



Women
With
Disabilities
Australia
(WWDA)



Australian Multicultural
Women's Alliance



natsiwa
NATIONAL ABORIGINAL AND
TORRES STRAIT ISLANDER WOMEN'S ALLIANCE

National Women's Alliances

Submission to the Select Committee on Women's Health

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Acknowledgement of Country

[The National Women's Alliances](#) acknowledge the Traditional Custodians of the land on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and future. We value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We extend our respect to Aboriginal and Torres Strait Islander women who for thousands of years have preserved the culture and practices of their communities on country. This land was never surrendered, and we acknowledge that it always was and always will be Aboriginal land. We acknowledge the strength of Aboriginal and Torres Strait Islander people and communities. We acknowledge that Australian governments have been complicit in the entrenched disadvantage, intergenerational trauma and ongoing institutional racism faced by Aboriginal and Torres Strait Islander people. We recognise that Aboriginal and Torres Strait Islander people must lead the design and delivery of services that affect them for better life outcomes to be achieved.

About Us

The National Women's Alliances are comprised of five organisations that play a key role in ensuring women's voices are central to policy development.

- [The Australian Multicultural Women's Alliance](#) (AMWA).
- [The National Aboriginal and Torres Strait Islander Women's Alliance](#) (NATSIWA).
- [The National Rural Women's Coalition](#) (NRWC).
- [Women With Disabilities Australia](#) (WWDA).
- [The Working with Women Alliance](#) (WwWA).

Together, the Alliances advocate for evidence-based, intersectional gender equality across five priority areas outlined in [Working for Women: A Strategy for Gender Equality](#) - gender-based violence, unpaid and paid care, economic equality, health and leadership.

Executive Summary

The National Women's Alliances (NWAs) welcome the opportunity to make a submission to the Select Committee on Women's Health. The NWAs represent Aboriginal and Torres Strait Islander women, multicultural and migrant women, women with disabilities, women living in regional, rural, and remote Australia, and women experiencing economic disadvantage and gender-based violence. This submission brings together these perspectives to demonstrate the intersecting and systemic discrimination experienced by women seeking healthcare.

Approximately two of three Australian women experience discrimination in healthcare.¹ The exclusion of women and gender-diverse people from medical research and clinical trials underpins the absence of gender-responsive medical curricula, training, and practice. Male biology remains the default in Australian university textbooks,² and only one in four medical students feel adequately trained regarding women's pain presentations.³

For marginalised women, representations of disability, racial diversity, and sexual diversity are even fewer. This underrepresentation results in particularly poor outcomes for women's health issues, including perinatal health, reproductive health and chronic pain conditions.

This submission is broken into three sections. The first describes the nature of compounding discrimination in the healthcare system, and suggests a multi-systems approach to ensure women, especially marginalised women, are represented across all elements of healthcare: clinical practice, medical curricula, data collection, and regulation. The second section describes access barriers to postpartum healthcare and the risk of gender-based violence in the postpartum period. The final section addresses the intersection of reproductive health and chronic pain, explaining the cumulative cost barriers and experiences of medical misogyny that women with chronic and reproductive health conditions face when accessing treatment.

Australia's healthcare system has gendered accessibility barriers 'baked-in' to its design. Women's health issues have long been overlooked and continue not to be taken seriously. This leads to routine experiences of medical misogyny, dismissal of pain, and delayed diagnoses, particularly concerning perinatal health, reproductive health, and chronic pain conditions, which are all interrelated.

Addressing health inequality requires a deliberate approach in undoing the gender-bias in Australia's healthcare system. It also requires policy settings that are designed for diverse health needs, reflecting the diversity of Australia.

Summary of Recommendations

1. Correct the Failures of the Healthcare System

- 1.1 Ensure responding to gender-based violence is core business in healthcare.
- 1.2 Establish Mandatory Baseline Accessibility Standards for Commonwealth-funded healthcare.
- 1.3 Embed women's health and diverse representations in education and training.
- 1.4 Embed women's health in life-course education.
- 1.5 Collect representative data.
- 1.6 Strengthen patient feedback loops and regulation.

2. Strengthen Postpartum Healthcare

- 2.1 Remove cost barriers for continued postpartum healthcare.
- 2.2 Recognise postpartum healthcare as an intervention point for gender-based violence.
- 2.3 Provide postpartum education in the antenatal period.

3. Improve Affordability of Treatments for Reproductive Health and Chronic Pain

- 3.1 Ensure reproductive healthcare is universally accessible.
- 3.2 Ensure treatment of chronic pain conditions is gender-responsive.

Why the Commonwealth Government Must Lead

Health equality must be addressed at the Commonwealth level. Women's health directly impacts more than half the population and has indirect consequences for everyone. Health conditions that disproportionately impact women have significant impacts on Australia's productivity.⁴ Health inequality is costly for Australia:

- 80% of women who suffer migraines reported that their work had been affected, Deloitte estimating the total cost of migraines to the Australian economy at \$35.7 billion annually.⁵
- Chronic Pain Australia estimates that the annual cost of chronic pain for Australia could rise to \$215.6 billion by 2050.⁶
- The Women's Health Gap report demonstrates that 50% of the women's health burden affects women in their core working years, between the ages of 20-64.⁷

Addressing health inequality requires a shared commitment to health, dignity, and human rights for all, and an understanding that individual health has a direct impact on social and economic health.

The NWAs recognise and welcome the Commonwealth Government's focus on women's health. The landmark \$792 million for the women's health package has delivered meaningful gender-responsive initiatives such as the introduction of Pelvic Pain Clinics, items for complex pelvic ultrasounds under the Medicare Benefits Scheme (MBS), and expanded ultrasound performing rights for sexual health physicians, establishment of Long Acting Reversible Contraception (LARC) centres, coverage of contraceptives, hormone therapies and endometriosis treatments under the Pharmaceutical Benefits Scheme (PBS), and perinatal mental health centres.

The NWAs also recognise broader reforms to make Australia's healthcare system more equitable and accessible, such as the establishment of Urgent Care Clinics, new bulk-billing incentives, and a commitment to increase cost transparency of healthcare specialists. The Commonwealth Government is leading significant improvements at a time when Australians are increasingly forgoing or delaying their appointments and prescriptions, treating healthcare as a secondary need, below food and shelter.

However, due to a history of medical research that has neglected women, and continuing under-representation of women in clinical trials and medical curricula, gender health gaps persist, with even bigger gaps for marginalised women.⁸

The Commonwealth Government must initiate national and cross-portfolio reforms to strengthen the accessibility and quality of Australia's healthcare - particularly for

marginalised women. This includes embedding gender- and intersectional-capabilities in medical curricula, research and data collection, and medical practice. It also requires a dedicated focus on postpartum healthcare, gender-based violence, reproductive healthcare, and chronic health and pain conditions.

These reforms cannot be left to state and territory governments, who do not have access to national levers or market incentives, including the MBS, PBS, Commonwealth-funded programs, national data collection, and regulation. Additionally, the Commonwealth Government is responsible for systems that are allied to healthcare, including education, social security, and housing. State initiatives, such as the Victorian Women's Pain Inquiry, have laid the foundation for a national focus on distinct women's health issues, advocating for national reform to address cost and access barriers.⁹ The Commonwealth Government now has an obligation to identify national policy levers and address persistent health inequalities.

This aligns with the government's commitments and priorities under the:

- [*National Women's Health Strategy 2020-2030*](#)
- [*National Plan to End Violence Against Women and Children 2022-2032*](#)
- [*Our Ways – Strong Ways – Our Voices: National Aboriginal and Torres Strait Islander Plan to End Family, Domestic and Sexual Violence 2026-2036*](#)
- [*National Stillbirth Action and Implementation Plan*](#)
- [*National Agreement on Closing the Gap*](#)
- [*National Women's Health Advisory Committee*](#)
- [*Working for Women: A Strategy for Gender Equality*](#)
- [*Woman-centred care: Strategic directions for Australian maternity services*](#)

Why We Need an Intersectional Healthcare System

The NWAs emphasise that the burden of women's health issues are not shared equally by all women. Women from marginalised communities, including those with disabilities, Aboriginal and Torres Strait Islander women, multicultural and migrant women, gender-diverse people, LGBTIQ+SB people, and women living in rural and remote Australia, face intersecting disadvantage when navigating healthcare. For example, women with disabilities experience disproportionate chronic pain, and women whose primary language is not English access help for chronic pain at nearly half the rate (57%) of the general population (95%).¹⁰ Women from regional, rural and remote communities face increased costs due to travel and accommodation associated with healthcare, and the maternal

mortality rate among Aboriginal and Torres Strait Islander women remains four times as high as the general population.¹¹

The NWAs also emphasise other social and economic determinants of health that disproportionately impact women. This includes economic insecurity, unpaid caring responsibilities, and experiences of gender-based violence. People living in poverty and experiencing economic stress, primary carers, people living in violence, and victim-survivors face distinct healthcare challenges and barriers to equitable treatment.

Australia's healthcare system coexists with other systems that disproportionately harm or underserve marginalised women, such as the National Disability Insurance Scheme (NDIS), child protection services, housing services, gender-based violence services, social security, immigration, and justice systems. Gender- and ideological-based discrimination is embedded in these systems that have a strong interaction with healthcare.

Consequently, marginalised women may experience compounded inequality across systems and poorer health outcomes. This exacerbates experiences of medical mistreatment, including dismissal of pain and delayed or incorrect diagnoses. The Victorian Women's Pain Inquiry found that 90% of respondents have experienced pain lasting longer than a year, and 71% of respondents felt ignored or dismissed.¹² Women with chronic pain site cost, delayed- and misdiagnosis as barriers to care.¹³ This is especially exacerbated for rural women, who miss out on average \$1,218 per person per year in healthcare spending.¹⁴

Women's Health Priorities

1. Correct Failures of the Healthcare System

Australia's healthcare system is gender-biased by design. Medical research, diagnostic frameworks, and clinical practices have historically centred white male biology, resulting in the dismissal of women's health issues and worse health outcomes for women.

Further accessibility barriers exist for marginalised women. Examples include healthcare infrastructure that is inaccessible for people with disabilities, culturally inappropriate practices, lack of translated resources and interpreters, eligibility restrictions associated with visa status, and limited services in rural and remote Australia. The burden of enduring, 'working around,' and correcting these systemic failures falls on women seeking healthcare. For marginalised women, healthcare comes at the additional expense of intersecting experiences of discrimination, including sexism, racism, ableism, transphobia, homophobia, geography, or all the above. The rhetoric that mainstream

healthcare serves everyone, and that equity and inclusion measures are ‘add-ons’ must be dispelled. This is because:

- Women, make up 51% of the Australian population.¹⁵
- 32% of Australians are born overseas.¹⁶
- 21.4% of Australians are people with disabilities, with a greater proportion women.¹⁷
- 27.8% of Australians live in regional, remote, or very remote areas.¹⁸
- Aboriginal and Torres Strait Islander people experience disproportionate rates of mortality, illness, and injury, compared to the rest of the population.¹⁹

A healthcare system that does not serve these populations does not serve Australia. To address these systemic barriers, Australia’s healthcare system requires nationally coordinated, multi-system reform. This must extend beyond clinical healthcare settings, to education, data collection, and regulation. This reform agenda must be informed by social and economic determinants of health, including economic security and experiences of gender-based violence.

Recommendation 1.1: Ensure responding to gender-based violence is core business in healthcare.

Experiences of gender-based violence are a crucial determinant of health for women and gender-diverse people, and healthcare settings are essential prevention and early intervention infrastructure.

Women disproportionately bear the health impacts of all forms of gender-based violence. Experiences of violence impact health outcomes, through both the direct perpetration of violence, and the resulting impacts of violence, including financial stress, homelessness, and chronic health conditions.²⁰ Child abuse is the leading risk factor contributing to total burden of disease, and Intimate-partner violence is a leading cause of death among women.²¹ For marginalised women, the health risks associated with experiences of violence are even higher. Women and children living in rural, regional, and remote Australia face a higher prevalence of domestic violence, and a higher risk of being hospitalised due to violence.²²

Healthcare services are often the first or only point of contact for victim-survivors before, during and after experiences of violence. Research demonstrates that patients are significantly more likely to disclose intimate-partner violence (IPV) or reproductive coercion and abuse (RCA) when directly asked by a healthcare professional.²³ Clinical screening not only facilitates safe disclosures, but helps link victim survivors to vital support services. Where screening has been implemented effectively, data reveals a 16-fold increase in counselling appointments for IPV after clinical screening.²⁴ Research also

indicated that perpetrators of violence are far more likely to disclose to healthcare practitioners than any other service.²⁵

A health system that routinely encounters victim-survivors and perpetrators of violence, but cannot respond appropriately, is a system that fails its patients. We must move towards a view that responding to gender-based violence as a core responsibility of the healthcare system and support a system-wide approach. This should move beyond workforce capability alone and embed gender-based violence responses across healthcare policy, governance, service delivery and accountability frameworks.

Spotlight – SHQ Intimate Partner Violence and Reproductive Coercion and Abuse Screening and Education Program

The Western Australian branch of Sexual and Reproductive Health Australia, [*Sexual Health Quarters*](#) (SHQ) delivers numerous RACGP-accredited education and training programs for health professionals, focused on screening for intimate partner violence and reproductive coercion and abuse. Their programs are targeted at counselling, clinical and disability services, and include:

- Talking about IPV and RCA with Patients.
- Inquiring about IPV and RCA: Whole of Practice Clinical Screening and Education.
- Supporting LGBTIQ+ Clients with Experiences of IPV and RCA.
- It's OK to SAY: Screening and Supporting People with Disability Who are Experiencing Violence, Coercion or Abuse.
- CALD Communities Education: Empowered Reproductive Choices and Healthy vs Unhealthy Relationships.

SHQ also provide training in regional and remote Western Australia, developed with an evidence-based and intersectional approach. Their IPV and RCA programs have been developed after winning awards for pilot programs, It's Okay to Say and Safe to Tell, and extensive clinician-led research. SHQ's pilots found that clients wanted to disclose experiences of violence in a variety of ways. Their screening process is inclusive, with options like private spaces, easy-read forms, and self-complete screening forms.

Recommendation 1.1: Ensure responding to gender-based violence is core business in healthcare by:

- Recognising prevention and response to gender-based violence as a core function of Australia's healthcare system.
- Supporting and fund integrated models of care that strengthen collaboration between healthcare services, legal services and specialist Family, Domestic and Sexual Violence (FDSV) services.
- Recognising legal assistance as a core component of the comprehensive and integrated service response to FDSV, particularly in settings where victim-survivors commonly seek help, including health, community, family and early childhood services.
- Commit dedicated investment to the national infrastructure required to build system-wide capability for cross-sector service integration, providing the mechanisms, relationships, processes and supports needed to connect and coordinate different parts of the service system.
- Upskill rural health practitioners to be able to respond to gender-based violence disclosures for rural, regional, remote and very remote women

Recommendations 1.2: Establish Mandatory Baseline Accessibility Standards for Commonwealth-funded healthcare.

Currently, Australia's healthcare system relies on a patchwork of diversity and inclusion measures that support marginalised patients, compensating for the fact that mainstream services have not been designed for those who use them. This includes:

- the *Health in My Language program* which trains bicultural interpreters to explain health information
- Aboriginal Community Controlled Organisations who provide culturally safe, comprehensive care grounded in community governance and self-determination
- community-controlled maternity services
- specialised women's health services
- NDIS support coordinators
- community health justice partnerships
- patient transport subsidy schemes.²⁶

Spotlight – Barriers to Maternal and Reproductive Healthcare for PALM Migrants

Women from migrant backgrounds are more likely than the general population to face additional barriers to accessing healthcare in the maternal period. This is due to language barriers, isolation from culture and family, discrimination when accessing services, and Medicare eligibility gaps for newly arrived migrants.²⁷

- Migrant status is associated with an increased risk of maternal health outcomes especially post-partum depression and intimate-partner violence.
- Migrant status is associated with a higher risk of low-birthweight babies.
- Migrant women are more likely to have undergone female genital mutilation or cutting (FGM/C), which requires specialised management during childbirth.

These risks are multiplied for workers under the Pacific Australia Labour Mobility (PALM) scheme who do not have access to Medicare and are required to have private health insurance. However, private policies generally have a 12-month waiting period for pregnancy and birth-related services.

The 2025 *'Its not illegal to be pregnant'* report records numerous cases of pregnancy involving reproductive coercion and abuse, sexual violence, and significant access barriers to adequate healthcare. Mothers often felt pressured to seek an abortion, adopt out, return home, or to keep the pregnancy and baby hidden. One interviewee recounted *"they don't want the agent to know [about the baby] so they keep it quiet. They don't want to be sent back home. They need to keep working to send money to their families. They don't want to be caught."*

Dr Trudi Beck from a women's health clinic in Wagga Wagga said "its a combination of all the things Australians don't want to talk about – abortion, racism and exploitation of our Pacific neighbours."²⁸

The NWAs support a long-term plan to address failures of the healthcare system and ensure critical services like these are embedded into mainstream healthcare to create a streamlined system that is designed for everyone.

In the meantime, these programs, especially services led by community organisations face challenges due to short-term funding cycles and fragmentation. Pilot funding cycles limit the ability of organisations to evaluate outcomes or build sustainable models. In the short-term, these programs must be sustainably funded to meet demand.

Recommendations 1.2: Establish Mandatory Baseline Accessibility Standards for Commonwealth-funded healthcare by:

Long-term Plan

- Establishing Mandatory Baseline Accessibility Standards for Commonwealth-funded healthcare, connected to funding agreements.
 - This should include an annual accessibility assessment to identify deficits, which can be used to inform Commonwealth funding decisions.
 - Funding decisions should prioritise accessibility barriers relating to women's health issues.
 - Investigate and fund new models to provide healthcare services outside metropolitan areas.

Short-term Plan

- Providing sustainable funding for interpreters in healthcare settings, including establishment of a mandated framework for when interpreters are required.
- Resourcing the Community Health Navigator and bicultural liaison models as permanent, paid infrastructure, not volunteer labour, with hours that match community need rather than fixed shifts.
- Extending Medicare eligibility to close the gaps currently faced by newly arrived migrants and specific visa categories.
- Ensuring the Disability Discrimination Act includes a positive duty on healthcare providers to offer accessible services, and empower the Australian Human Rights Commission to respond to systemic discrimination.
- Nationalising and increasing subsidy rates for state-based patient transport schemes to reduce out of pocket costs for regional, rural and remote women accessing health care.
- Prioritising and funding more female health practitioners including General Practitioners (GPs), General Practitioner Obstetricians and Nurse Practitioners in rural, regional, remote and very remote Australia.

Recommendation 1.3: Embed women's health and diversity in higher education and training.

Women's health issues and diverse representations must be embedded in core curriculum for medical science, allied health, nursing, and other relevant undergraduate qualifications. Currently, a number of women's health issues are only covered in electives or through post-graduate courses, rather than mandatory coursework. For example, Jean Hailes provides a dedicated menopause education program for GPs, nurses and midwives because many clinicians require further training after graduation.²⁹

Spotlight – National Health Curricula Audit

Funded under the National Women's Health Advisory Council, the Centre for Sex & Gender Equity in Health & Medicine, in partnership with a number of Australian universities, is conducting a national audit of Australian university health and medical training to assess how well sex and gender is integrated.³⁰ Early findings from nine universities across Victoria and 318 courses, found that 93% of all units and 60% of healthcare courses lacked sex and gender terms in their descriptors.³¹ The national audit is expected to be published in 2026 and should be used to inform changes to medical curricula.

Recommendation 1.3: Embed women's health and diverse representations in the National Registration and Accreditation Scheme by:

- Making women's health and sex- and gender-responsive care a cross-profession priority for accreditation reform under the National Registration and Accreditation Scheme through the Health Ministers Meeting.
- Tasking the Independent Accreditation Committee, alongside the Health Professions Accreditation Collaborative Forum, to develop nationally consistent women's health competencies and oversee their incorporation into accreditation standards for relevant health professions.
- Requiring accreditation standards to ensure that education providers demonstrate how women's health is integrated across compulsory curricula, clinical training and assessment, rather than confined to elective or specialist subjects.
- Requiring women's health organisations and diverse women with lived experience to have decision-making roles in developing the competencies and monitoring their implementation.

Recommendation 1.4: Embed women and girls' health in life-course education.

Improving women's health outcomes requires investment in reproductive health literacy across the life course, that is tailored to the diverse needs of the Australian community. Too many women spend years being told that severe pain and other debilitating symptoms are 'normal.' Comprehensive reproductive health education supports women to recognise when symptoms may indicate an underlying condition and when to seek care. Earlier access to information can support the identification of conditions such as endometriosis, Polyendocrine Metabolic Ovarian Syndrome (PMOS) (Formerly called Polycystic Ovarian Syndrome (PCOS)) and Pre-Menstrual Dysphoric Disorder (PMDD) therefore reducing delays in diagnosis.

On average, young women and girls experience menstrual onset at an earlier age and with more irregularity.³² A significant proportion of students are getting their first period as early as year three, without receiving puberty education until year five. Early menstruation and irregular periods are risk factors for a number of future and comorbid health conditions,³³ and can have a significant impact on school attendance and extracurricular activities. Half (51%) of women present with reproductive conditions that they had assumed were normal.³⁴

Awareness of reproductive health is critically low among young Australians. A 2025 survey identified that only 62% of participants understood that the contraceptive pill does not decrease long-term fertility, only 56% knew that chlamydia can make women infertile, and only 34% considered the topic of menstruation to be covered well.³⁵ Healthcare misinformation is exacerbating this issue, with more women likely to 'self-diagnose'

through AI, friends, or social media and recurring deceptive claims about reproductive health circulating online.³⁶ Emerging research by NRWC and NATSIWA about access to contraception found that even after receiving information about contraception from their school or female guardian, 59% did not feel they had enough information to choose the right contraception for themselves.ⁱ This highlights the need for improved education for women about their own sexual and reproductive health.

Menstruation education improves young women's confidence in asking for pain relief for painful periods and improves their knowledge, attitudes, and management of menstruation. It also correlates with stronger school attendance rates.³⁷ With a diagnosis of endometriosis taking six and a half years on average, and other diagnoses such as PMOS and PMDD also likely to be delayed, menstruation education is necessary so that girls know when and where to seek support.³⁸

School education programs must include resources that also support parents' health literacy and build the communication skills needed to engage in conversations with their children about puberty and reproductive health.³⁹ Parents are largely supportive of puberty and reproductive health education, but often report that it can be difficult to facilitate conversations about these topics.⁴⁰

Many young women and parents remain unaware of appropriate support services. Nearly half of multicultural women report not knowing where to access suitable reproductive healthcare.⁴¹ In line with recommendation 4.4 from the Victorian Women's Pain Inquiry, the government should expand school education programs for reproductive and sexual health.⁴²

Spotlight - The Pelvic Pain Foundation of Australia

The Pelvic Pain Foundation of Australia (PPFA) runs a program on endometriosis (PPEP Talk), that has been funded by federal and state governments. The post program data audit found that 94% of students assigned female at birth found it informative, and 85% found it empowering. The program is free for secondary schools in Western Australia, South Australia, and Queensland. PPFA also delivers menstrual education that addresses critical gaps in current school-based education, at the cost of \$500 per session.

Recommendation 1.4: Embed women and girls' health in life-course education by:

- Mirroring the National Respectful Relationships Education Framework to deliver a national curriculum on comprehensive sexual health education.

ⁱ Research is not yet published but is available on request.

- This program should be co-designed with reproductive health education providers.

Recommendations 1.5: Collect representative data.

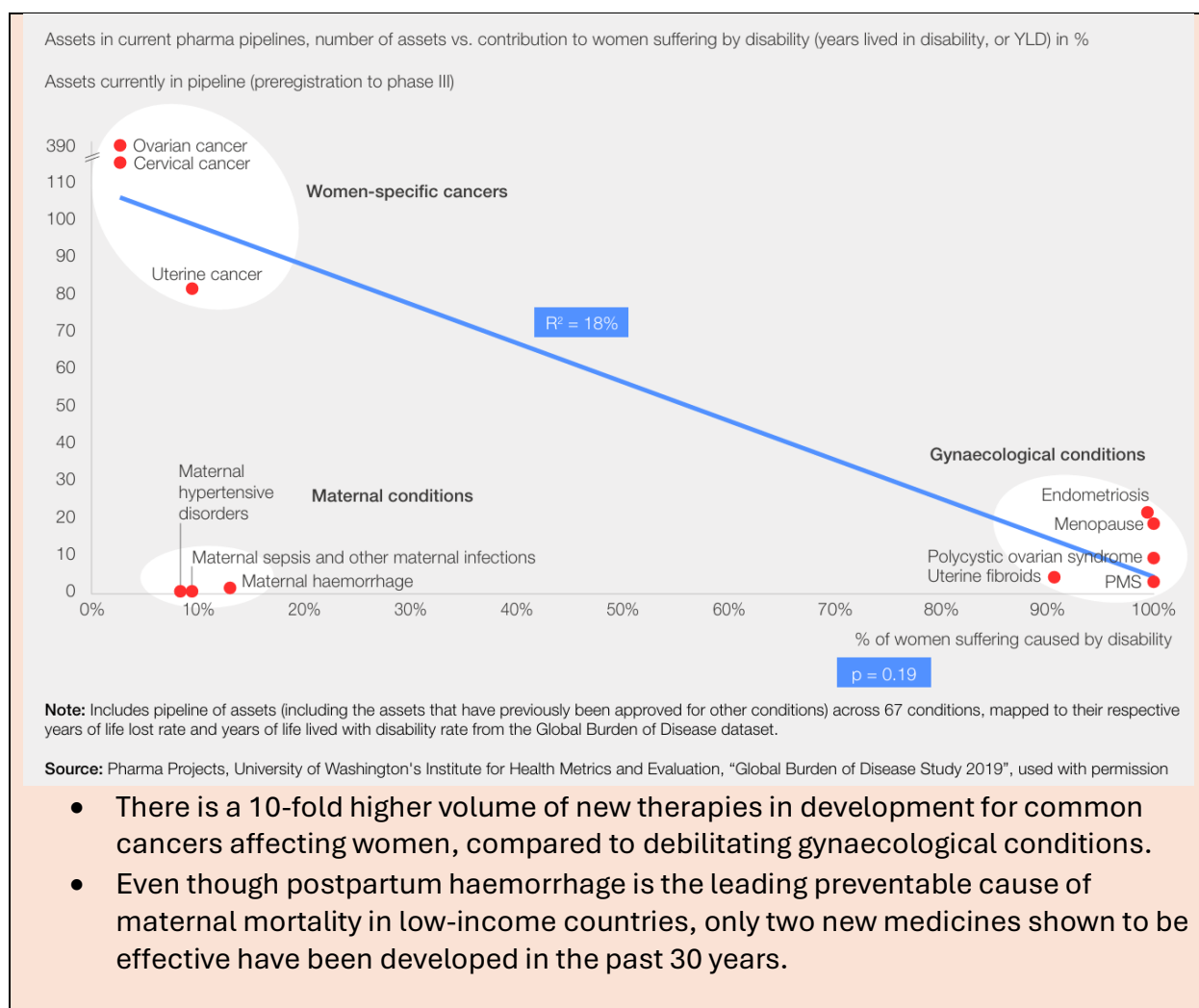
Health data and research gaps prevent problem identification, stifling investment into support for women's health issues. As identified by the Australian Institute of Health and Wellbeing (AIHW), women have distinct biological, social and cultural experiences that influence their health across the life course.⁴³ Systemic issues such as unequal caring responsibilities, socioeconomic inequalities, and gender-based violence also have substantial impacts on health.

Data sets often fail to capture these intersectional experiences, and do not consistently disaggregate by both gender and sex: Globally, only about 5% of clinical trials report the number of participants by sex.⁴⁴ This creates a particular data gap for gender-diverse people, and for people who experience compounding systemic disadvantage. Data gaps are directly correlated with patient outcomes and safety.

- Since 2000, women in the United States have reported adverse events from medicines 52% more frequently than men, and serious or fatal events 36% more frequently.⁴⁵
- A study in Denmark revealed that women were diagnosed later than men for more than 700 diseases.⁴⁶

Spotlight – The Women's Health Gap Report

[The Australian Women's Health Alliance](#) estimates that investments to address the women's health gap could boost the global economy by \$1 trillion annually by 2040. Closing the data gap plays a significant role in this. The report found that research in women's health primarily focuses on diseases with high mortality rates as opposed to chronic diseases and those leading to disability. The below graph demonstrates investment in different women's health issues.



Data gaps start at the definitions of women's health. There are no consistent definitions for conditions and symptoms affecting women, nor pain instruments and scales. The World Health Organisation estimates that 10% of women are living with endometriosis. In contrast, the Global Burden of Disease estimates this figure to be 1-2%.⁴⁷

Better outcomes for women's health require nationally coordinated, standardised data. This includes longitudinal data, disaggregated by race, ethnicity, religion, age, sexuality, socio-economic status, experiences of gender-based violence, Aboriginal and Torres Strait Islander Status, geographical location, and disability. Data and research initiatives must be targeted at women's health issues that have been historically underfunded and for which, women continue to receive delayed diagnoses.

Aboriginal and Torres Strait Islander data must be governed in line with Indigenous Data Sovereignty. This requires Aboriginal and Torres Strait Islander authority over priorities, definitions, access, interpretation and reporting. Research funding should prioritise

community-led work and include the costs of participation, translation into practice and returning findings to communities.

Data collection methods must also allow for everyone to participate, including translated surveys and questionnaires, plain English options, and multimodal formats.

Spotlight - National Health and Medical Research Council (NHMRC) and Medical Research Future Fund (MRFF) Grants

Grant opportunities provided by the NHMRC and MRFF now require applicants to consider sex, gender, variations of sex characteristics and sexual orientation at all stages of every research project.⁴⁸ Applicants must also use consistent definitions according to the Australian Bureau of Statistics Standards.⁴⁹

This initiative was implemented to counter research practices that use male subjects and then extrapolate outcomes to the rest of the population.

Recommendations 1.5: Collect representative data by:

- Establishing a whole-of-government mandatory Data Standards Framework to ensure data collection is consistent and standardised across the ABS, Australian Institute of Health and Welfare (AIHW), Australian Institute of Family Studies (AIFS), Australian Institute of Criminology (AIC), and other relevant bodies.
 - These standards must include standardised definitions and a mandate to disaggregated by race, ethnicity, religion, age, geography, sexuality, socio-economic status, experiences of gender-based violence, Aboriginal and Torres Strait Islander Status, geographical location, and disability.
- Ensuring NHMRC and MRFF grants also require consideration of identified characteristics, beyond gender, sex, and sexual orientation.

Recommendations 1.6: Strengthen patient feedback loops and regulation.

Medical mistreatment of women frequently arises due to unaddressed discrimination and systemic failures. Barriers to healthcare should be removed before an individual encounters them. This requires effective complaints and regulatory mechanisms.

Complaints mechanisms are fragmented and can be confusing, with patients unsure whether to approach hospitals, state complaints bodies, insurers, Medicare, Australian Health Practitioner Regulation Agency (AHPRA), or a professional board. Fragmentation makes complaints mechanisms especially inaccessible for marginalised communities. Migrants and multicultural people may be unfamiliar with Australian systems, and may face language barriers which make systems more difficult to navigate.

Formal complaints mechanisms can also be sites of discrimination, where women experience further systemic harm, and may be dismissed or face accessibility barriers. For example, members from NATSIWA note that Aboriginal and Torres Strait Islander women

must be able to report by phone, online or through a trusted Aboriginal community-controlled organisation, with interpreting, advocacy and trauma-aware support.

Fragmentation and systemic discrimination can deter women from making formal complaints. As a result, patterns of behaviour may not be captured in formal complaints data. Patient-reported data collected by health services can help address this issue, supporting early identification and intervention of problematic patterns. Monitoring patients' reports of worsening pain after treatment, poor informed consent experiences, or patients' feelings of dismissal, can help identify and prevent problematic practice. The Australian Commission on Safety and Quality in Health Care notes that patient reported measures can uncover problems that otherwise might go unnoticed.⁵⁰

Patient reporting can be a more accessible avenue to close feedback loops, particularly for marginalised communities. However, to be truly effective, patient reported measures must be co-designed with women and must include equity and accessibility metrics. A study focused on equity-oriented health care, found that patient reported outcomes are not necessarily underpinned by equity and can be limited by exclusive survey design.⁵¹ For example, experiences of sexism and racism cannot be imputed by variables like satisfaction or access.

Spotlight – PREMs and PROMs in Maternity Care

Curtin University project, [*Improving the safety and quality of maternity care in Australia*](#), is developing Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) to best measure the experiences and outcomes that are recognised as most important by those giving birth. The project aims to subsequently pilot and evaluate these patient reported measures. The project will deliver the first consumer co-designed maternity PREMs and PROMs in the world.

Case Study – Endometriosis Scams and Regulatory Failures

In February 2026, the Australian Broadcasting Corporation (ABC) investigated Melbourne-based, former obstetrician and gynaecologist, Dr Simon Gordon, for allegedly performing unnecessary and life-altering surgeries for endometriosis despite pathology reports showing little or no evidence that severe endometriosis had been diagnosed.⁵²

Two women complained about Gordon's conduct in 2024, and were dismissed by the AHPRA, reassured that he had acted to an acceptable standard. The ABC reported that numerous complaints about Dr Simon Gordon had been made to the AHPRA in the preceding four years. It was also reported that when a medical practitioner attempted to approach AHPRA about Gordon, they were advised that complaints had to come from patients.

The Federal Health Minister advised the Victorian Government to consider commissioning a Safer Care Victoria Inquiry. The Victorian Government instead, said that a Safe Care Victoria representative would sit on a review panel set up by the hospital where Gordon worked.

AHPRA announced they will be conducting an investigation, including commissioning a panel of independent medical experts to support the investigation, and assessing their methodology for managing these cases.⁵³

In line with the Victorian Women's Pain Inquiry, the NWAs support improved feedback and complaints processes, with increased accessibility and accountability. While complaints mechanisms must be made accessible to all patients, Australia cannot rely on fragmented and systemically biased complaints mechanisms to identify problematic practices in healthcare, particularly pertaining to women's health. Patient-reported measures could support stronger feedback loops, however they must be co-designed with marginalised communities.

Regulatory accountability must also be strengthened. Regulators should publish de-identified information on complaint patterns, investigations, timeframes and actions to increase public accountability and transparency for consumers.

Recommendation 1.6: Strengthen patient feedback loops and regulation by:

- Establishing a National Patient Experience and Safety Data platform.
 - This would host de-identified information from formal complaints and health services' patient reported data. It would include information on complaints patterns, investigations, timeframes, and actions.
- Establishing National PREMs and PROMs data collection standards, codesigned with women and marginalised communities.
 - Standards should set out minimum measurables that consider how intersectional experiences impact quality and safety of healthcare.
- Requiring regulators and accreditation bodies to explore mechanisms to incorporate PREMs and PROMs into quality assurance and regulatory systems.
- Establishing a no-wrong-door approach that supports patients in making formal complaints.

2. Strengthen Postpartum Healthcare

Postpartum healthcare should not end when women leave hospital. The postpartum period can be immensely physically, psychologically, and economically stressful. It can involve pain, serious medical complications, reduced mobility, sleep deprivation, and

significant mental health challenges such as depression, anxiety, post-traumatic stress, shame, and grief. Women who experience miscarriage, stillbirth, neonatal death or infant death often face a sudden loss of support once pregnancy or infant-focused services cease. Following miscarriage, stillbirth, neonatal death or infant death, care should include immediate and ongoing bereavement support, practical assistance, cultural and spiritual options, follow-up of physical recovery and future pregnancy planning. The mother must not disappear from care because there is no living baby attending child health services.

- Up to 1 in 5 women experience anxiety and/or depression during pregnancy, and/or following birth.⁵⁴
- More than a third of women experience lasting health problems after childbirth, including:
 - Pain during sexual intercourse (dyspareunia), affecting 35% of women.
 - Urinary incontinence, affecting 8-31% of women.
 - Anxiety, affecting 9-24% of women.
 - Depression, affecting 11-17% of women.
 - Perineal pain, affecting 11% of women.
 - Secondary infertility, affecting 11% of women.⁵⁵

Challenges in the postpartum period are magnified for marginalised women. Migrant women and women with disabilities are more likely to report postpartum depressive symptoms,⁵⁶ and research shows that standard screening tools, such as the Edinburgh Postnatal Depression Scale are inadequate in identifying postpartum depression in Aboriginal and Torres Strait Islander women.⁵⁷ Poor postnatal health outcomes for marginalised women must be understood as an outcome of systemic discrimination.

Economic effects after childbirth are also significant. Reduced paid work, increasing caring responsibilities, costs associated with transport, medicines, formula, feeding equipment, physiotherapy, counselling and specialist fees can place families under severe pressure.

- The birth of a first child is associated with a reduction in household income of 27% for one-parent households and 18% for two-parent households.⁵⁸ Within five years of a first birth, 37-40% of households either enter poverty or remain in poverty.⁵⁹
- Without government family payments, poverty rates would increase to 63% for one-parent households and 20% for two-parent households following the birth of a child.⁶⁰
- 37% of one-parent households and 11% of two-parent households still experience poverty after childbirth.⁶¹

Costs are greater for single mothers, families who must travel and cover accommodation to access healthcare, families with accessibility needs, families experiencing violence, and families who must remain away from communities of care and Country. Government family payments play an important role in reducing the risk of poverty following childbirth, but they do not eliminate it. The above data demonstrates that existing income support measures help mitigate financial hardship, but do not fully offset the full economic impacts of childbirth.

The postpartum period can also have significant impacts on partners and other support people, especially where miscarriage, stillbirth, neonatal death, infant death, or a traumatic birth has occurred. Men may experience specific pressures associated with returning to work and providing economic and emotional stability. Postpartum depression affects approximately 10% of men, and has a high comorbidity rate with maternal postpartum depression.⁶²

Recommendations 2.1: Remove cost barriers for continued postpartum healthcare.

Best practice postpartum healthcare must guarantee continuity of care and connected multidisciplinary support. This means care that begins before discharge and continues for at least the first year after birth. It must empower women to recognise complications, know where to help-seeking, and ensure that services are connected, affordable and culturally accessible.

Postpartum care often includes numerous appointments, different referral rules, long wait times and repeated out-of-pocket fees. Women may need to access infant feeding supports, mental health supports, physiotherapy and pelvic health services, pain management services, and related allied health services. Many of these services are not covered by Medicare. Navigating multiple appointments and the associated financial burdens is an access barrier in the postpartum period. A range of services commonly relied upon by women, including genetic screening and aspects of postnatal care, are either inadequately funded or excluded from Medicare altogether.⁶³ The Australian College of Midwives notes that midwives can only claim rebates for appointments where both mother and baby attend, with no item code for parent-only appointments.⁶⁴

The NWAs emphasise the importance of connected and continued care to ensure mothers and families can access necessary healthcare throughout the first year of the postpartum period. Patients and healthcare providers report that woman-centred discharge, integrated care, and continuity of care are critical for effective transitions.⁶⁵ Continuity of care has been shown to be particularly important for establishing successful breastfeeding.⁶⁶

Evidence shows that Australian postnatal transition between hospitals and primary care is inconsistent and ineffective, hindering follow-up care.⁶⁷ This creates a significant risk for women who experience birth complications – disproportionately women with disabilities.⁶⁸ In 2025, more than one-third of maternal care provided in Australia had no continuity of care at any stage of the maternity period.⁶⁹ Only 8-15% of women have access to midwifery continuity of care models.⁷⁰ Continuity of care models are more prevalent in private maternity services (94%) than in public services (72%).⁷¹ Quality of care and safety of mothers and children should not be limited to those who can afford it.

For marginalised women, postpartum healthcare is often inaccessible. Aboriginal and Torres Strait Islander women and migrants and multicultural women may face exacerbated discrimination and distrust of the healthcare system where cultural practices conflict with Australian healthcare standards. Lack of access to navigators, liaisons, translated resources, interpreters, and Aboriginal healthcare workers contributes to this issue. Patient reported birth outcomes for Aboriginal and Torres Strait Islander women continue to be significantly worse compared to the non-indigenous population.⁷² However, Aboriginal and Torres Strait Islander women show a consistent preference for Birthing on Country models which integrate traditional practices, holistic wellbeing and continuity of care.⁷³ Aboriginal community-controlled maternity services, Continuity of Midwifery Care models, multidisciplinary maternal health hubs, and home-visiting models can also be more accessible to marginalised women.

Similarly, women with disabilities experience poor maternal health outcomes relative to the population, particularly experiences of postpartum care.⁷⁴ Data on disability status is not routinely collected in maternity services, limiting the understanding of women with disabilities' experiences of maternity care in Australia.⁷⁵ However, women with disabilities have reported a lack of continuity of care and inconsistent information from healthcare professionals as contributors to poor maternal healthcare experiences.⁷⁶ While 71% of Australian maternity services routinely ask women about disability status, 68% do not offer specialised services, with only 13% having specialised training.⁷⁷

The cost and accessibility of postpartum healthcare is a continuing problem for mothers in rural, remote and regional Australia. Across Australia there is a shortage of many allied health services including physiotherapy and psychology, which are critical to providing high-quality postpartum care.⁷⁸ This shortage is more pronounced in rural and remote areas, with much lower rates of allied health services in large rural towns (MM3), medium

rural towns (MM4), small rural towns (MM5), remote communities (MM6), and very remote communities (MM7), with small rural towns showing the lowest rates.^{79 ii}

Lack of available services means increased wait times for services, increased travel times, and less choice for rural, regional and remote mothers.

Postpartum healthcare must be designed for the patients accessing it. More than a third of women giving birth in Australia are migrants.⁸⁰ Postpartum healthcare must be designed for all parents, including:

- Culturally and linguistically diverse women, offering peer connection with women from the same cultural background, translated resources, culturally diverse practitioners, and system navigation support.
- Aboriginal and Torres Strait Islander women, delivered by community-controlled services that support self-determined and culturally safe healthcare, and incorporate traditional practices such as Birthing on Country.
- Women with disabilities, providing inclusive healthcare infrastructure and practices.
- Women living in regional, rural, remote and very remote areas, prioritising high quality and consistent care provided close to home.
- LGBTIQ+ and gender diverse people, providing inclusive, affirming care and recognising diverse family structures.

Postpartum care must also understand other social and economic determinants of health, such as socio-economic status and experiences of gender-based violence as barriers to access.

Spotlight– Birthing on Country Programs

Birthing on Country programs demonstrate how Aboriginal and Torres Strait Islander governance and community-led provision of maternal healthcare can be incorporated into, and supported by mainstream services through collaborative approaches.

The [*Birthing in Our Community*](#) program (BiOC), established in Queensland, involves a partnership with the Institute for Urban Indigenous Health (IUIH), other Aboriginal and Torres Strait Islander community organisations, Mater Mothers' Hospital, Metro North Hospital, and other midwifery and maternity services.⁸¹ BiOC is overseen by an Aboriginal and Torres Strait Islander steering committee and provides Indigenous students with midwife cadetships and placement opportunities. There are now five BiOC hubs across Queensland.⁸² Alongside BiOC, the IUIH offers targeted services for

ⁱⁱ Codes MM1 to MM7 refer to the Modified Monash Model (MMM), which is the Australian Government's classification system for measuring how metropolitan, regional, rural, remote, or very remote a location is.

children, mothers, fathers, and people with disability, including support navigating the NDIS. They also offer a range of other post-partum related services, including paediatric services, persistent pain, physiotherapy, post-operation services, mental health and wellbeing, and family wellbeing services.

The evaluation of the BiOC program report that it achieved increased attendance at antenatal care, reduced preterm birth, increased breastfeeding at discharge, and overall better maternal outcomes.⁸³ The IUIH's multidisciplinary care environment also supports a holistic approach to maternal and postpartum health, increasing access to allied health.

Recommendations 2.1: Remove cost barriers for continued postpartum healthcare by:

- Creating a Medicare item for GPs, midwives, child and family nurses, obstetricians and perinatal health practitioners to spend more time with patients affected by violence during and after pregnancy.
- Expanding Medicare-supported postpartum care beyond the standard six-week review, including for pelvic floor physiotherapy, lactation support and mental health support.
- Increasing the number of Medicare-covered pregnancy counselling sessions.
- Fund public hospitals to expand Continuity of Care models.
- Investigating subsidises for allied health providers operating in regional, rural and remote areas to maintain access to services in thin markets.

Recommendation 2.2: Recognise postpartum healthcare as an intervention point for gender-based violence.

Postpartum healthcare provides opportunities for early identification of gender-based violence through regular mother and infant health check-ups. The AIFS and AIHW have acknowledged that pregnancy and the postpartum period are high-risk phases for gender-based violence, especially intimate-partner violence and first-time use of violence.⁸⁴

- Research suggests the prevalence of violence increases as the post-partum period progresses from the first six months.⁸⁵
- The 2021-22 Personal Safety Survey estimates that 15% of pregnant women experienced violence.⁸⁶
- Pregnant women hospitalised for physical violence are eight times more likely to experience foetal death and six times more likely to experience neonatal death.⁸⁷

- More pregnant women experience gender-based violence (15%) than they do preeclampsia (approximately 3%), which is constantly screened for and monitored.⁸⁸
- More than one in four migrants experience intimate partner violence in the first 12 months postpartum.⁸⁹

Pregnancy and early parenthood serve as opportune times for early intervention as women are more likely to have contact with health and other professionals. The NWA's emphasise the findings of *Unlocking the Prevention Potential*, which identifies the healthcare system as an untapped prevention mechanism, especially for women experiencing violence during and after pregnancy.⁹⁰ The Commonwealth government must adopt recommendations from this report to ensure postnatal care is tailored to screen for gender-based violence, and support mothers who have experienced consequent infant death and birth trauma.

Evidence shows that violence can first emerge during pregnancy or following the birth of a child. The transition to parenthood can reshape household dynamics, caregiving responsibilities, financial arrangements and expectations around gender roles, creating circumstances in which coercive and controlling behaviours may first become apparent.⁹¹

RCA are distinct forms of gender-based violence that include behaviours that pressure, force or manipulate reproductive decisions about contraception, pregnancy continuation and termination. This can co-occur with other forms of violence and has serious consequences for victim-survivors' safety, health, economic security, and ability to make decisions about their own body.⁹² RCA remains under-identified in Australia, in part because there is limited national data and inconsistencies in data collection. However, available evidence indicates that one in seven people seeking pregnancy options counselling in Australia report experiences of RCA.⁹³ For Aboriginal and Torres Strait Islander women, migrant and refugee women, young women, women with disability, gender diverse people, and women facing socioeconomic disadvantage this risk is heightened.⁹⁴ Aboriginal and Torres Strait Islander people have been subject to state-supported, structural and interpersonal forms of reproductive coercion since colonisation. Similarly, women with disabilities and multicultural women experience distinct forms of forced sterilisation and FGM/C. Responses to this issue must be grounded in cultural safety, self-determination and partnership with affected communities.

More women experience gender-based violence during pregnancy than many conditions, such as pre-eclampsia, for which routine screening is standard practice. Given this is a high-risk period for the onset of violence, pregnancy and early parenthood should be recognised as an important prevention opportunity. Regular contact with healthcare services provides opportunities to engage fathers and partners, identify emerging

concerns, and connect families with support before patterns of violence become established. There are some resources, including the Victorian Government's implementation guide, to support healthcare services screen for family violence in the antenatal period.⁹⁵ This needs to be mirrored in the postpartum period.

Recommendations 2.2: Recognise postpartum healthcare as an intervention point for gender-based violence by:

- Recognising pregnancy and the postpartum period as high-risk phases for the onset and escalation of gender-based violence, including RCA.
 - This should be recognised in the Second Action Plan under the National Plan to End Violence against Women and Children 2022–2032.
- Recognising pregnancy and early parenthood as critical opportunities for violence prevention and early intervention, for both victim-survivors and users of violence.
- Embedding routine screening and risk assessment questions into antenatal and postpartum healthcare.
- Creating a Medicare item for fathers in the postpartum period.
- Designing evidence-based interventions to prevent intimate partner violence targeting new fathers.

Recommendation 2.3: Provide postpartum education in the antenatal period.

Postpartum health education must begin in the antenatal period, preparing both birthing and non-birthing parents before periods of high stress. Education in the antenatal period must be understood as a protective factor for the postpartum period, helping women to identify postpartum health issues and relevant support avenues.

The caring burden in the postpartum period often falls entirely on women. Women are often expected to manage postpartum health issues privately, leaving them without support networks. Education in the antenatal period must be catered to partners and support people as well as mothers. It must also cater to marginalised women. Most public hospital antenatal classes are run in English only, particularly those that are free. This is despite more than a third of birthing parents in Australia being migrants, and despite one in five Australians speaking a language other than English at home.⁹⁶ Where postpartum and maternal health education has been delivered in-language, through trusted community organisations, maternal health outcomes are better.⁹⁷

Recommendation 2.3: Provide postpartum education in the antenatal period by:

- Funding freely accessible postpartum preparatory classes in every maternity unit.
 - Ensure there are streams for distinct communities.

3. Improve Affordability of Treatment for Reproductive Health and Chronic Pain

In 2023-24 Australia spent an estimated \$270.5 billion on health goods and services – this contributes to 10.1% of the total GDP and equates to an average of \$10,037 per person.⁹⁸ This figure is likely higher for women, who spend more on healthcare than men, particularly on services to treat chronic disease and mental health conditions.⁹⁹ Women also experience increased spending patterns during childbearing years and between the ages 70-74.¹⁰⁰ In addition to reproductive health conditions, women are more likely to have multiple chronic health conditions, requiring numerous specialist and allied health services.¹⁰¹

Women with reproductive and chronic health conditions experience cumulative cost barriers to accessing adequate healthcare. This happens for several reasons, with women more likely to:

- See multiple practitioners to manage chronic and complex health conditions.
- Need multiple appointments before receiving a correct diagnosis.
- Need multiple appointments before finding a practitioner who is culturally appropriate, inclusive, trauma-informed, and takes women's health concerns seriously.
- Require specialist and allied healthcare services, which have greater out-of-pocket fees.
- Require regular medications and medical devices.
- Lose income through reduced workforce participation.

Women's health cannot be understood through a single-condition lens. Reproductive and chronic health, chronic pain, disability, and mental health are deeply connected, with many women experiencing co-occurring and intersecting conditions that exacerbate their health needs. This means that addressing barriers to access including cost, medical misogyny, and coordination of care is essential in ensuring women receive adequate healthcare.

Recommendations 3.1: Make reproductive healthcare universally accessible.

Reproductive healthcare is not considered essential. It is largely delivered through practitioners who have done post-graduate and specialist training in women's health. As a result, women's healthcare costs more and 'mainstream' healthcare is often inadequate.

Healthcare services administered to women often cost more than comparable services for men. For example, imaging of the pelvis is more expensive for women, due to the

additional time necessary to scan female reproductive organs. Medicare rebates often do not account for the larger gap fee that this creates for women. Similarly, the cost of a DEXA scan for osteoporosis is only subsidised for women under 45, who have persistently low hormones, while it is subsidised for all men. This is despite the fact that women are more prone to osteoporosis, particularly after menopause and that 80% of deaths caused by osteoporosis are among women.¹⁰²

This reflects a broader pattern within the healthcare system where women's health needs are treated as secondary or adjunct to other areas of care, resulting in avoidable costs and reduced access to support during critical life stages.

Specialist fees for female-specific services are also more expensive relative to other specialist streams and are continually increasing. Median out-of-pocket costs for obstetrics and gynaecology have increased over the period 2018-2023 from \$121 to \$149, and neonatal and perinatal medicine has increased from \$16 to \$53.¹⁰³ Medicare data reports obstetrics and gynaecology specialist fees ranking in the top percentiles of specialists who charge fees that are excessive of the MBS schedule fee.¹⁰⁴ This might be explained in part, by increased demand for reproductive healthcare. Women are having children later in life, which increases complexity associated with pregnancy and fertility. However, price growth is not entirely associated with natural market behaviour.

Without full price transparency, patients are subject to information asymmetry which limits their ability to compare specialist fees and expertise. Additionally, where specialist healthcare is essential, patients have little choice but to pay the set fee. For women, this power inequality is amplified by medical misogyny. Women's choice of specialist healthcare is significantly reduced by which providers have adequate training in women's health, and which are culturally appropriate, inclusive, and trauma-informed. This information asymmetry forces patients to 'test the market,' spending money on providers until they find a 'match.' In particular, for women's health specialists, this allows providers to charge fees in excess of the MBS Schedule Fee and the market median fee, while patients are expected to absorb rising costs. Australians are accessing their superannuation accounts on compassionate grounds more than ever before. Second to dental procedures, \$74.2 million was approved for In-vitro Fertilisation (IVF) treatments in 2025.¹⁰⁵ Research shows that where specialists do charge excessive fees, they are not set based on patient complexity or ability to pay, but rather, experience, reputation, and perceived quality difference relative to the market.¹⁰⁶

Women are also more likely to access healthcare services that are not subsidised by Medicare. This includes allied health services such as physiotherapy, dietetics,

occupational therapy, and pain management treatments that are associated with reproductive health and chronic pain conditions.

While the costs of reproductive healthcare are increasing, employees – both men and women, cannot legitimately use Personal Leave for reproductive health needs.¹⁰⁷ The value of lost productivity due to reproductive health conditions currently costs the economy \$21.3 billion per year. Intense menstrual pain, endometriosis, IVF and menopause have the heaviest burden on productivity loss, and these conditions amount to 13 to 26 days lost annually per person due to presenteeism.¹⁰⁸ Employees with reproductive health needs have no other choice but to use up their personal leave, annual leave, take leave without pay, or continue to attend work.¹⁰⁹ Of employees who did not take leave despite their reproductive health condition, 65% did so due to limited leave, and 49% delayed medical care due to an inability to take leave from work.¹¹⁰ This contributes to cost barriers in accessing healthcare by diminishing women's earning potential, whilst they simultaneously front excessive healthcare costs.

Recommendations 3.1: Make reproductive healthcare universally accessible by:

- Reviewing and strengthening Medicare support for abortion, contraception and RCA-related consultations.
- Amending the National Employment Standards to include 10 days of reproductive leave.
- Ensuring universal free access to contraception.
- Ensuring the Green Whistle (Penthrox) is offered to patients undergoing IUD insertion
- Requiring that all public hospitals that receive federal government funding provide medical and surgical termination services or establish timely and affordable referral pathways to local providers.
- Developing treatment guidelines so there is national service consistency in relation to abortion provision.

Recommendations 3.2: Ensure treatment of chronic pain is gender-responsive.

Women are more likely to experience chronic pain than men, and less likely to be prescribed the pain relief they need.¹¹¹ A global study of the gender pain gap revealed that women experience more severe pain across all areas of the body, but particularly, regarding headaches and abdominal pain.¹¹² This corroborates findings that migraines are the leading cause of disability worldwide for women aged 18-49, and an Australian study that found that one in three women suffer migraines.¹¹³ A survey of patients with chronic pain found that 76% of respondents had mental health issues associated with living with chronic pain, and 49% had considered taking their own life because of their pain.¹¹⁴

The Victorian Women's Pain Inquiry found that of the 90% of women who experience chronic pain, more than half (52%) accessed six or more services to manage pain, and 23% accessed more than ten services.¹¹⁵ Women are more likely than men to see multiple health professionals for the same health condition, and are more likely to report issues caused by lack of communication between health professionals.¹¹⁶

Similarly, WWDA hosted a 2025 Economic and Employment Survey and found that 75% of respondents reported experiencing health insecurity in the last six months.¹¹⁷ Women with disability require numerous medical appointments and coordinated care. The AIHW found that 47% of people with 'severe or profound disability' saw three or more professionals for the same condition.¹¹⁸ Approximately 30% of people with disability need help with healthcare activities.¹¹⁹ Healthcare services are often exclusive to women with disabilities, with practitioners lacking disability-specific training, and healthcare infrastructure and equipment that is physically inaccessible. Women with disabilities and/or chronic health conditions also incur additional costs through repeated consultations before symptoms are believed, short appointments that cannot accommodate complex needs, and inaccessible local services. Affordability is produced by service design as well as price.

Case Study – Inaccessible Assistive Reproductive Technology

A member of WWDA spent more than 300 days attempting to access egg freezing. Clinics repeatedly advised that they lacked the equipment or trained staff to assist her to transfer from her wheelchair to a treatment bed. These purported 'practical limitations' operated as a refusal to make reasonable adjustments, delayed care and affected her fertility options.

Current healthcare settings do not adequately account for the additional expenses fronted by women with complex health conditions, including reproductive health conditions, chronic pain conditions, and disability. Despite 38% of Australians living multimorbidity, and women with chronic health issues accessing more than ten practitioners, Chronic Condition Management Plans (CCMP) only provide five subsidised allied health appointments per year.¹²⁰ Some members from WWDA exceed this threshold in a matter of weeks.

Further, NDIS reforms now require applicants to try 'all appropriate treatments' before applying for funding. This will increase financial pressure on women with disabilities, potentially requiring them to access more healthcare support that may have otherwise been covered by the NDIS.

GPs should have the ability to expand the number of subsidised sessions in CCMPs where necessary, like with Mental Health Treatment Plans. This would allow for more comprehensive support for those who need frequent appointments to manage chronic

pain and health conditions. Expansion of the CCMP is unlikely to be exploited, as only 37% of patients with CCMPs utilised all five of their subsidised sessions in 2019.¹²¹ Rather, it would allow for a greater spectrum of support and would target those who are currently underserved by CCMPs.

Recommendations 3.2: Ensure treatment of chronic pain is gender-responsive by:

- Implementing price ceilings for specialists, aligning with the Grattan model.¹²²
- Reforming Chronic Condition Management Plans to allow for additional subsidised allied health appointments.
- Improving the understanding of women's pain in relation to available supports under Centrelink and NDIS policies.
- In line with the Victorian Women's Pain Inquiry, developing a women's pain action plan.

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