a lot of people don't have that capacity, so they're sent off again for the ultrasound. The other thing ultrasounds are useful for is ectopic pregnancies. I don't know the study offhand, but if you take a comprehensive history and ask the woman or pregnant person their symptoms of pregnancy, you can often diagnose an ectopic pregnancy. I'm not a medical professional, but that's what I've read. Then the blood works associated with EME, WHO says are basically unnecessary as well. Those are three things that come to mind.

Senator WATERS: Thank you; that's fabulous. Can I move now to the Victorian Women's Health Network. Thanks for being here. We've talked about abortion deserts today and previously, and your submission sets out that there are in fact, if I'm reading your submission right, 12 local government areas that have no local surgical providers, 14 that have no medical abortion dispensing pharmacies and six that have no-one who can insert IUDs. Is there a concentration of access barriers in regional areas?

Ms S Hill: Six of those 12 belong in my region. Despite our encouragement, advocacy and bringing training into the region, that still exists, and I feel that this conservative approach really stops people wanting to take on this new service. They're nervous, and typically this idea around the ultrasound comes into play because they're taking on a new service for the first time and they're nervous that something might happen—adverse outcomes. In rural and regional areas our experience is people are very conservative and very nervous.

Senator WATERS: To provide the service?

Ms S Hill: To provide. The ones who are, I'm really pleased to say, are not having adverse outcomes, are doing really well and are often a great source to encourage others in the local area, but it's really slow. I think, without some kind of mandate or clear direction, people are unwilling to take that on.

Senator WATERS: Has that what I'll shorthand-call stigma amongst practitioners in any way been reduced by 1800 My Options, which we heard from earlier, whereby actually a lot of those providers now are willing to be listed publicly? Is that having an effect in your area, or is it maybe a bit too slow?

Ms S Hill: It's so slow, but it absolutely is. When we put that map on the table, it proves to people where the gaps are and it shows that others are doing it, so it's a really critical piece for moving things forward—but, unfortunately, just a little bit too slow.

Senator WATERS: Just give me your on-the-ground sense of this. In those abortion deserts, or where there are a significant number of medical abortions that are being sourced from outside the local government area, is that because of telehealth or is that because of people having to travel to access the service?

Ms S Hill: We can't tell, but my sense is it's both. It must be both. It could also be for privacy. You might choose to go elsewhere. So that might be a choice, but I would say a significant number would be travel.

Senator TYRRELL: Dr Millar, you referred to the provision of free surgical abortion in Tassie since 2021. We know that medical terminations still cost money. Have you done any analysis on whether there are now more surgical terminations than medical terminations taking place in my state?

Dr Millar: I haven't done any. There's no data on that that I know of. No, surgical abortions wouldn't be overtaking early medical abortions. You would know that there was a shift of public provision of surgical abortion, which is awesome. Tasmania is a leader that other states should be following. So we now have public provision in three hospitals in Tasmania—one serving the south, in Hobart; one serving the north, in Launceston; and one serving the north-west, in Latrobe. But they're not offering abortions every day. They've still got their lists. I can't remember off the top of my head how much they're doing a week, but it wouldn't be the majority. The thing that's kind of strange in Tasmania is that you've got free surgical abortions now, and—

Senator TYRRELL: That's why I asked the question.

Dr Millar: That's what you already said, yes.

Senator TYRRELL: Because it's actually affordable to have it as a surgical termination.

Dr Millar: The other great thing that you've got is the Women's Health Fund. They often fund the gap for those people in need.

Senator TYRRELL: There is a turnaround, which is amazing. Is there one state or territory that demonstrates best practice across the field when it comes to access to reproductive health care?

Dr Millar: I think there are gaps everywhere. The Northern Territory are doing a great job since they decriminalised. If you look at the website for the Family Planning Welfare Association of the Northern Territory, you'll see that they say, 'We offer medical abortion for free.' I think—and I'm sorry I don't know this 100 per cent—that they also offer a telehealth service. I know that the hospital in Darwin is establishing a really world-class surgical abortion service there that does surgical abortion up until relatively late because of the skilled practitioners there. South Australia has been a leader—as we heard earlier today—since 1992, with the establishment of the Pregnancy Advisory Centre. The problem with South Australian access is that the Pregnancy Advisory Centre has really taken the whole load of the state, and it's a geographically huge state. So we have people travelling really long distances in South Australia. That's not ideal either.

Senator TYRRELL: Is there a country we should aspire to be in this field?

Dr Millar: The fact that I can only speak English is a real impediment to me. I think places like Sweden are the leaders in this. I was going to say that I can't think of any, but I think I mentioned Sweden in my submission. In Sweden all abortion is really delivered by midwives. You can't conscientiously object to abortion provision if you want to train as a midwife or an obstetrician-gynaecologist. All surgical abortions are performed in hospitals and obviously are all free. So I think somewhere like Sweden.

Senator TYRRELL: So a Nordic country.

Dr Millar: Always, eh!

Ms S Hill: I want to raise one point about medical versus surgical. It comes back to the other point, about conservatism. Doctors want to know that there will be surgical backup. If they're going to establish a medical abortion service, they want to know that they will have surgical backup if anything happens. So, if we don't solve the surgical abortion access, we can't unlock the capacity of early medical abortion. That's just an important part of the jigsaw puzzle.

Senator TYRRELL: It's a symbiotic relationship. Talking of crossing borders, do many of my fellow Tasmanians pop across to Victoria to access your services? Do you know?

Ms S Hill: I wouldn't know. Through our 1800 My Options team we might be able to get a sense of that. Possibly through somewhere like the Royal Women's—

Ms Taylor: Prior to the changes down in Tasmania, I think that was happening a lot. On notice, we could just let you know how many calls we're having from Tassie. We'll do that.

Senator TYRRELL: Thank you.

Senator PAYMAN: Ms Taylor, in your submission you suggest that there is a need for a coordinated approach to SRH service delivery incorporating both mainstream and specialist services. Could you talk about what it should look like, in your opinion?

Ms Taylor: Yes, absolutely. Our submission is calling for a national task force to plan and monitor sexual and reproductive health access across Australia. As part of that, it's fundamental to have a monitoring and evaluation framework because we need to understand the number and types of sexual and reproductive health services that are available. We need to understand what initiatives are effective so that we can scale them up. We also need to understand where there are sexual and reproductive health gaps and set some KPIs and standards not only at a national level but also at a state and regional level. We would like to see this task force look at policy and legislative reform because we know that's critical. We'd also like to see leadership on research and evaluation, and then an exploration of best practice for sexual and reproductive health initiatives. In our submission we spoke about free contraception for people under the age of 25. We think the permanent introduction of telehealth would be amazing, but this shouldn't be a substitute for local services, particularly in rural and regional areas. We'd like to see the establishment of an emergency fund whilst the public health system builds capability around sexual and reproductive health services, particularly abortion access.

I can keep going, but obviously we have a number of other requests for extending Medicare to include all migrants. We'd like a review of the Medicare Benefits Scheme and PBS to have contraception and medication abortion in line with international best practice. The other thing, which I think you've heard about today, is we'd like a centralised system so that health consumers can call up their state and territory hotlines, as we have in Victoria through 1800 My Options, and access timely sexual and reproductive health service provision, abortion and contraception. That hotline not only provides a best-practice example for consumers but also builds capability within the services system to understand demand and where demand is not being met. Those are the critical elements that we see as fundamental.

Senator PAYMAN: Does that hotline help with regional and rural areas as well?

Ms S Hill: Absolutely.

Senator PAYMAN: Dr Millar, in your submission you suggest that abortion deserts are largely due to the private provision of abortions that predominates in much of Australia and the related fact that most public hospitals, including those in rural and regional Australia, do not perform abortions. In your opinion, should all public hospitals be providing abortions as part of reproductive health care, or are specialist clinics more suited to doing that, or should there be a mix?

Dr Millar: That's a great question, and I think you've hit the nail on the head in many ways. I think there should be a mix as in public hospitals there are capability frameworks for maternity and newborn services, as it's called in Victoria. In those there are inbuilt different levels of hospitals, and in those capability frameworks it would be really useful if abortion care were included. Perhaps then they shouldn't be called maternity frameworks but pregnancy frameworks or something like that. A level 1 hospital that's staffed by a nurse in, say, a rural town could provide early medical abortion and that could be stepped up until we get to level 6 tertiary hospital, which should be providing second trimester surgical abortions.

Second trimester surgical abortions are technically difficult. You also need to be doing them frequently in order to keep up your skill at performing them. There is a case to be made that places like the Royal Women's Hospital are specialist services that offer that kind of care. There should be more of them so the load doesn't fall disproportionately on them, but I think it should be graded. The demand for abortion is such that one in four people with a uterus will have an abortion in their lifetime, and public hospitals will probably not be able to meet that demand.

Of course, I think abortion care should be free; there are models like the UK model that do that through privatising. It shouldn't only be the solution; I think it should also be very much integrated into the public health system because, if we don't have that, we don't have medical students, nursing students and midwifery students being exposed to abortion care in their training. We know this exposure is the No. 1 predictor of whether or not they're going to be providing abortions further on in their careers.

Senator PAYMAN: Thank you so much.

CHAIR: Thank you very much, the three of you, for presenting your evidence today. It was really valuable for the committee. I'm not sure whether you took questions on notice, but, if you did, they are due at close of business on 5 May. We're reporting to the Senate on 11 May.

Bianca, Private capacity

Charlotte, Private capacity

[17:06]

CHAIR: Welcome. I'm going to invite each of you to make a statement, and then we might ask you some questions if you're happy to be asked questions—if we've got some time; we're running pretty short on time. Bianca, did you want to kick off?

Bianca: Sure. I'm 30 years old. I hold a master's degree in science, and today I work full time as an environmental scientist. I want to start by stating that sharing my story today is somewhat challenging for me, and I apologise if my delivery is a little broken.

Relevant context to understanding what led to the circumstances I will share with you is that I was living in Townsville, working remotely in Central Queensland, and it was April 2020, the beginning of the chaos of COVID-19. At this time, rules were changing every day, twice a day. People were frightened and control measures were at some of their most strict, outside of what would later become our lockdown procedures. For example, we were not allowed to have visitors over, flights were being grounded, industries were shut down, businesses were closed, we couldn't travel outside our living area and so forth. Meanwhile, supplementary support systems were not yet in place.

I found out relatively early that I was pregnant, which I ignorantly expected to mean that I had the advantage of time to organise a termination. Becoming a parent is something I have always wanted and I consider of the utmost importance. My personal circumstances at the time saw me in the early stages of a separation from my fiance, which I would not have had the confidence to follow through with had I continued with the pregnancy. I did not want to be responsible for bringing another unwanted child into this world and subjecting it to a lifetime of challenges because of the resources I did not have to provide it with, such as a secure and loving home and financial means. My feelings on this matter meant that I was sure of my decision to terminate the pregnancy, despite the emotional or physical discomfort I knew was yet to come.

I think it is important to share that I consider myself to be a lucky and privileged person. I by no means grew up with an abundance of wealth, but my parents worked hard to provide for me, raised me to be a resilient person and provided me with opportunity. I believe it's important to share this context with you because I'm afraid people will unfairly stereotype me as an irresponsible girl, which is exactly how the GP who prescribed me my abortion pill made me feel at what was a very vulnerable and terrifying time of my life.

I found out I was pregnant and immediately started researching my options. I discovered an abortion clinic in Townsville run by Marie Stopes. What I didn't realise is that this clinic, the only surgery provider of abortion services in Far North Queensland, was exclusively serviced with interstate resources. That is to say, the practitioners which worked there did not live in Far North Queensland. I learned this the hard way, when the clinic rescheduled my appointment multiple times over two weeks and then finally phoned me to cancel the clinic entirely. They explained that they couldn't get any practitioners from interstate into Townsville to provide the service. All flights had been grounded and they were working on organising private charter flights, but they couldn't be sure when the clinic would reopen.

At the time of this phone call, two weeks had passed since I had discovered that I was pregnant. Research and discussion with Marie Stopes staff had me quickly realising I was not going to be able to access the surgery in the entirety of Far North Queensland and I would have to travel to Brisbane by car if I wanted to explore this option. Unfortunately, I was running out of time. The abortion pill is typically not prescribed after nine weeks' gestation, and I was soon approaching eight weeks. In regular circumstances, maybe I could have sourced a vehicle and driven to Brisbane, but given the time line, a series of other details I do not have time to share with you today and the uncertain circumstances of COVID at the time, it was too high a risk.

I was standing in the Central Queensland outback, working on Good Friday morning, when Marie Stopes phoned me and delivered this news. In disbelief, I asked them: 'What am I going to do?' The receiver replied, 'I don't know. I suggest you try the local hospital.' I had to wait until the following Tuesday morning to make the series of embarrassing phone calls to explore my options. I phoned the women's and children's clinic and, through tears, explained my situation. Again, the receiver said they couldn't help me and that I needed to source a GP and, if I could not figure out an option with them, then I should try emergency services.

At this point, I was considering walking myself into emergency services at the local hospital and threatening to undertake the procedure myself if no-one would help me. I'm sharing this because it depicts where I was at

mentally. I was stressed and I hadn't kept food down in about five days. I was really sick with nausea. I was exhausted and completely terrified that I wasn't going to be able to access abortion services.

That day I found a GP to see me. Keep in mind that this alone was no easy task during the early days of COVID-19. She was lovely, and I fully credit her with helping me access the service in the end. She looked up accredited prescribers of the abortion pill in Townsville. There were approximately five on the list, and we called each one of the clinics they belonged to. None were available to help. Phone call after phone call, through word-of-mouth my GP found an accredited prescriber. I couldn't get in for an appointment for another three days. The clock was ticking.

That Friday, I saw this new doctor. He was hesitant to provide me the service. He said he wanted me to think about it over the weekend, by which time the clock would have entered week 8. I couldn't afford to risk losing yet another three days, and I was certain of my decision, which I explained. This frustrated me, because I did not express confusion or indecisiveness, yet I felt like I had to defend my decision. I basically told him that I wasn't leaving without the script. He agreed, but with a note that I was 'not allowed' to get another abortion after this one and I would have to go on proper contraception after this. I silently agreed, despite my disgust and protest at this discrimination, because I had not a single other option to access this service through.

He provided me minimal explanation of what was yet to come and said that I should expect typical period pain and would not need stronger pain relief, which, of course, was a lie. I later realised this was likely intentional. What better way to deter women from undertaking an abortion than by providing them with the authentically painful experience? But, at the time, I was too sick and too desperate to think about this pragmatically. When I filled the script, the female pharmacist was shocked and concerned that I didn't fill an additional script for pain relief. She asked me where it was. Again, I didn't consider this interaction or moment seriously enough. I just wanted to get home and get this over with.

The pain and trauma of the abortion pill is something I'll never forget. I remember thinking, 'How is this the common method of abortion—women alone in their homes taking this medication without proper medical guidance or aid?' This concerned me.

The major issues that stand out to me from my experience, which I want to take this opportunity to highlight, are these. There is a barrier of having to source an accredited prescriber. This system entirely failed me. I was forced to choose a doctor who intentionally discriminated against me and withheld pain relief. If I had been allowed to undertake this process with the original GP I found, I have no doubt that I would have had a much less traumatic experience, guided without personal bias.

Younger, more impressionable women are falling victim to this kind of discrimination. I am fortunate enough to have a good education and consider myself a fairly resilient person. Seeking abortion services is not a feel-good experience without the added discrimination of medical staff or other people. Women who are far more vulnerable than myself may have been pressured to make a different decision to what they actually wanted. In fact, not a single permanent, locally staffed clinic which provides abortion services, including the surgery, is in Queensland outside of Brisbane. This may not be the case now, but this was my experience.

What I would like to see changed in access to reproductive services for women is this: Get rid of the accreditation required of GPs. This is an unnecessary barrier and creates a platform of inequality for women accessing health care. I cannot overstate the importance of being able to undertake this process with your personal GP—someone you know and trust, who understands your circumstances and who can therefore provide you with far more personal and supportive care. It should be standard practice to facilitate appropriate pain relief for women who choose to undertake the abortion pill method and to guide them through the process. We need a system that supports a far more rapid and timely response for reproductive services. Lastly, reproductive health services should be more broadly available, and not be restricted to or dependent on the operation of dedicated clinics alone.

CHAIR: Thank you so much, Bianca, for sharing your experience with us, and thank you for your courage and your strength in doing it. We really appreciate it. There's huge a value to the committee to hear from you your firsthand experience. Charlotte?

Charlotte: I'm here. I'm not as good at speaking as Bianca, though! I'm not very well worded.

CHAIR: You'll be great!

Charlotte: I'm not currently working. The start of all this was in 2021. I had just found out my brother had run off his moped and had died, so I was grieving and am still grieving very badly. I then found out I was three weeks pregnant. I went to the doctor, I told him I was grieving for my brother and that I had just found out I was pregnant and the doctor sent me for a scan. I then went back to the doctor and he suggested Marie Stopes, so I

rang Marie Stopes, and they told me about Children by Choice, because I didn't have the money to fund the abortion. Then I went back to the doctor and told him that I had heard about Children by Choice and that I needed a referral from the doctor. Sorry, I've just got a rough copy of my opening statement, here.

CHAIR: That's all good.

Charlotte: I was sent to the Royal Women's Hospital. The amount of times I went back to that doctor was ridiculous. From then on, I believed this doctor was against abortions. The referral was never sent. I was nearly 19 weeks pregnant and they received the referral in the mailbox, which he was supposed to send to the hospital but never did. This was on Christmas Day. I ended up having to give birth on Christmas Day.

CHAIR: Thank you.

Charlotte: I've not said everything. I'm really nervous.

CHAIR: That's all good.

Charlotte: This whole time that I was going to see this doctor, he was pretty much against abortions. He no longer works at that medical centre. Every time I rang the medical centre and asked if the referral had been sent off, the people behind the counter said, 'All the referrals have been sent off today.' No—none of the referrals got sent off at all. In the end, he ended up saying that he didn't know what I wanted to do with this baby, when he knew from the start that I was grieving for my brother. The amount of times I had to go back to him to get him to send this referral, knowing I was grieving for my brother and still am—he never sent a referral out until it was nearly 19 weeks, and then, by Christmas Day, I had to give birth to a baby. He was so beautiful—perfect, if I do say so myself. He was a little boy, so I named him Jared, after my brother.

CHAIR: Thank you, Charlotte, for sharing that experience with us. It's just so difficult.

Charlotte: I did say I found out when I was three weeks pregnant. It was from three weeks up until 19 weeks—that's how long I couldn't get the referral.

CHAIR: Wow! Committee members, would you like to ask Bianca or Charlotte some questions?

Senator WATERS: Yes, I'd love to. I'm from Queensland, and it sounds like both of you are, too. There's not a dry eye in the house after your stories. Thanks very much for having the courage to share them. It really is very helpful for us to learn how much needs to be fixed. Charlotte, were you in Brisbane or in regional Queensland?

Charlotte: I was in Caboolture, right where the medical centre is. Everything is accessible.

Senator WATERS: I'm so sorry that you were so negligently and, in my view, criminally treated by this bloke who thought he knew better than you did about your own body. I deeply apologise for that. We still don't have good regulation for how to deal with what are called conscientious objectors, who are basically dudes that want to tell women what to do and don't think that we get the right to make our own decisions. That's probably a bit of a casual way of describing it. I don't mean to offend anyone, but it's something I feel very strongly about. So thank you for reminding us just how important it is that, when there are conscientious objectors, there are systems so that health care can still be provided. At the moment there's no obligation for there to be a referral from someone who doesn't want to provide an abortion to someone who is willing to provide an abortion. That's something in the law that desperately needs to change, because other people shouldn't get to make those decisions for you. That's your decision to make.

Charlotte: The third time that I went to go back and see this doctor after he told me he was going to send a referral I could never get back in contact with him again. I've never seen him again. When I'd ring the doctors, I'd ask for that certain doctor that did that to me but then a different doctor would ring back and tell me that he was unavailable. So I never got to talk to him. And I still haven't. I've never seen him ever since around the fourth week.

Senator WATERS: You said he's not working at that centre anymore, and I hope he's not.

Charlotte: No, he's not working there anymore.

Senator WATERS: I hope he's not working in the field of reproductive health care at all. I think he needs to reconsider his career choices and have a good, long, hard look at himself.

Charlotte: Children by Choice have tried to contact him many, many times by email and that and have had no response.

Senator WATERS: Bianca, I've got some good news for you in that we just heard from the TGA, the people who say yes to medicines, that in a short while, possibly in as little as a few weeks and possibly as long as two months, they will tick off on an application that means that doctors don't have to be registered anymore to provide

any of those abortion pills. So that hurdle that you suffered under and that so many people have suffered under looks like it's 99 per cent going to be removed, which is just such wonderful news. It's long overdue.

Bianca: That's good.

Senator WATERS: Isn't it great? My understanding is they're also going to take off the restriction on pharmacists to be registered as well. So in regional areas—and everywhere—it's just going to make it so much easier to access that script and to get it filled. So, hopefully. it won't take all of that constant toing and froing that you had to go through in a really stressful time in order to just get basic health care.

Bianca: That would be a game changer, I think, for so many people.

Senator WATERS: I don't have any other questions, but I just wanted to thank you again for sharing. That really helps us strengthen our advocacy to fix these issues.

Senator TYRRELL: Go you girls for standing up for yourselves and your bodies.

Charlotte: Thank you very much. We're doing this so we can help a lot more women out there that may come across this problem.

Senator TYRRELL: Charlotte, you're killing it. You're alright. If you had the lawmakers in front of you today, what would be the one thing that you would want them to say?

Charlotte: What does that question mean?

Senator TYRRELL: If you had the lawmaker right in front of you today and you had the opportunity to say to them, 'You made my life shit,' how would you do it? How could they fix it for you?

Charlotte: I really don't know how to answer that.

Senator TYRRELL: That's alright. You don't have to have an answer. There's no right or wrong. It's just sometimes—

Charlotte: Do you mean like if I was sitting in front of a doctor?

Senator TYRRELL: Yes. Go with that.

Charlotte: Well, I think I'd tell him that he's an arsehole and that he has pretty much planned a murder. If he was against abortions, why would he let me go from three weeks to 19 weeks growing a baby in my stomach, rejecting all the times I tried to contact him? Why didn't he just help me from the start? I think he's an arsehole and I'm—

Senator TYRRELL: That's a technical term, Charlotte—it's okay.

Unidentified speaker: And we're all thinking it too.

Senator TYRRELL: Sorry, that's my sense of humour coming out. Bianca, what would be the one thing you would say to the bureaucrats that held you back?

Bianca: God, I don't know: 'Shame on you!'

Senator TYRRELL: Go that! Alright, ladies. I'm sorry to put you on the spot.

CHAIR: Senator Payman, did you have any questions or comments you would like to make?

Senator PAYMAN: I don't have any questions but I want to commend both the girls for their bravery, their courage. I've got a younger sister who has a beautiful baby boy. Hearing your stories, I was like: 'If my sister was in that position, it would break my heart to see her go through what those guys have.' I commend you for your bravery. Thank you for sharing your stories. I can only imagine how desperate you must have been. It definitely will help us. I'm representing another senator, Senator Smith, who couldn't be here for this session, and I'm sure that she feels the same way. Thank you.

CHAIR: Yes—thank you both again for sharing your stories. It's of immense value to the committee to hear your firsthand experience. These are the human stories that are the result of the changes, and they're why we need to get change.

Unidentified speaker: Well done, both of you.

Unidentified speaker: Thank you for having me.

CHAIR: We're going to be reporting to the Senate on 11 May, so you'll be able to access a report after that. That concludes today's hearing. Thank you to all the witnesses who appeared, to Hansard and Broadcasting, and to the committee secretariat for their excellent work as usual.

Committee adjourned at 17:27