Australian Government
Department of Health and Aged Care

National Women's
Health Advisory
Council

# #EndGenderBias Survey Detailed Report

2024

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The online survey on which this report is based was developed by the Australian Government Department of Health and Aged Care in conjunction with the National Women's Health Advisory Council.  The report was prepared by the Australian Women and Girls' Health Research Centre at the University of Queensland

# Contents

# 1. Introduction

In 2023 the National Women's Health Advisory Council conducted the #EndGenderBias survey to ask Australian women and gender diverse people about their experiences of barriers and bias in the health system.

Women, girls, and gender diverse people, as well as experts (academics, healthcare professionals and peak stakeholder groups) were invited to take part. The views of priority populations were specifically sought including First Nations Australian, lesbian, bisexual, transgender, intersex, and queer people, those with culturally and linguistically diverse backgrounds, lower socio-economic households, regional and remote communities, and people with a lived experience of disability.

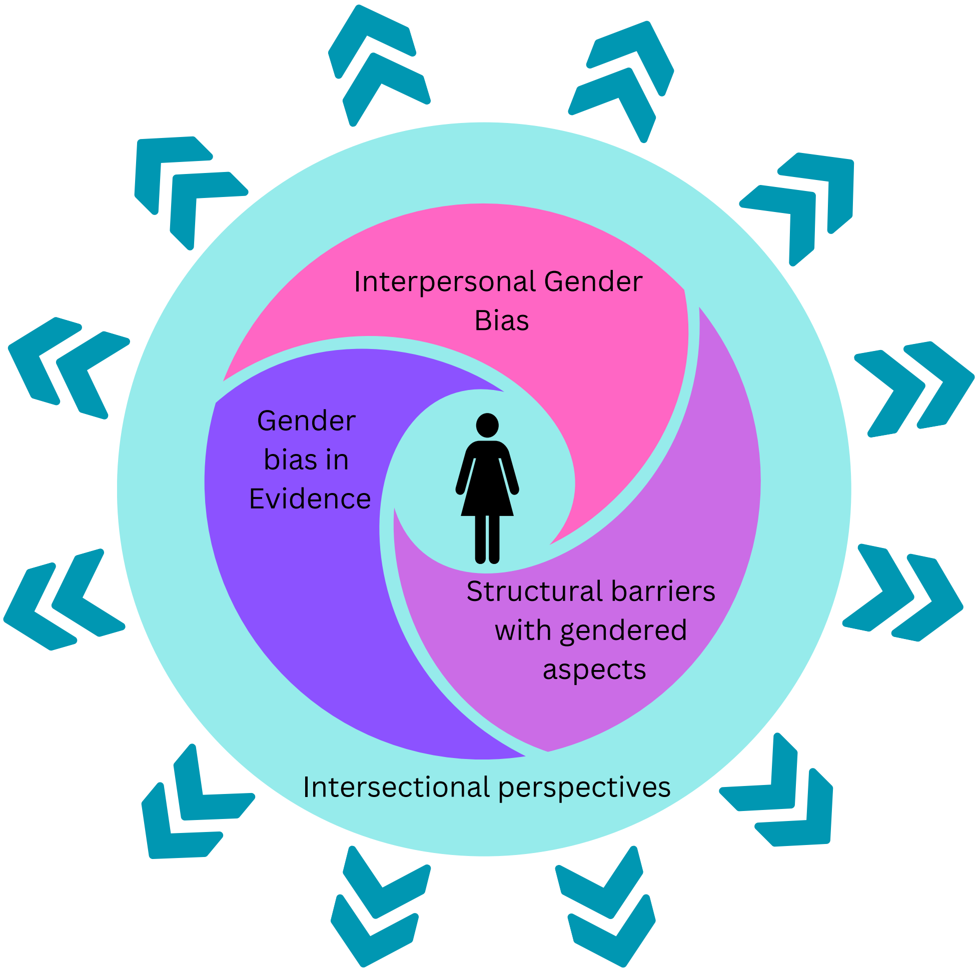
Respondents reported on their own experiences or on the experiences of someone they know.

# 2. Key findings

Two thirds of participants reported experiencing gender bias or discrimination in their own healthcare within the last ten years, and 80% reported such an experience on behalf of someone else. These percentages were even higher for some priority groups such as participants with a disability (84%), those who identified as LGBTQI+ (84%) or who had experienced violence or abuse. However, members of other priority populations including culturally and linguistically diverse respondents and First Nations Australians did not report gender-based bias more commonly than other participants. More than 50% of participants felt they were treated very or extremely differently in healthcare settings due to their gender. More than 70% felt their opinions were not heard or considered.

Participants reported experiences of gender bias in healthcare that were layered and overlapping, and included:

- **Interpersonal experiences** - consultations between individuals and their healthcare providers
- **Structural barriers**, affecting the accessibility and affordability of healthcare
- **Evidence base** underpinning healthcare and medical innovation
- **Intersectional** experiences of gender bias - related to other aspects such as age and rurality.



As a result of each layer of gender bias, gender bias in healthcare has **far reaching impacts** on respondent's lives, including:

- Feelings of abandonment, shame, blame and self-doubt
- Significant financial burden, lost educational and career opportunities
- Delayed diagnosis and treatment led to disease progression, fewer treatment options and worse health outcomes.

Nevertheless, respondents also recounted positive healthcare experiences that stemmed from strong interpersonal interactions and relationships.

More than half of the health professionals, researchers, and consumer advocates who responded to the survey did not believe Australian research guidelines fostered inclusion of sex and gender in the design of health research or that research in relation to women's health was incorporated into guidelines or implemented into clinical practice or public health and policy settings.

# 3. Who responded to the survey?

There were 2,570 responses about respondents' own experiences, 86 responses from people responding on behalf of others, and 497 responses from expert stakeholders.

Almost 90% of respondents reporting their own experiences were aged between 25 to 64. Among people reporting the experiences of others, more than half were responding on behalf of their children, while others were reporting about an older person (aged 75 years or more) (Figures 1 and 2). For both groups, almost 70% lived in metropolitan areas and a quarter lived in regional areas.

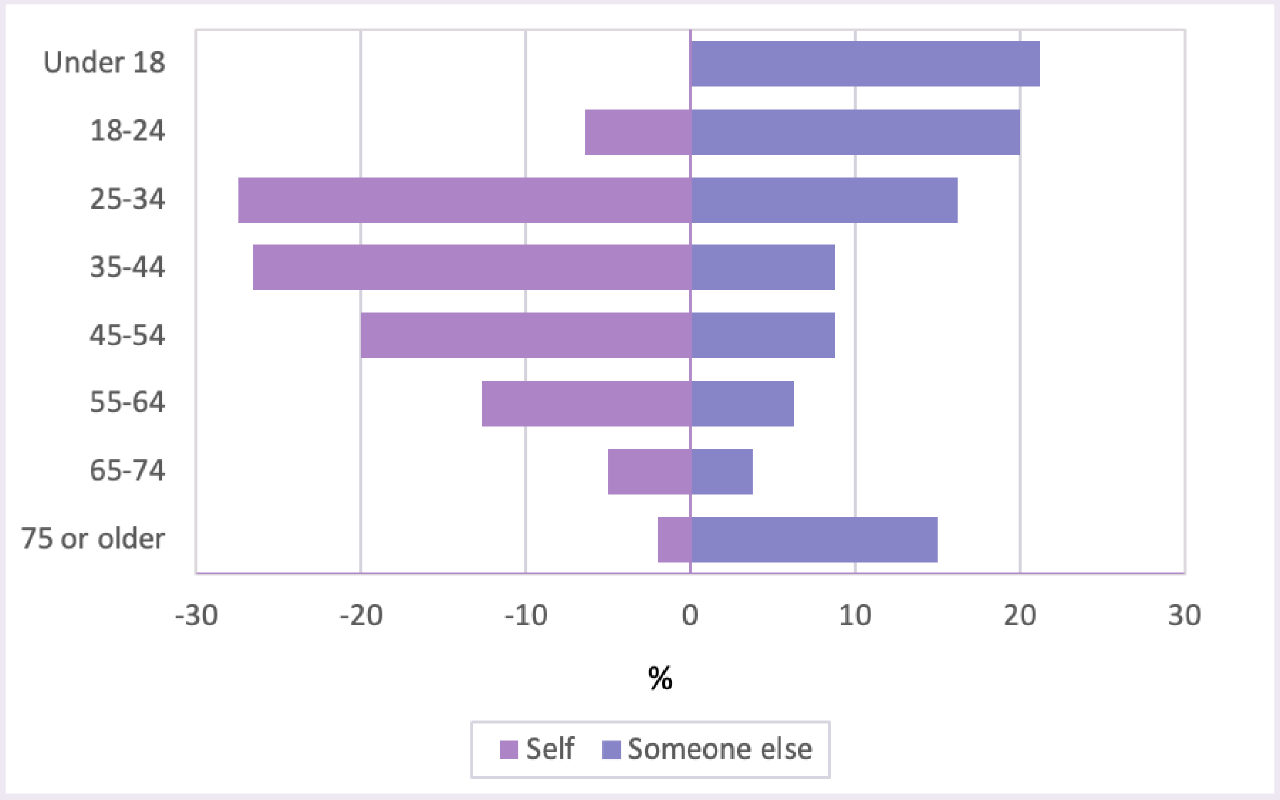


Figure 1: Age distribution of participants responding on their own behalf, and of people whose experience was reported by someone else.

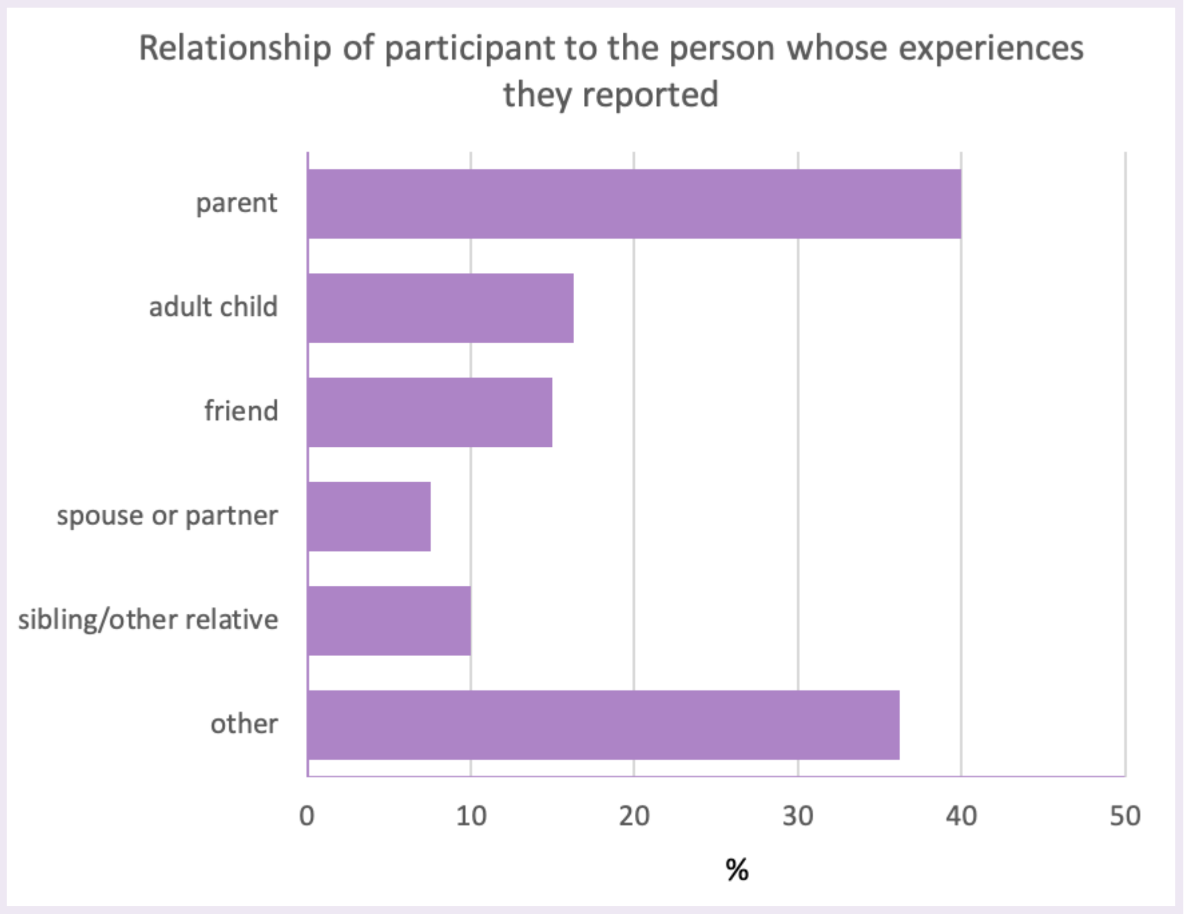


Figure 2: Relationship of participant to the person whose experiences they reported.

People with a disability were the largest priority population group, with 25% of those reporting their own experience reporting a disability and 34% of those reported by someone else having a disability. The next largest groups were people who had experienced violence and/or abuse (25% for personal experience and 12% reported for someone else), and people identifying as LGBTQI+ (19% in both groups). Far fewer participants responding on their own behalf were from culturally and linguistically diverse backgrounds (10%) or were First Nations Australians (61 women, less than 3%) (Figure 3).

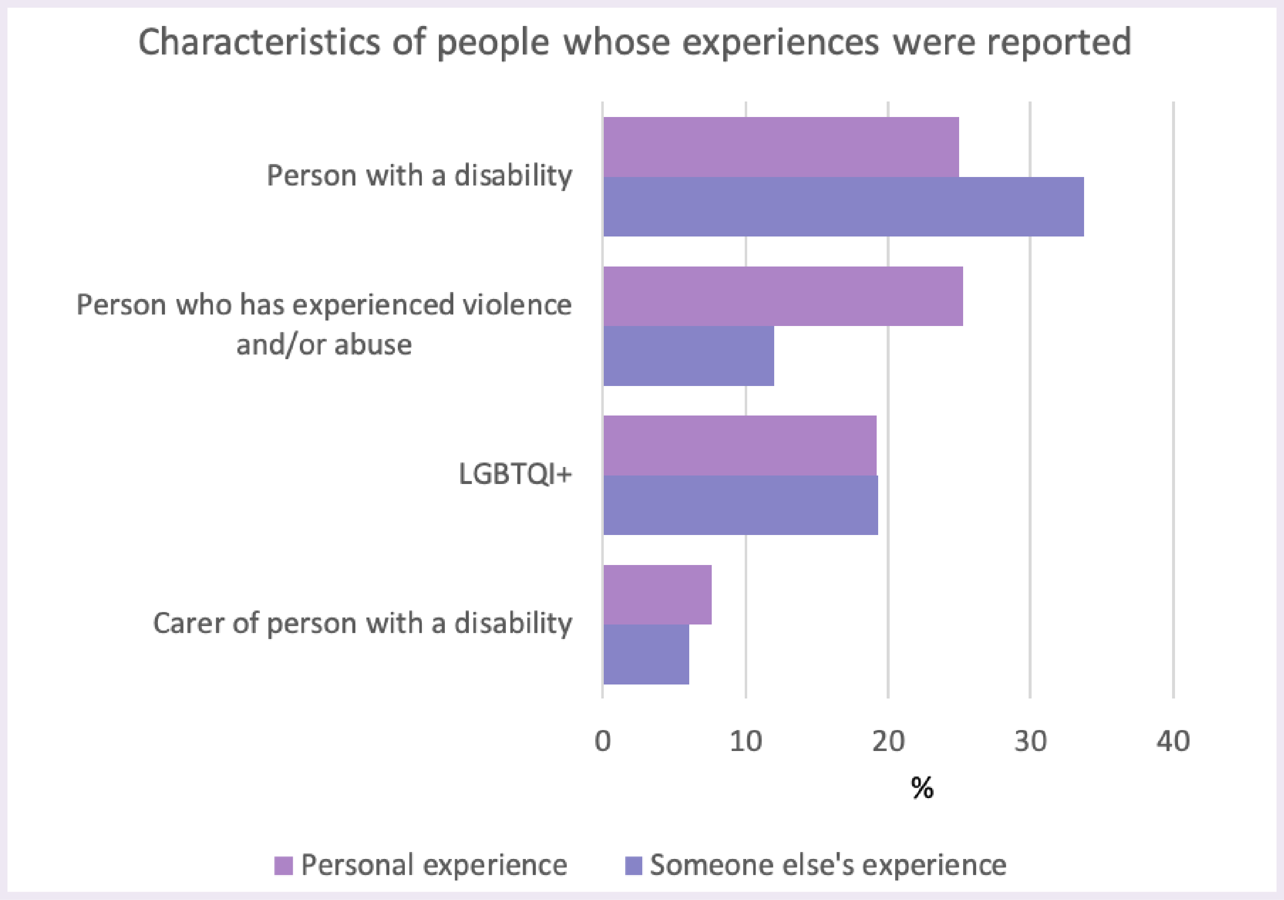


Figure 3: Characteristics of participants responding on their own behalf, and of people whose experience was reported by someone else.

Expert stakeholders could respond either individually or on behalf of their organisation. Most responses from individuals were received from nurses or midwives (28%), researchers (24%), allied health professionals (20%) and medical practitioners (19%) - responses from multiple perspectives were possible (Figure 4).

Figure 4: Area of work or expertise of stakeholder participants.

Among organisations, most responses were received from those representing people with a disability (27%), pregnant women (25%), and groups from low socioeconomic backgrounds (25%) and cultural and linguistic diverse populations (23%) (Figure 5).

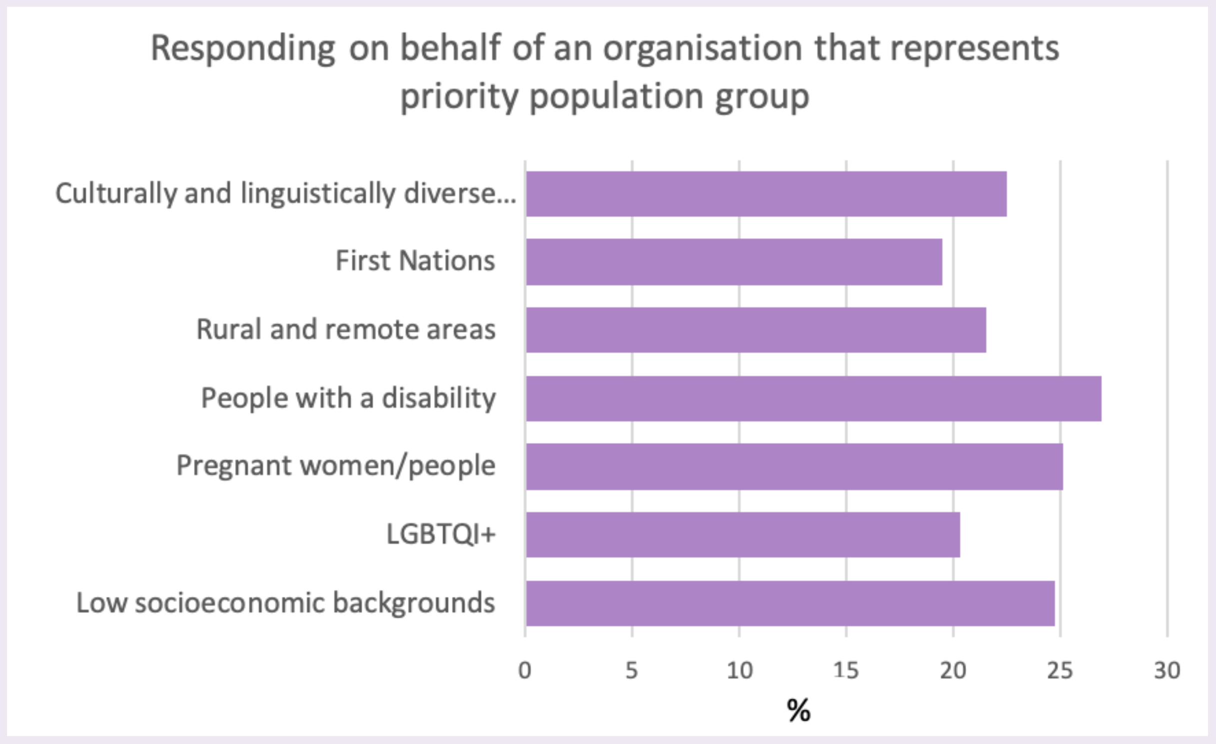


Figure 5: Responses from organisations representing the most common priority population groups.

# 4. Experiences of gender bias

## 4.1. Context of gender bias

When participants reported they or someone else had experienced gender bias in healthcare, they were asked to provide more information about the context of those experiences. **More common health conditions and more commonly encountered situations were therefore more likely to be reported, so the results should be interpreted with caution**.

Experiences of gender bias were most reported in relation to sexual and reproductive health, chronic pain, and mental health conditions (Figure 6), in the diagnosis and treatment of health conditions (Figure 7), and in general practice (GP) and hospital settings (Figure 8). Generally, the same contexts and situations were reported by participants describing their own experience and by those reporting for someone else. Other conditions, parts of the healthcare journey and healthcare settings were identified with gender bias by fewer people, usually because these were less common conditions or situations.

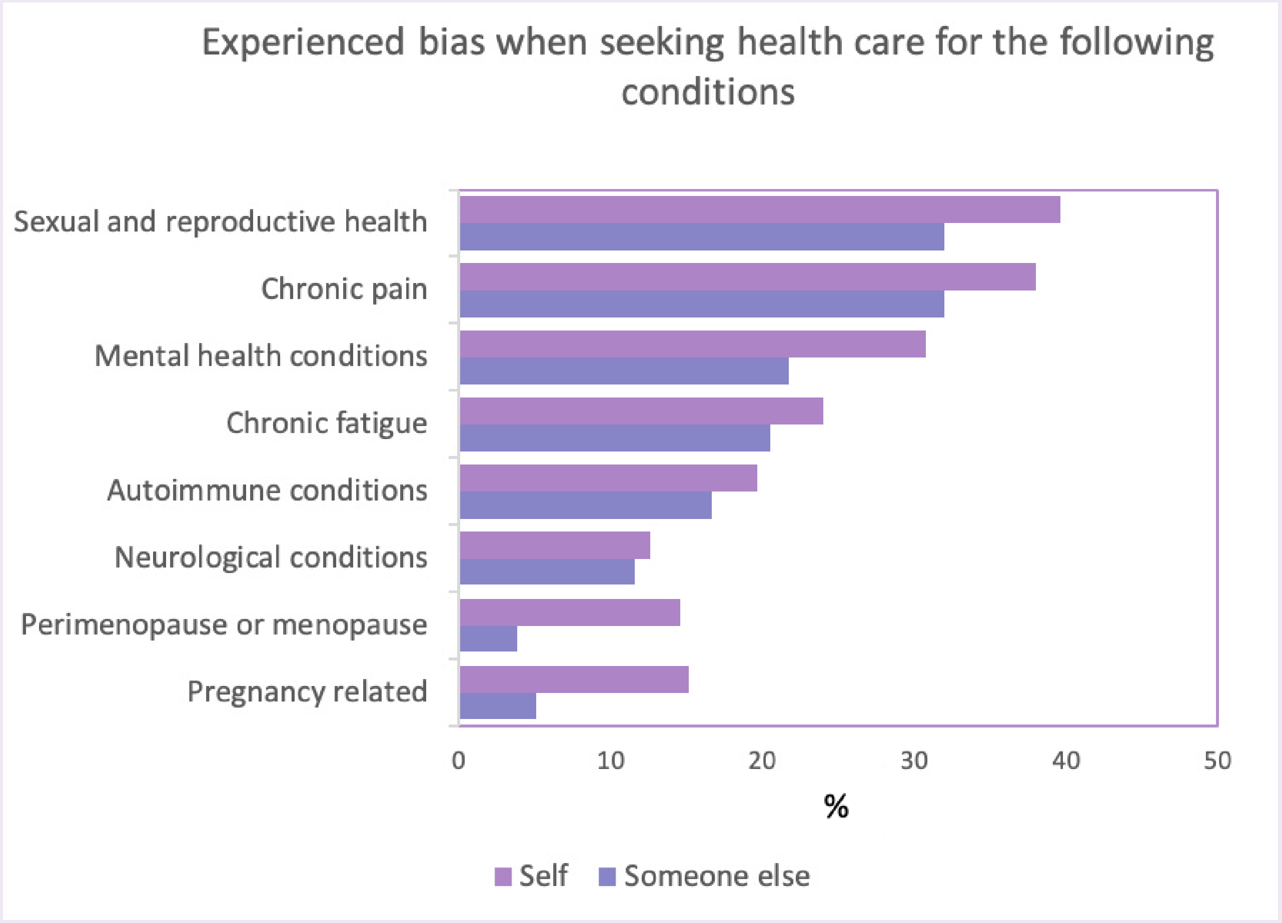


Figure 6: Gender bias in care for specific conditions.

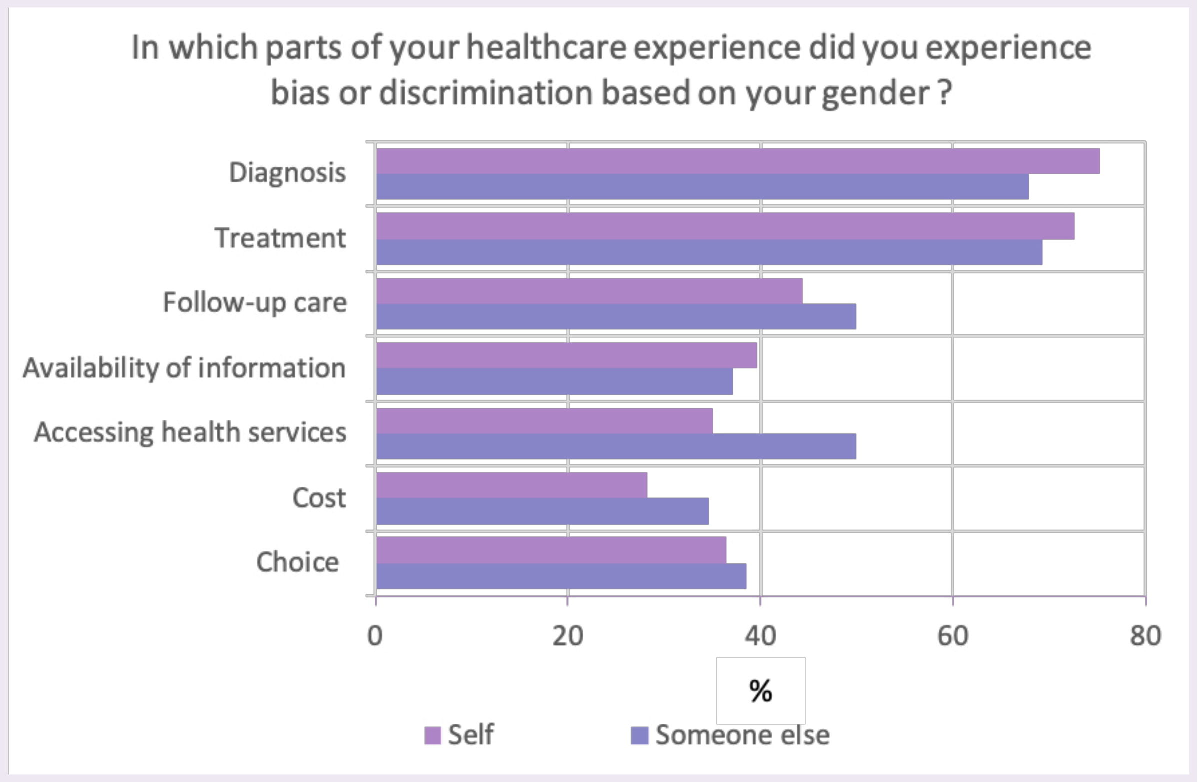


Figure 7: Gender bias at different parts of healthcare experience.

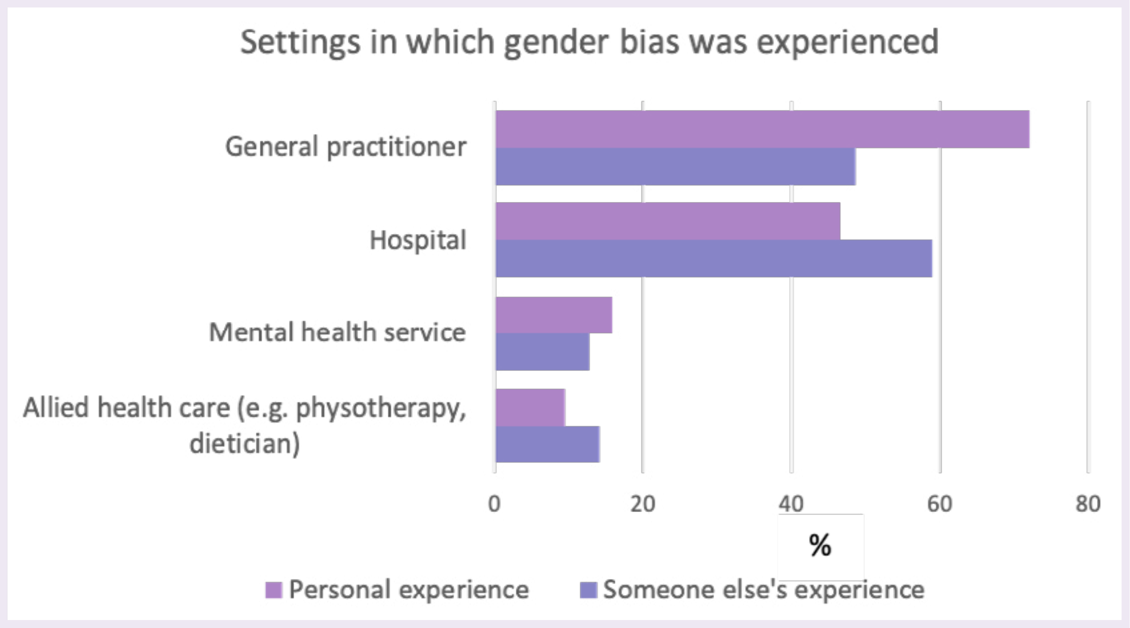


Figure 8: Gender bias in most commonly identified healthcare settings.

## 4.2. Experiences with healthcare

Participants who reported experiencing gender bias were asked detailed questions about how they felt they were treated in healthcare settings.

More than 50% of participants felt they were treated very or extremely differently in healthcare settings due to their gender (Figure 9) and more than 60% were dissatisfied with the amount of information shared with them (Figure 10).

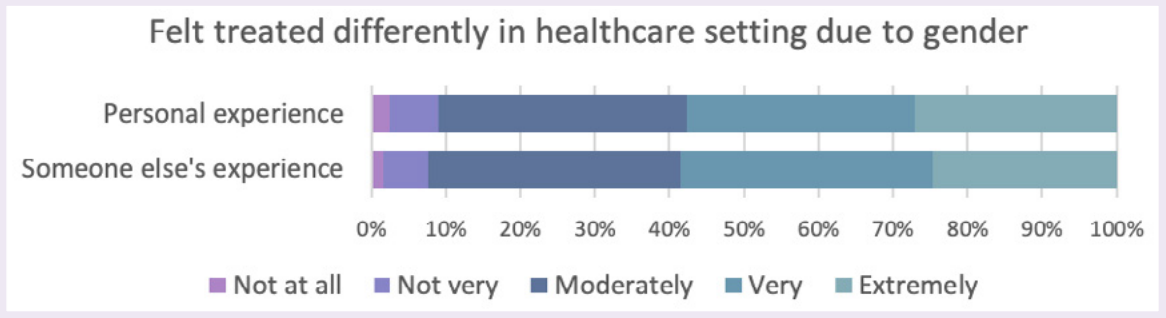


Figure 9: Responses about participants' feelings of being treated differently in health care settings due to their gender.

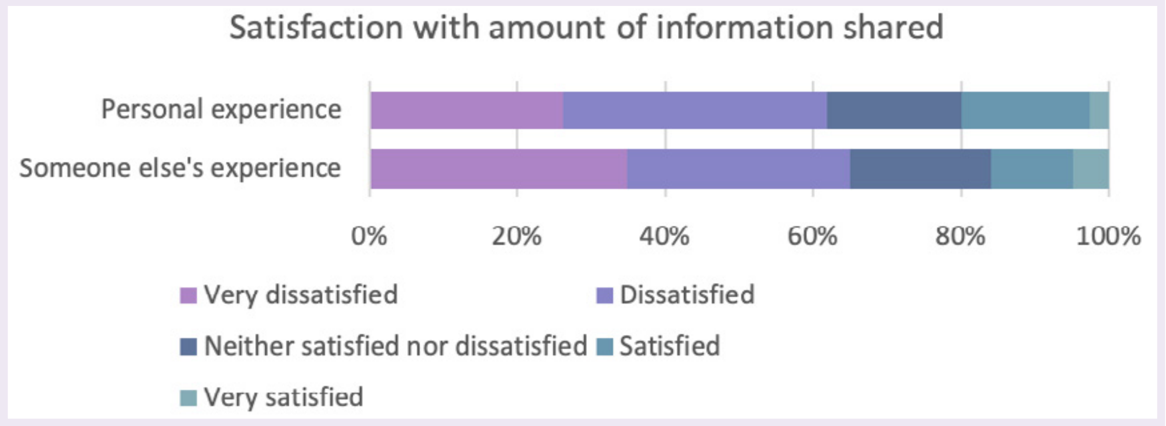


Figure 10: Satisfaction with the amount of information shared.

Respondents reporting for themselves did not feel confident about speaking up as part of the decision-making process in healthcare, and lack of confidence was even higher among those whose experience was reported by someone else (Figure 11). More than 70% felt their opinions were not heard or considered (Figure 12).

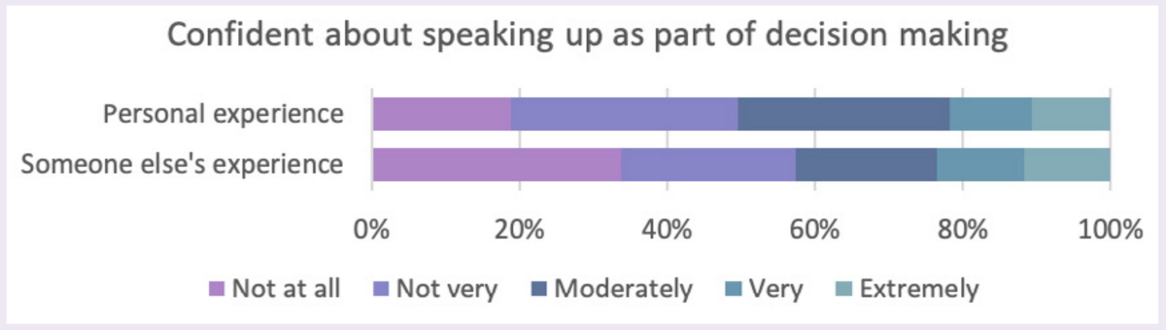


Figure 11: Responses about feeling confident about speaking up.

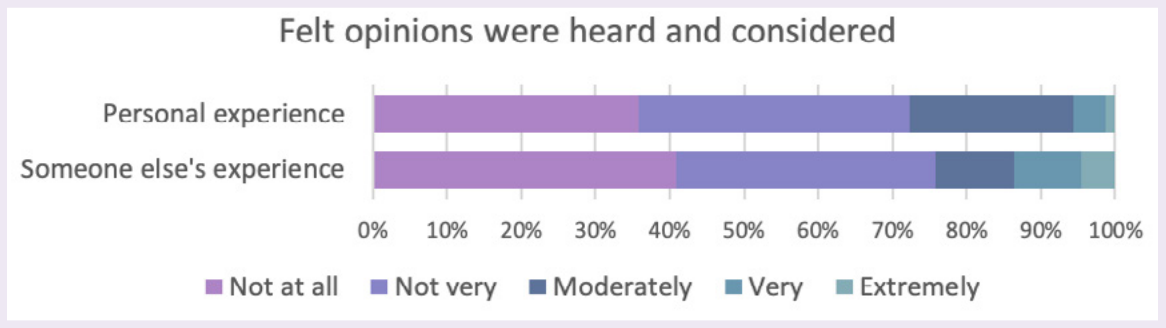


Figure 12: Responses about feeling their opinions were heard and considered.

More than half of the respondents thought their healthcare was inappropriate (Figure 13). When reporting about their own experiences, about 35% felt unsafe or very unsafe and over half of respondents reporting someone else's experiences felt that person was very unsafe or unsafe in healthcare settings. (Figure 14).

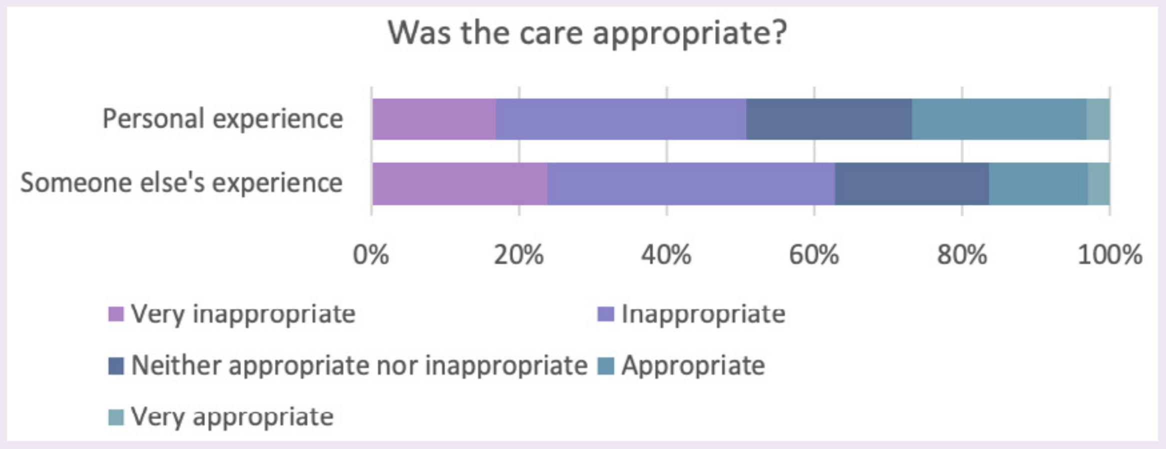


Figure 13: Perceptions of appropriateness of healthcare.

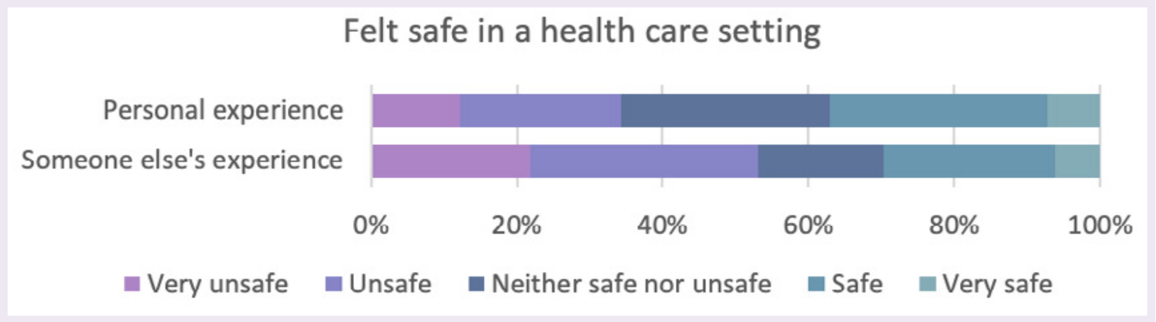


Figure 14: Feelings of safety in healthcare settings.

## 4.3. Choice and satisfaction with healthcare

Amongst people who reported experiencing gender bias in healthcare, more than 60% felt they had little or no choice about any of the aspects of healthcare that was relevant to them (Figure 15). Amongst respondents reporting the experiences of someone they cared for, who had experienced gender bias in healthcare, this rose to almost 80% (Figure 16).

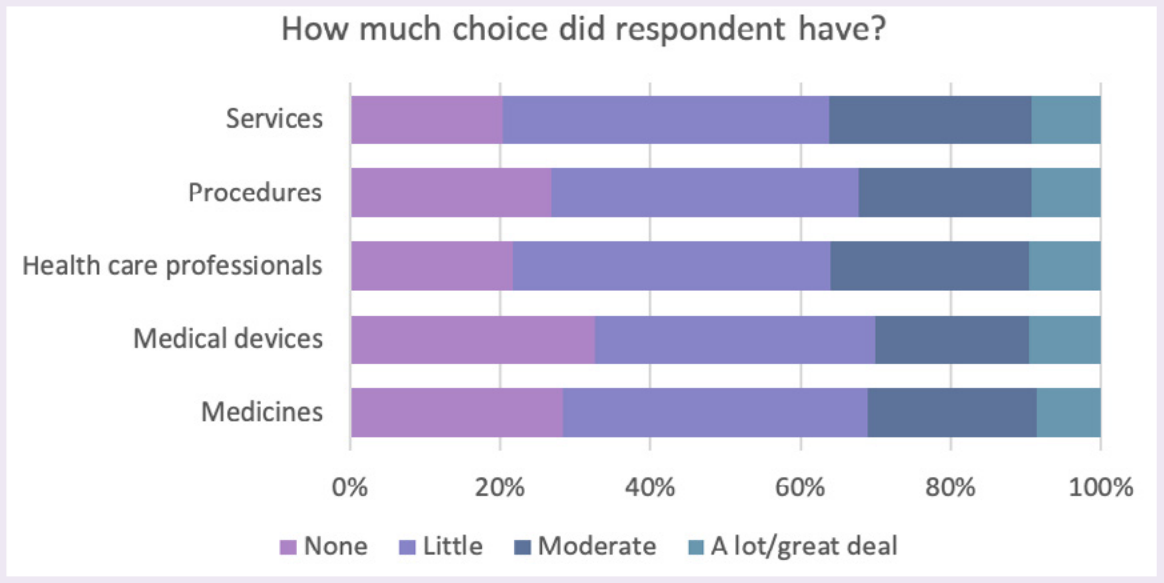


Figure 15. Choice of healthcare services reported by the participants themselves.

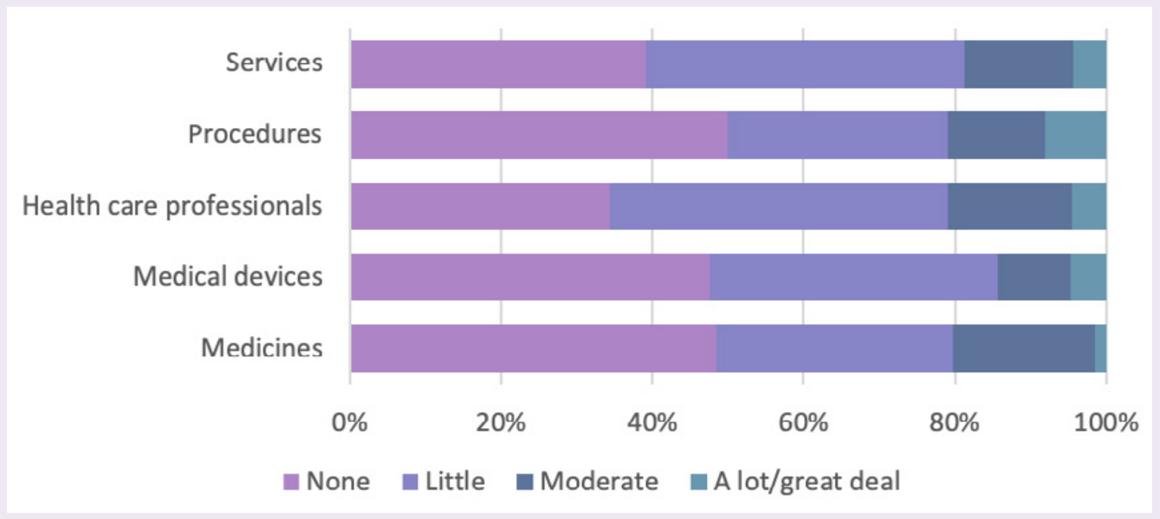


Figure 16. Choice of healthcare services reported for someone else.

Among people who reported experiencing gender bias in healthcare themselves, dissatisfaction with level of choice of services, time to access care, and time spent with the healthcare professional, was over 50% (Figure 17). For those whose experience was reported by someone else the level of dissatisfaction was somewhat higher (Figure 18).

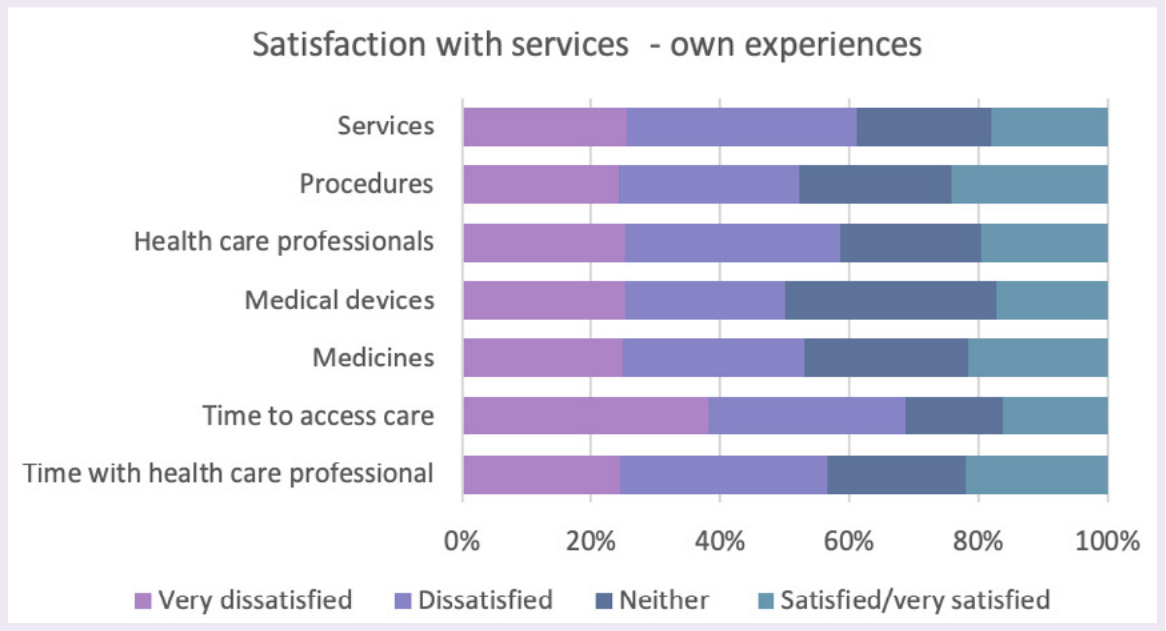


Figure 17: Level of satisfaction with services among respondents reporting on their own experiences.

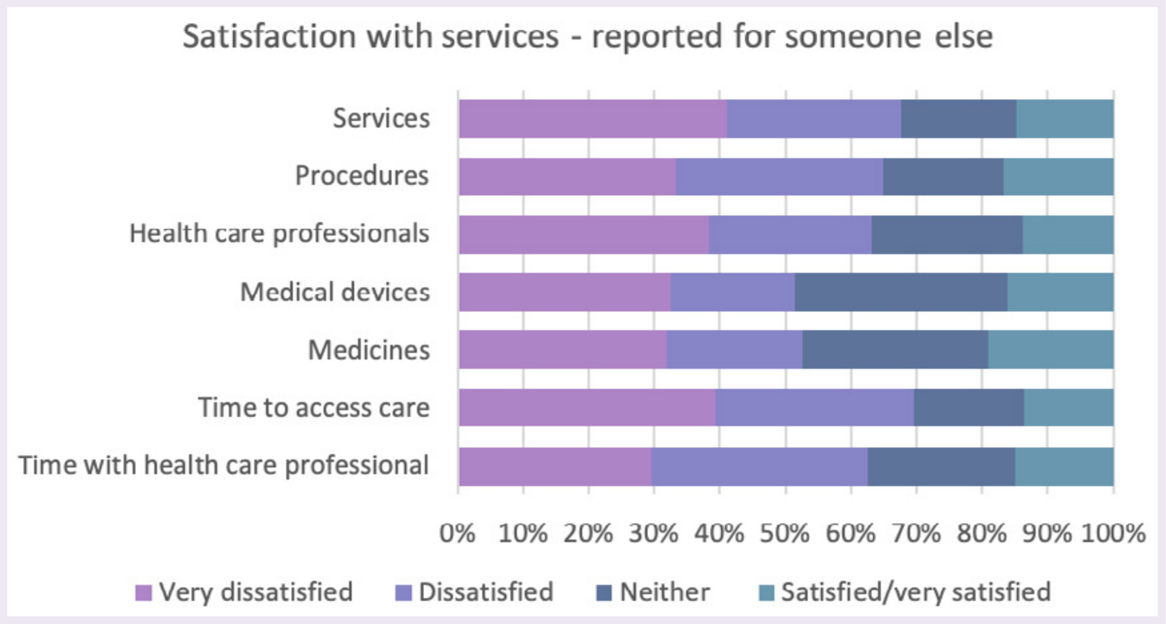


Figure 18: Level of satisfaction with services among people whose experiences were reported by someone else.

## 4.4. Stakeholders’ perceptions of women’s experiences with healthcare

People who responded as stakeholders (researchers, healthcare workers, policy makers and consumer representatives) were also asked about their perception of the barriers and enablers in healthcare experienced by women. Forty-eight percent thought women had little or no choice about their healthcare, 40% thought women had a moderate amount of choice and 12% thought they had a lot of choice. More than 60% of stakeholders thought women did not feel heard or believed about their health issues, or only slightly (Figure 19). While about 60% of stakeholders thought women had access to safe care never/rarely or only sometimes had access to safe care, more than 90% thought women never/rarely or only sometimes had access to tailored care (Figure 20).

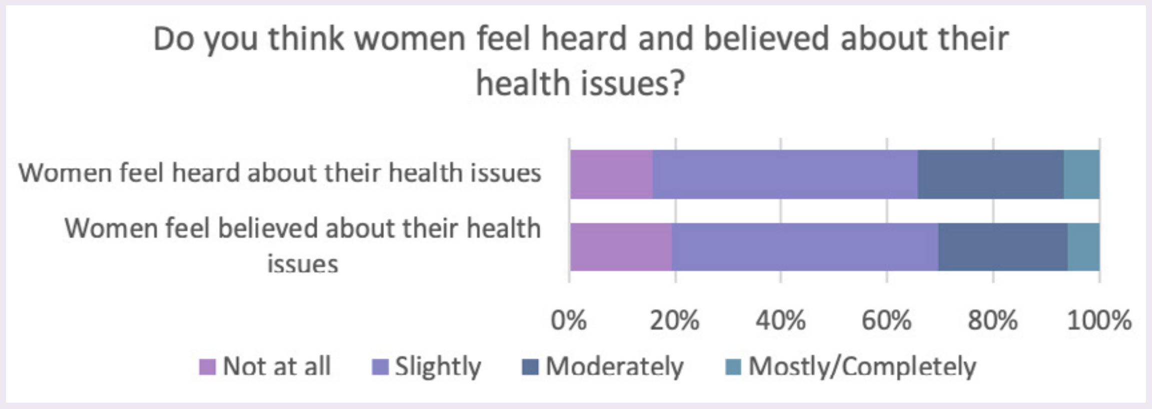


Figure 19: Stakeholders’ perceptions of women feeling heard and believed about their health issues.

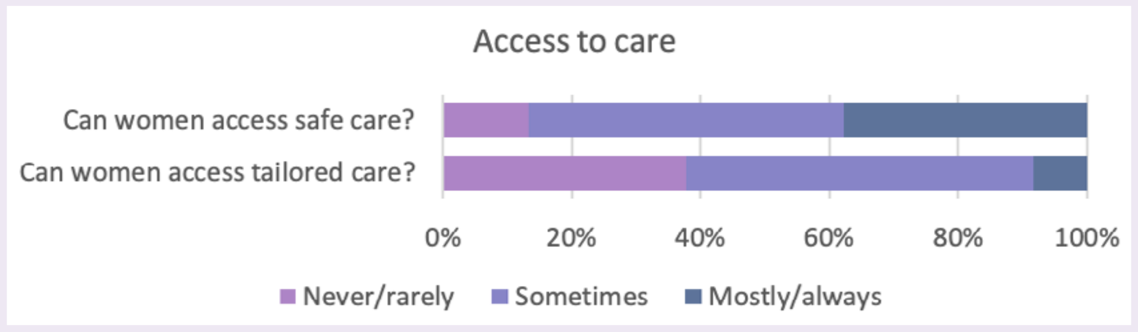


Figure 20: Stakeholders’ perceptions of women’s access to safe and tailored care.

# 5. What participants said

Participants reported experiences of gender bias in healthcare that were layered and overlapping. In describing their experiences of seeking and accessing healthcare, participants described pervasive gender bias.

> Riven through with gender discrimination – in the actions and judgements of doctors, the costs of all the repeated scans, the lack of expertise to see endometriosis on ultrasound scans or read pain diaries, in the historical and ongoing lack of research funding to advance our knowledge of pelvic pain, in the underlying belief that it is normal for women to experience pain.
>
> **[35-44 years, woman, metropolitan]**

Stakeholder submissions also supported this overarching idea:

> Women disproportionately experience delayed diagnosis, overprescribing, and a failure to properly investigate symptoms. More than half our population is comprised of women and girls, yet female health has been overlooked and underdiagnosed for too long.
>
> **[Health Professional Society submission]**

Five domains were identified to summarise participants' accounts of gender bias in healthcare (Figure 21):

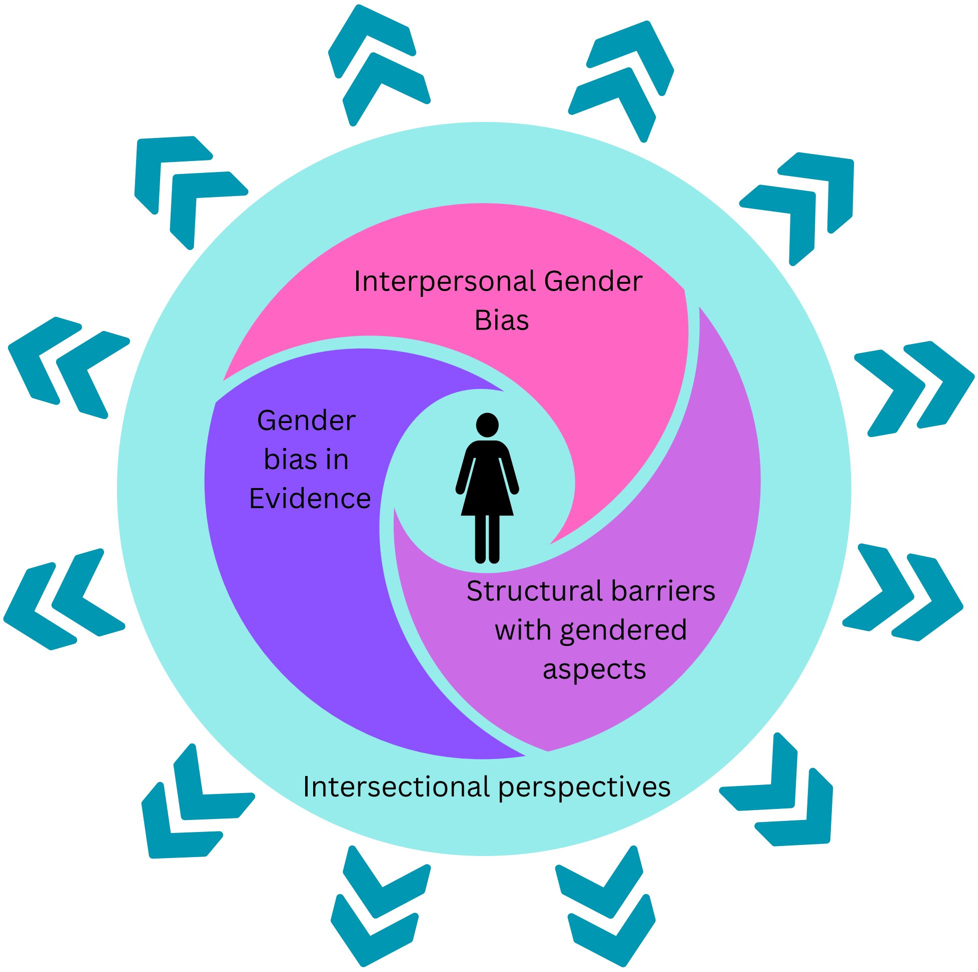


Figure 21: Thematic map of gender bias in healthcare

- **Interpersonal** experiences - consultations between individuals and their healthcare providers
- **Structural barriers**, affecting the accessibility and affordability of healthcare
- **Evidence base** underpinning healthcare and medical innovation
- **Intersectional** experiences of gender bias - related to other aspects such as age and rurality
- As a result of each layer of gender bias, gender bias in healthcare has **far reaching impacts** on participants' lives.

## 5.1. Interpersonal Gender Bias

Among people who reported gender bias in healthcare for themselves or another person, the majority did not feel their opinions about their healthcare were heard and considered in the decision-making process (see Figure 22). This was also born out in participants' responses to free-text questions about their experiences, where four themes were generated from participants' descriptions of their experiences of interpersonal gender bias in healthcare. On one hand participants described being 'dismissed and disbelieved' and experiencing 'dehumanising interactions'; on the other hand, participants recounted positive experiences that stemmed from strong interpersonal interactions and relationships.

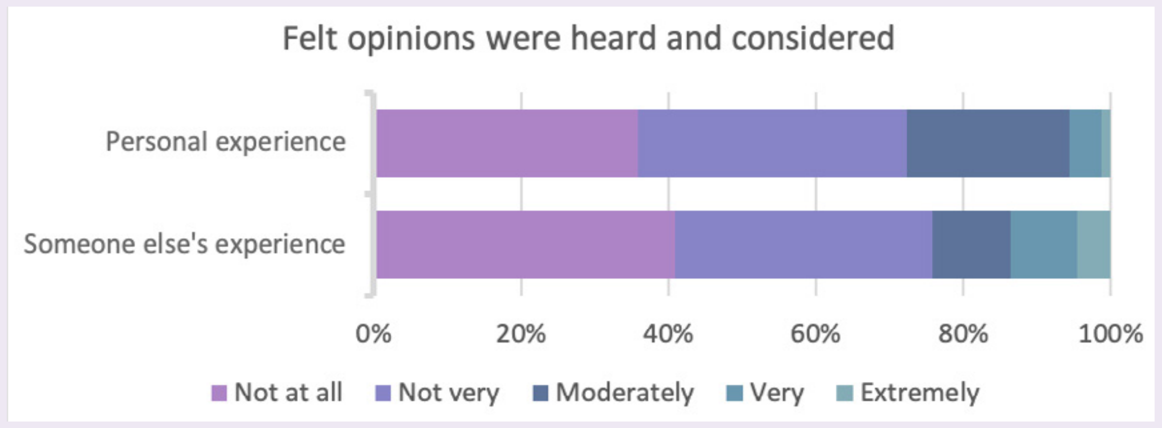


Figure 22: Perceptions of people who responded about their own or someone else's experiences of gender bias in healthcare, about whether their opinions were heard and considered.

### 5.1.1 Dismissed and Disbelieved

Participants' accounts of gender bias in healthcare centred on being dismissed and disbelieved. These experiences were described in a range of healthcare contexts, including general practice care, emergency department, consultation with medical specialists and as inpatients in hospital. While general practice and emergency departments (in particular) were commonly mentioned in participants' free text accounts of gender bias, it is important to contextualise this within the gatekeeping role these services play in the health system. In some cases, participants may have felt dismissed and disbelieved in the context of unwelcome advice, such as to not undertake non-evidence-based investigations or treatments.

Despite these caveats, in many cases, when participants were unable to access the care they sought, they experienced this as being seen as "hysterical":

> I felt dismissed, not listened to or believed, and was treated like I was just 'hysterical'.
>
> **[Woman, 25-34y, regional]**

> In the hospital emergency room, checked in for chest pain, I was treated as though I was wasting the staff's time and hysterical. They dismissed my concerns and … made me feel stupid and worthless.
>
> **[LGBTQ+ person, 25-34y, metro]**

For some participants, the experience of being dismissed and disbelieved was extremely commonplace, to the point that it was accepted as a 'normal' part of seeking healthcare.

> I think I've almost normalised not being taken serious or listened to.
>
> **[Woman, 35-44y, regional]**

Participants perceived that healthcare professionals too readily attributed their experiences to other, benign, causes. This often prevented more thorough investigation of the causes of their symptoms. The range of 'other causes' to which participants' experiences were attributed was diverse and included it simply being part of the female life course.

> I have seen multiple doctors over the last 15 years, noting how exhausted I was. I was given the assurance - you are a teenage girl, girls are always tired....then I became a mum at 20 and I was assured it was because I had children and all mothers were exhausted … I was finally referred to a sleep clinic and I was diagnosed with Type 1 Narcolepsy.
>
> **[Woman, 25-34y, metro]**

> I was constantly dismissed by GPs and told that experiencing pain, especially period pain, was just a 'normal' part of being a woman.
>
> **[Woman, 25-34y, regional]**

For many participants, physical symptoms were dismissed as originating with mental health.

> I suddenly came down with extreme shoulder pain and some difficulty breathing … Over the … next two weeks … i went to multiple GPs who all … told me it was anxiety, panic attacks … [Eventually] an older lady GP was THE FIRST doctor to listen to my chest and I was immediately told to get a chest x-ray asap … I had a hemothorax.
>
> **[Woman, 45-54y, metro, participant's emphasis]**

Conversely, participants who sought help for mental health concerns also experienced those concerns being dismissed and disbelieved.

> When I tried to speak to another male GP about mental health concerns I was dismissed as overreacting. I was having auditory hallucinations, hearing voices telling me to kill my baby and suffering severe anxiety. I ended up needing antidepressants and antipsychotics for 3 years.
>
> **[Woman, 25-24y, metro]**

Lifestyle factors, such as diet and exercise were also readily blamed for participants' health experiences, often in ways that prevented more thorough investigation. These experiences are also further unpacked in the theme 'Intersectional Perspectives'.

> I've been told that I was just fat for my whole life by GPs and told over and over to lose weight WHATEVER medical issue I was seeking treatment for.
>
> **[Woman, 55-64y, metro]**

Most participants' accounts related to being dismissed and disbelieved about pain. Participants were disbelieved because their demeanour did not accord with the clinician's expectations.

> They did not believe a young woman could be in as much pain as I was in while appearing calm/composed … I was not given any pain relief at the hospital and was instead given exercises to complete at home by the physio and a prescription for [pain relief]. The prescribed medication did not provide any relief from the pain of what I now know was a broken hip.
>
> **[Woman, 25-34y, metro]**

Participants also described being denied adequate pain relief for procedures.

> I was prescribed Valium 10mg and paracetamol … to take an hour before insertion [of an IUD]. The pain of insertion was excruciating, and I went into shock … The excruciating pain lasted for approx 48hrs after insertion and I did not have adequate pain relief. I believe that women are undermedicated when it comes to pain relief … due to inherent misogyny in the healthcare system that perceives women's pain … as less deserving of medical intervention than men's pain.
>
> **[Woman, 25-34y, metro]**

The experience of being dismissed and disbelieved was also described in maternity care. In some cases, participants' experiences were dismissed because the focus was on the wellbeing of the baby.

> The failure to diagnose was directly related to the fact that the pain was mine and the problem was mine, and not the baby's, whose health and wellbeing was prioritised at all times over mine in the care I received … told that the baby was fine so I should stop worrying, and I was sent home … My clearly expressed and truthful statements that the baby was fine but that I needed emergency care [for ruptured fallopian tube] were disregarded as being somehow selfish or distasteful by the midwives.
>
> **[Woman, 35-44y, metro]**

For some participants, having their pain dismissed and disbelieved meant that healthcare professionals assumed they were exaggerating in order to access tightly controlled medications, or avoid activities like work or school.

> I've been treated like a drug seeking junkie and also been told to just stop being dramatic about my pain.
>
> **[Woman, 25-34y, metro]**

> Doctor said an ultrasound was an expensive and unnecessary diagnostic test … [and] sent her home without painkillers saying she wasn't a priority and probably trying to get out of school … She had an 8cm ovarian cyst that twisted 8 times and ripped fallopian away from uterus that resulted in emergency surgery.
>
> **[Participant responding on behalf of woman, <18y, rural]**

Conversely, where participants preferred to avoid strong pain relief medications, this was used as further evidence to dismiss their symptoms.

> I was very angry that my reluctance to use opiates, which are highly addictive, was taken as a sign that my pain was not serious and that even after requesting additional pain relief I was denied it because I asked for panadol and not opiates.
>
> **[Woman, 35-44y, metro]**

Participants' experience of being dismissed and disbelieved, meant that their access to appropriate care and treatment was delayed. Sometimes this delay was measured in hours, but many participants described years long delays.

> Staff completely ignored my mum for 17 hours between her transfer from ED to the ward. She wasn't allowed to move out of bed [due to suspected injury] … and was given no water, food or recourse to empty her bladder.
>
> **[Woman, 35-44y, metro]**

> 28 years is … the average delay in diagnosis a woman with Ehlers-Danlos Syndrome in Australia endures … For men, it is less than half that. Women are affected far more often and more severely than men. Many women die of it without ever being diagnosed, as I nearly did.
>
> **[Woman, 25-34y, metro]**

### 5.1.2 Dehumanising interactions

Participants described disrespectful and demeaning interactions with healthcare professionals. Many of these experiences occurred in vulnerable situations, such as intimate examinations and childbirth. The cumulative effect of these interactions was dehumanising.

> I think it [healthcare] would be improved if doctors approached me from a perspective that I'm a person. Often, I feel dehumanised, as if they're just checking a box speaking to me or that I'm nothing but a burden.
>
> **[Woman, 25-34y, metro]**

> During the birth of my child, a bunch of male doctors stood around looking at my vagina and trying all kinds of ways to get my baby out, completely destroying my pelvic area. Leaving me incontinent and unable to have sex without pain again. Not one person considered that I was a person and that maybe for my future wellbeing there might be a better way to deliver my baby. I was butchered and left to suffer the consequences for the rest of my life.
>
> **[Woman, 45-54y, metro]**

These dehumanising interactions existed on a continuum which caused participants increasing distress. At the least intrusive end of the continuum, participants described being given insufficient information to make informed choices, and exert their right of autonomy and self-determination.

> Without preamble or discussing risks/benefits, [doctor] presented two choices … like it was a McDonald's drive through option. How can you decide without context, facts, risks, long term impacts?
>
> **[Woman, 55-64y, regional]**

> At the reception I asked to see another doctor as I wasn't happy with his diagnosis. The receptionist told me they couldn't do that because they don't go against their doctor's diagnosis.
>
> **[Woman, 35-44y, regional]**

Disrespectful maternity care and birth trauma were the focus of many participants experiences. This included lack of empathy in informed decision making, including in the context of pregnancy loss.

> I had a male doctor who completely lacked empathy, gave me very few details regarding treatment options, gave zero mental health support options, harassed me for a decision less than 10mins after first seeing me and then said he "needed to make sure I understood all contraceptive options available and wanted to know what my preference was"… My dead baby was still inside me at that point.
>
> **[Woman, 35-44y, regional]**

In some cases, participants described how the limitations on their informed decision making extended to being given misinformation and disinformation to sway them away from their preferred treatment.

> Doctor after doctor denied me the right to try this treatment [menstrual suppression]. They fed me all kinds of unfounded misinformation and disinformation – 'It'll shrink your ovaries, 'it'll give you cancer', 'it will shrivel your uterus' … 'kill my libido'.
>
> **[Woman, 25-34y, metro]**

In other cases, participants described being explicitly refuse access to the treatment options they preferred.

> A specialist neurosurgeon … refused to perform a surgery on me in regards to recurrent disc protrusion stating "what are you worried about, you have a partner, he will support you" and then wrote a report using … Hospital letterhead stating that there is nothing wrong with my spine, and I should go and get ovaries checked instead.
>
> **[Woman, 35-44y, regional]**

For many participants, these experiences related to accessing permanent contraception. While permanent contraception in young adults is clearly a challenging situation for healthcare professionals to navigate, the gender bias lies in the refusal to even discuss options with health consumers or the suggested need to involve others in the woman's autonomous decision making.

> The gynaecologist refused to explain the [sterilisation] procedure to me and noted that "I would need to meet your mother and your partner".
>
> **[Woman, 18-24y, metro]**

> I have repeatedly requested a hysterectomy. I do not want children, and have never wavered about not wanting children. Not to mention I have a genetic condition that would make pregnancy life-threatening for me. But still, I have been refused … because I have not done my apparent social duty of having children … The medical profession apparently trusts me to choose that I do want children, but not choose that I don't. I am 34, and continue to be denied this option.
>
> **[Woman, 25-34y, metro]**

Participants also contrasted their experiences with that of their male partners seeking permanent contraception.

> My partner ended up getting a vasectomy as I was having so many issues getting even just information on getting my tubes tied. Not once did the doctor ask him about whether his partner knows, he didn't require a referral, he didn't need to go through someone asking him over and over again whether he was sure, and he was able to gain access to this procedure with minimal difficulty.
>
> **[Woman, 25-34y, metro]**

Further along the continuum of dehumanisation and lack of autonomy, other participants described being bullied into accepting treatments that they did not want.

> I was coerced into getting induced and was not provided with enough information to make an informed decision … I felt I was not treated with respect or as a person. I felt like things were being done to me without my consent or involvement. I felt violated.
>
> **[Woman, 35-44y, metro]**

> I was bullied into accepting another IUD during this surgery [for endometriosis]. I was told that the surgery would not be scheduled if I did not consent to an IUD.
>
> **[First Nations Woman, 18-24y, metro]**

Some practices that may be routine in healthcare were also perceived as demeaning by participants.

> Don't make a woman stand in a room full of clothed men and women, take her underwear, make her lift her gown up under her breasts, have a man wipe her down with antibacterial wash, then make her get up and lie on the table (naked from the waist down), before finally coming at her vagina with a strip of "dignity tape". This happened to me at my last lipoedema surgery. That whole shame nightmare of being the only person in a room full of clothed people!
>
> **[Non-binary person, 45-54y, regional]**

Participants were particularly vulnerable to demeaning interactions during or around intimate examinations.

> "[The doctor] was very rough with his internal examination and when I told him he was hurting me, he replied with a comment along the lines of 'well, you got yourself into the mess, you'll just have to deal with it."
>
> **[Woman, 55-64y, metro]**

> While preparing for the [transvaginal] ultrasound, she [sonographer] asked me if I was sexually active, which I replied I wasn't. Then she asked me if I had ever had sex, to which I replied I hadn't. She then looked at me shocked and questioned me saying "what? you've never had sex before? as in ever?". It made me feel really ashamed … Then she told me that she would not perform the intravaginal ultrasound because it would not be ethical for her to do so … I was left without any diagnosis and felt embarrassed about my lack of sexual experience.
>
> **[Woman, 25-34y, regional]**

Finally, at the most extreme end of dehumanising experiences, participants described receiving treatment without their consent.

> The anaesthesiologist refused my request for gas [instead of needle to induce anaesthesia for a surgical procedure], and even as I starting getting very distressed [he] inserted the needle into my arm without any warning, whilst I was crying and hyperventilating.
>
> **[Woman, 18-24y, metro]**

> I suffered a fourth degree tear [during childbirth]. My male OB said it could have been worse at least I have a healthy baby … later when I was having difficulty with sex my female GP told me my Dr put in extra stitches “for my marriage” which was done without my consent.
>
> **[Woman, 35-44y, regional]**

### 5.1.3 Listened to and believed

Despite their many encounters with gender bias in healthcare, participants also described positive experiences. Participants emphasised the positive impact that being listened to and believed had had on their wellbeing.

> When you find a good doctor who listens and is willing to help, it makes so much difference. It brought so much optimism back into my life.
>
> **[Woman, 25-34y, metro]**

Being listened to and believed supported participants to make informed decision about their health and healthcare.

> These doctors have listened and asked thorough questions, taken concerns seriously, booked follow up appointments to ensure the issue is attended to … going through options and explaining pro’s/cons and side effects of the medication.
>
> **[Woman, 25-34y, metro]**

However, it often required a significant investment of time and resources to find (and keep) such a doctor.

> After over a decade, I have finally found a female GP who [is] not only empathetic, but is willing to listen to me and advocate for me to get the treatment I need.”
>
> **[Woman, 25-34y, metro]**

> After all of my issues I have now found a GP who listens … She recently moved practices and I have followed her and am travelling a significant distance to do so as I have lost all faith in the medical system and will cling onto her as she is the only medical person I have seen in the last 15 years who is competent and caring and will listen to me when I say something is wrong.
>
> **[Woman, 35-44y, regional]**

Participants often perceived that personal characteristics of doctors (such as age, gender and interest area) were important contributors to their positive experiences. Many singled out individual practitioners by name.

> Young, female GPs appear to be more modern and understanding in their approach to female health.
>
> **[Woman, 35-44y, metro]**

> I have found a really great, young male GP who has assisted me from the beginning of my journey. He understood my desire to be taken seriously and not just treated as a 'hysterical female.'
>
> **[Woman, 25-34y, regional]**

> Female practitioners who specialise in pelvic pain are great - I find that they take me and my chronic pain a lot more seriously. There is still room for improvement, but I have found that practitioners in the [specific health service] provide services without gender bias or discrimination.
>
> **[Woman, 25-34y, metro]**

Many participants described very positive encounters they had had, especially with nurses, midwives, and other allied health professions. However, participants also acknowledged there were limitations to the help these professions could offer.

> The nurses were all really good too. The impression I had was of a busy hospital system under enormous strain but where the staff were trying their best to do the right thing for the patients.
>
> **[Woman, 45-54y, regional]**

> Many many caring people, especially nurses and allied health. The sexism more often comes from the doctors - patriarchy puts them in positions of power and the nurses, physios, OTs etc can't do much to help you.
>
> **Woman, 45-54y, metro]**

In contrast to experiences of being dismissed and disbelieved, participants described how finding a doctor who listened and took their concerns seriously was often a turning point in their healthcare. It became a gateway to formal diagnosis and therefore to support and treatment.

> Once I finally found specialists who diagnosed me, they created a network to continue the search for answers because they knew more was wrong. One also suggested I apply for disability pension due to the nature of my conditions (and expenses), and I was approved first go due to his thorough report.
>
> **[Woman, 18-24y, regional]**

Stakeholder submissions also emphasised the importance of timely diagnosis.

> Delayed diagnosis is particularly problematic for illnesses where the effectiveness of treatment is time sensitive … Women who do not have a diagnosis report that they struggle to navigate the health and social care system … because our health system relies heavily on diagnosis to summarise symptoms and present a path forward.
>
> **[Health Professional Society submission]**

However, healthcare professionals shared that although their approach was highly valued by patients, it also created immense complexity in their workload which was ultimately not rewarded by the health system.

> The community see me as a "lady doctor" and this means a lifetime of complex, chronic and mental health work, and day after day of mental trauma, but also the expectation that I will be kind, compassionate and cheap. "When I have something simple" they say "I see [male doctor], but I don't want to bother him with my mental health, I come to you".
>
> **[Medical doctor]**

Other stakeholders acknowledged these difficulties, and noted that it was difficult to provide this standard of care in the context of short consultations and workforce shortages.

> Many women describe not feeling heard as they are rushed through consultations and that consultations are more about ticking the box and meeting institutional needs vs individualising care. As a clinician I find the time pressures mean that I am not providing the care that the woman will benefit from.
>
> **[Health Professional]**

> Adequate workforce is the main barrier - midwives, GPs, nurses are very time poor and not well renumerated and so cannot spend time with women to listen to them.
>
> **[Research, policy maker, medical doctor]**

### 5.1.4 Building positive relationship-based, person-centred care

Participants wanted and reported positive experiences where healthcare professionals invested time in individualising their care. This meant discussing options, explaining procedures carefully and asking questions to elicit the woman's experiences. These things were seen as foundational to culturally safe and trauma informed care.

> I feel safer when doctors explain procedures and options first and discuss what they will do physically. I feel safer when we discuss ways to make that process be as comfortable as it can and what cues they should look for that I am overwhelmed and need to stop. I feel safer when they ask for feedback afterwards and we can adjust or refine our plan for next time. I feel safer when they listen to me and give me time to talk.
>
> **[Woman, 45-55y, survivor of childhood sexual abuse]**

Participants also valued healthcare professionals who were honest about what they didn't know and explicitly addressed power imbalances. This required healthcare professionals to respect the patient as an expert about their own experience.

> It would have helped if health professionals had understood that the person who best knew what I, as the patient, was feeling, experiencing, and understanding about my body was me.
>
> **[Woman, 65-74y, regional]**

> Listening to me and validating what my symptoms are rather than being dismissive. Being honest especially when you don't know the answer. It sucks to know that you are unusual, or an experiment but it helps to manage my expectations.
>
> **[Woman, 25-34y, metro]**

## 5.2. Structural barriers with gendered aspects

Structural barriers to accessing healthcare restrict people's choices. At times, these structural barriers are ingrained with implicit structural gender bias. For example, female health workforce shortages in rural areas may disproportionately affect the provision of women's health services. Furthermore, well over 62% of the participants who had experienced gender bias, also found healthcare unaffordable (Figure 23), and 45% found it inaccessible (Figure 24).

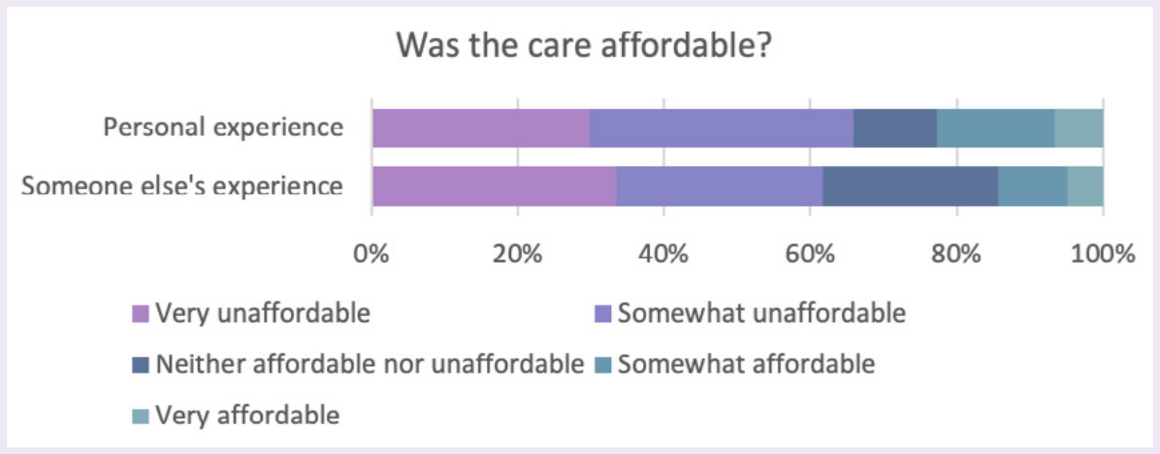


Figure 23: Affordability of care reported by people who completed the survey about their own, or someone else's experiences of gender bias in healthcare.

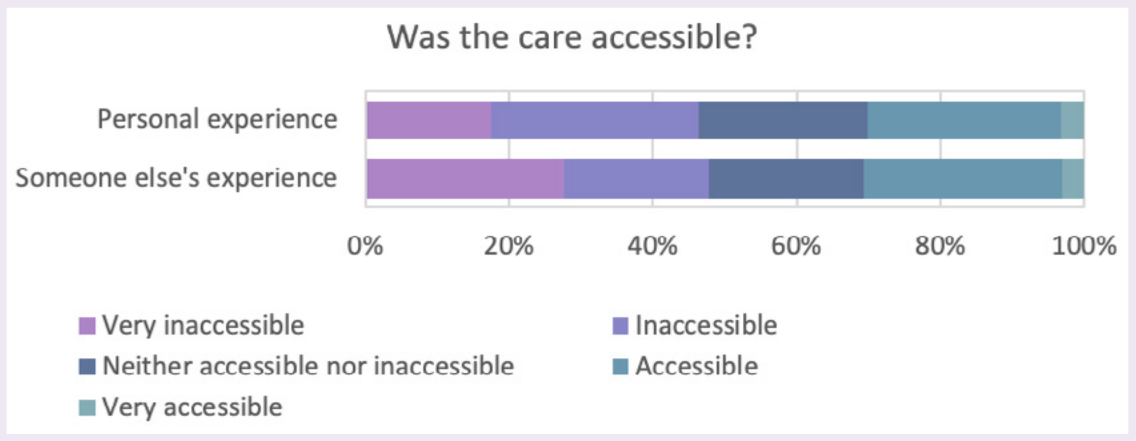


Figure 24: Accessibility of care reported by people who completed the survey about their own, or someone else's experiences of gender bias in healthcare.

### 5.2.1 Availability

Participants reported long waiting times to consult with healthcare professionals at every level, from primary care to medical specialists to treatment, including surgery.

> There are very extensive waiting times for specialist appointments … There is very little after hours medical care. There is no private Emergency service and wait times at [hospital] are very long.
>
> **[Woman, 55-64y, metro]**

> I have no choice if I want to see a [medical specialist] locally. She is only available every 6 months and one of those appointments will be by telehealth, which is pointless, except for a prescription renewal that the local Dr can't do.
>
> **[Woman, 65-74y, rural]**

In some cases, the impact on healthcare professionals who were inundated with patients was also highlighted.

> My GP tried to get me an appointment with the only immunologist in my area … She gave advice to my GP over the phone while in a meeting but burst into tears crying that she couldn't take on another patient who wasn't confirmed to be terminally ill.
>
> **[Respondent, 25-34y, metro]**

Stakeholders also reported how gender bias impacted on the way that scarce resources were allocated.

> For “non-urgent” gynaecological surgeries such as for urinary incontinence or pelvic organ prolapse, women often wait for years with significant costs to quality of life … I believe that this is due to systematic gender bias which has resulted in most gynaecology departments sharing their resources (particularly access to theatre time) with obstetrics. As obstetric emergencies always take priority over gynaecological surgeries, scheduling and planning for women’s health surgery suffers … This is yet another way that women disproportionately bear the costs of reproduction.
>
> **[Medical doctor]**

For GPs (predominantly women) who completed the survey, the cumulative nature of structural gender bias raised serious questions about the sustainability of their work. In 2020 and 2022, the Department of Health and Aged Care sent letters to GPs asking them to reflect on their practice and providing information to support them to reduce any overuse of services, tests or medicines that could not be linked to positive health outcomes. The approach of asking GPs to self-reflect was selected because overuse is very difficult to discern without understanding an individual GPs context, however the letters were perceived by GP participants to have targeted those who care for mostly vulnerable and marginalised people. MyMedicare is a new Australian Government initiative intended to support continuity of care.

> As a female GP, my work is not valued … The systemic, daily discrimination is heartbreaking, especially when you [government] are constantly telling me I’m failing. The nudge letters targeted women doctors. Whether they meant to or not, they did. MyMedicare will reduce support for women doctors. When I am forced to charge, patients can be quite abusive, because they just don’t understand. … You think I’m worth $50 per hour, but what you expect of me is crippling. If you want better healthcare for women, stop punishing us for doing it.
>
> **[Medical doctor]**

Participants also reported that the challenges of finding available health services were exacerbated by health workforce shortages, especially in rural areas. These shortages may disproportionately impact on access to women’s health services.

> GP funding for services related to intrauterine device implantation is poorly funded, resulting in many doctors declining to provide this service. … In rural and remote locations … fewer or no … GPs providing contraceptive services.
>
> **[Health Professional Society submission]**

> Approximately 30% of women reside in regions with no access to abortion care through their GP … 50% for women living in rural and remote [areas] … Abortion care largely illudes routine healthcare in public hospitals, further discouraging GPs from providing medical abortion, fearing that they will not have hospital back up.
>
> **[Health Professional Society submission]**

Given the emphasis placed on availability of health services in rural areas, it is worth comparing the experiences of participants. Participants living in metropolitan, regional or rural/remote locations reported similar levels of experience of gender-based bias or discrimination in healthcare (Figure 25).

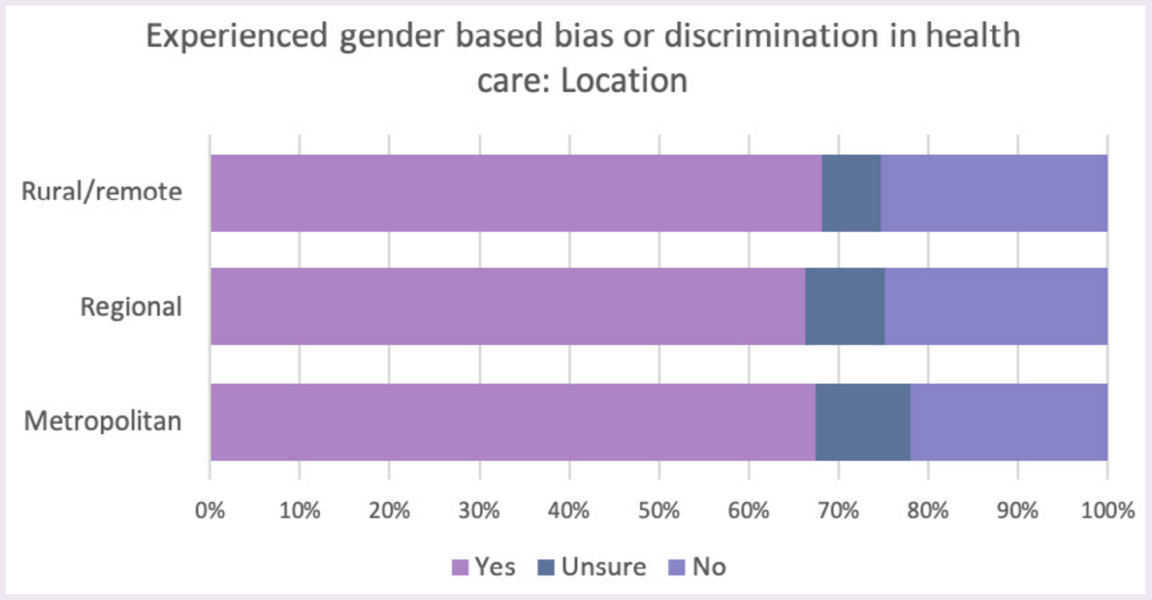


Figure 25: Experiences of gender-based bias or discrimination in healthcare, by area of residence.

People living outside metropolitan areas reported much less choice and less satisfaction with healthcare services, except for medicines, medical devices, and procedures.

However, people in metropolitan and non-metropolitan areas gave similar responses to the questions about appropriateness, affordability and access to services; satisfaction with information sharing; confidence in speaking up; feeling their opinions were heard and considered in decision making; feeling safe in a healthcare setting; or being treated differently due to their gender.

### 5.2.2 Affordability

Affordability of healthcare emerged as a key issue related to gender bias in healthcare. Experiences of gender bias in healthcare were most common among people who said they needed to think carefully about their household expenditure (Figure 26). Those who expressed more financial strain also reported less choice and less satisfaction with health services and were less likely to report that their healthcare was appropriate, affordable, or accessible. Participants experiencing financial strain were also less likely to feel their opinions were heard and considered in the decision-making process; to feel safe in a healthcare setting; and to feel they were treated differently in a healthcare setting due to their gender.

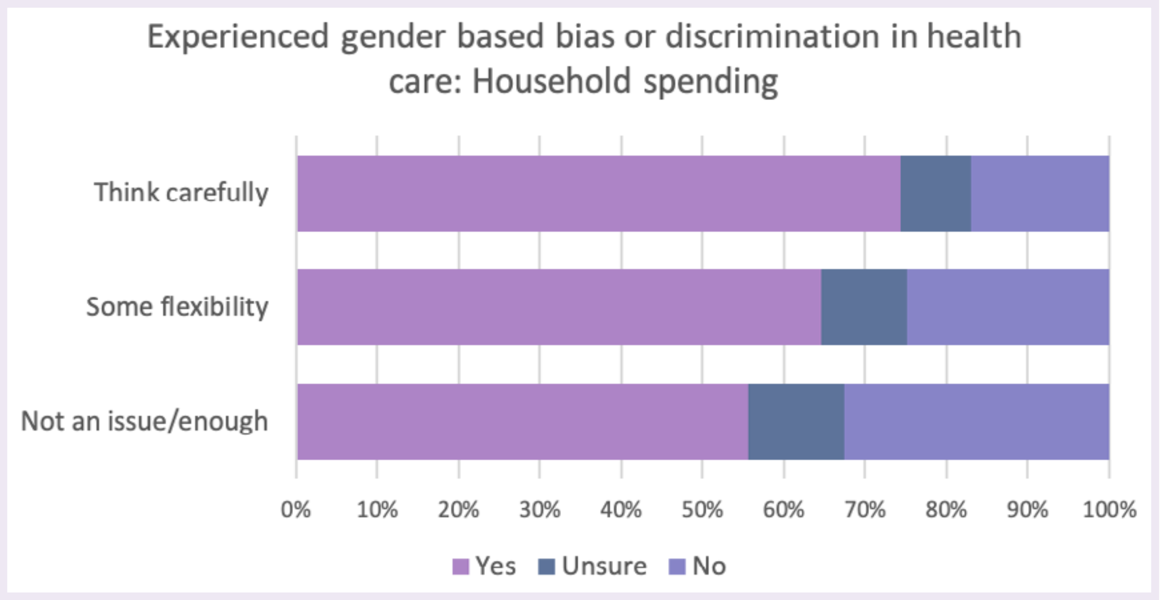


Figure 26: Experiences of gender-based bias or discrimination in healthcare, by household spending.

Consistent with this, participants emphasised the importance of publicly funded healthcare. For many participants, Medicare-subsidised healthcare was a significant positive in their healthcare experiences.

> I found an expert surgeon and had life-changing operations with him in the public system.
>
> **[Woman, 35-44y, metro]**

> My neurologist who works in the public system has been amazing at providing care and listening to me.
>
> **[Woman, 25-34y, metro]**

> I was able to access a great endometriosis surgeon and bowel surgeon through the public system in [capital city] and didn't have to wait too long due to the severity of my condition.
>
> **[Woman, 35-44y, metro]**

However for some women, access to care expeditiously, and in some cases at all, had only been dependent on their capacity to pay for private care.

> It was a massive stretch for us to be able to afford this as a private patient, [but we] still had yet to hear that the public system would even talk to me about an appointment… It's been a week since my surgery, and I cannot remember feeling this good in years.
>
> **[Woman, 25-34y, metro]**

> In 9 months, I spent over $1500 in GP appointments, over $600 in 2 specialist appointments, surgery costs and diagnostic testing. All as a part time worker, full time student under the age of 21.
>
> **[Woman, 18-24y, metro]**

For many participants, private health services were beyond their reach.

> Even doctors are telling us “go private if you want anything done urgently (within the next year)” and I can’t afford that at all.
>
> **[Woman, 25-34y, metro]**

It is also important to note that the relationship-based care that participants valued was often not available to those who are dependent on bulk-billed primary healthcare.

> Changing from a bulk bill GP to a private GP meant I finally started getting clear answers and got taken seriously with my concerns. For the sake of those who can’t afford a private GP, I wish that bulk bill surgeries were either better funded, better equipped or better informed, so that everyone can receive clearer and more compassionate treatment.
>
> **[Woman, 25-34y, metro]**

For some participants, these financial burdens were linked to delays and lack of availability of women’s health services.

> I’m paying out of pocket for pelvic floor physio and dietitian appointments to see if I can help myself deal with pain while waiting for surgery [for endometriosis].
>
> **[Woman, 35-44y, regional]**

Some participants observed that their financial burden was increased by apparent inequities in the way medications are subsidised. While subsidised ADHD medication may actually be available to people diagnosed in adulthood, misinformation and lack of awareness of this exacerbates gender inequity in the diagnosis of such conditions.

> When I was around 19 years old (2016), I was diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD) … because I had not been diagnosed before the age of 18, this medication would not be subsidised under the Pharmaceutical Benefits Scheme (PBS) [but] females … display less obvious observable symptoms [leading to] diagnosed later in life, if at all.
>
> **Woman, 25-34y, regional]**

In other cases, participants described subsidised access to medication only being available for certain indications, not those linked with women’s health.

> The PBS limits Valacyclovir as prophylactic medication to people who suffer genital herpes only, not cold sores … I have to pay hundreds and hundreds of dollars for a medication which is essential to manage a health issue directly linked to my menstruation.
>
> **[Woman, 35-44y]**

Stakeholders similarly acknowledged that the cost of healthcare is disproportionately borne by women, especially because aspects of women's healthcare may be less likely to attract subsidies.

> Women's out-of-pocket medical costs are disproportionately higher than men's for every single age grouping from 19 to 64, even when excluding pregnancy-related services.
>
> **[Health Professional Society submission]**

> There is a significant discrepancy in bulkbilling rates, between scans overwhelmingly required by women, and other ultrasound scans.
>
> **[Health Professional Society submission]**

> There is no pelvic ultrasound item accounting for the complexities of a women's pelvic organs … Male pelvic organs have separate items accounting for each structure, each uncapped [in the extended Medicare safety net], again highlighting that the female pelvis is valued less than their male counterparts.
>
> **[Health Professional Society submission]**

## 5.3. Gender bias in evidence

Participants perceived that the opportunity to access timely and appropriate women's healthcare was constrained by the evidence-base which underpins clinical practice. Two themes were generated to summarise participants' views and experiences in this domain: 'Women missing from the evidence base' and 'Limited translation of evidence into practice.' These two themes were collectively attributed to:

> Persistent inaction from universities and research institutions [that] reflects a broader culture of deprioritising women's health in Australia and internationally, stemming from a long history of gender bias and exclusion of women from medical research, both as researchers and research participants.
>
> **[Researcher and Advocate]**

### 5.3.1 Women missing from the evidence base:

Participants perceived that a lack of diversity in all aspects of research led to gender bias in the evidence available to inform healthcare and medical innovation. Calls for greater diversity related to the 'who', the 'what' and the 'how' of research.

**Who is taking part in research**: Historically health and medical research has often excluded women (and people assigned female at birth) from taking part in studies, leading to gaps in knowledge about sexed based physiological differences, responses to treatment and experiences of care. For these reasons, survey participants called for:

- Increasing the participation of women (and people assigned female at birth) in research, including those from diverse backgrounds.

> Medical literature often lacks research on women's health, in particular pharmaceutical - treatments, adverse effects. Cohorts of individuals included in studies - few women especially older women.
>
> **[Health professional]**

- Efforts to address barriers to participation such as caring responsibilities and the need for interpreters.

> [There needs to be a] reduction of the obstacles to having women involved at all levels of research. Support for women who provide much of the unpaid caring workforce to have childcare and renumeration for time spent participating in research.
>
> **[Medical doctor]**

- Reconsideration of exclusion criteria, such as those related to pregnancy and medication use.

> Concerns about preventing foetal exposure to research interventions that can place an additional burden on women study participants. These concerns have motivated requirements that reproductive-aged women avoid pregnancy while participating in biomedical research studies by taking oral contraceptives, often irrespective of risks and benefits or a woman's actual potential for pregnancy. For the same reason, pregnant women also continue to be excluded from most medical trials.
>
> **[Researcher, Advocate]**

**Who is doing research**: Women (and gender diverse people) are also underrepresented in the health and medical research workforce, particularly in leadership roles. Survey participants therefore recommended:

- Prioritising funding for research conducted by and led by women researchers.

> Those passionate about this work are often in small satellite research groups with little to no funding. Research funding should allow for encouraging smaller, female led research groups to encourage and sustain those who are doing work in female dominated conditions.
>
> **[Researcher, Nurse/Midwife]**

> There needs to be further investment into Aboriginal-led research and data around the health of Aboriginal and Torres Strait Islander women and the clinical practices that service them… To improve inclusion and participation of Aboriginal and Torres Strait Islander women, there must be significant investment into Indigenous Sovereign Data and Research.
>
> **[Health professional]**

- Prioritising funding for multidisciplinary research teams.

> Invite consultation at every level, from researchers and health professionals to consumers and potential participants, to contribute to design and implementation of projects, with an active focus on inviting women and female-identifying people.
>
> **[Medical professional]**

- Increasing diversity of those involved in research policy-making, including consumer and community representatives.

> Research guidelines relating to standards which promote equity and inclusion should be reviewed by women working in the health research sector, with a special focus on Aboriginal and Torres Strait Islander women working in the sector...
>
> **[Health professional]**

> The composition of the people who develop research guidelines will influence the development of these guidelines. Therefore, the Australian government may need to impose explicit expectations on the health and medical research sectors to address sex discrimination and gender bias, rather than relying on self-regulation.
>
> **[Health Professional Society Submission]**

**How is research being done**: As further steps to ameliorate gender bias in health and medical research, survey respondents called for methodological changes:

- Value qualitative and mixed methods research.

> The emphasis on a biomedical approach tends to lack a focus on how the individuals experience the disease. As … interventions around endometriosis become more advanced over time it is essential that we understand why these interventions are important in the first place. Without insight into how endometriosis affects those diagnosed, the continuation and development of strategies aiming to solve the problems are null and void.
>
> **[Researcher, Advocate]**

> Qualitative research, common in feminist studies to understand women’s health and wellbeing needs, have limited practice-based relevance to medical professionals who are not usually invested in or driven by this data. This is contributing to a major lag in knowledge translation.
>
> **[Researcher, Allied Health Professional]**

- Involve consumers and community members in all phases of the research cycle, including research priority setting.

> Include women and consumers in co-design and co-production of research… consultation of female consumers regarding priority areas of research, including women previously not consulted such as culturally and linguistically diverse minority populations, women living with disability… Establish models that promote consumer and community involvement in research… Develop a Lived Experienced/Consumer Research workforce.
>
> **[Researcher, Medical professional]**

- Ensure sex- or gender-disaggregation in data analysis. (Note: since the survey was conducted the National Health and Medical Research Council and Medical Research Future Fund (MRFF) have developed a Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research, which strongly encourages researchers to consider sex, gender, variations of sex characteristics and sexual orientation throughout all stages of their research projects.)

> "… need for the MRFF to specifically address this issue [gender-bias] by updating policies and practices to stipulate sex- and gender disaggregated data collection, analysis, and reporting in the research they fund. However, to date no action on this has been observed".
>
> **[Researcher, Advocate]**

What research areas are being overlooked?: Participants (both stakeholders and those with lived experience) identified numerous research gaps that impacted on women's health experiences and outcomes:

> We need to have a more strategic and gendered approach to women and their health care needs in terms of the life course.
>
> **[Researcher, Policymaker]**

From participants responses to the #EndGenderBias survey, the following under researched areas were harvested:

- Evaluations of grassroots programs or approaches that originate in practice.

> There is rarely funding available in community-led programs for proper evaluation, which hinders the development of an evidence-base.
>
> **[Nurse/Midwife]**

- Health experiences which are exclusively or more commonly experienced by women and people assigned female at birth:
    - Gynaecological health: female sexual dysfunction, menstruation, menopause, chronic pelvic pain, endometriosis, PCOS, dysmenorrhea, dyspareunia.

> Pelvic pain is a huge burden on the system yet there appears to be very little research or healthcare associated with it. Women come into ED in distress and they're treated as malingers when they desperately want relief and answers.
>
> **[Medical Professional)**

    - Pregnancy and childbirth: medication safety during pregnancy, pregnancy loss, abortion, obstetric violence, intrapartum care, labour analgesia, perinatal mental health.

> Vast gaps exist, but here I highlight obstetric violence towards females. This sex-based misogyny is done by health care professionals and institutions and extensive research is required.
>
> **[Nurse/Midwife]**

> There is a significant gap in supportive information to assist pregnant and lactating women to use medicines safely and effectively. While I consider that there are many reasons why this gap exists including our risk adverse nature, I also consider that there is an underlying attitude that the time a woman is pregnant, or breastfeeding is short and so if unwell during that time there is a pressure applied to that woman to 'suck it up and soldier on'.
>
> **[Researcher, Policymaker, Pharmacist]**

    - Autoimmune conditions

> In the autoimmune space, women are typically more affected than men. However, clinical trials … have favoured the selection of men due to limited understanding of the influence that gender plays in disease phenotype … No doubt delays in treatment will have resulted in poor quality of life and most probably long-term disability due to poor disease control.
>
> **[Researcher, Medical Professional]**

    - Chronic complex syndromes: chronic migraine, chronic pain, fibromyalgia, chronic fatigue, chronic urinary tract infection, POTS (postural orthostatic tachycardia syndrome).

> There must be a fundamental push to look at economic and social impacts of chronic complex syndromes in women so that these public health policies can be better informed.
>
> **[Researcher, Nurse/Midwife, Advocate]**

    - Lipoedema

> If lipoedema effected men, I bet the doctors would know all about it and it would be covered by medicare, and would probably have a cure by now! But because it only effects women (and at least 11% of the female population!) they don't care. It is an awful combination of sexist discrimination and fat shaming.
>
> **[Woman, 35-44y, metro]**

    - Ehlers-Danlos Syndrome

> [Research gaps include] Genetic and rare diseases - especially those the mostly affect women … Ehlers-Danlos Syndrome (EDS) … Clinician initiated medical trauma in women with EDS … Inequitable access to affordable genetic testing. EDS and pregnancy. Mast Cell Activation Disease and EDS. Incorrect diagnosis of anorexia in young women with EDS.
>
> **[Peer worker, advocate]**

  - Migraine

> Migraine is the second leading cause of disability globally, second only to low back pain. It is the leading cause of disability in women under 50. Despite the magnitude of the problem, we have no robust epidemiological studies of migraine prevalence in Australia.
>
> **[Advocacy Organisation Submission]**

- Situations where women present differently or have different experiences/outcomes to men:
  - ADHD, Autism and other neurodiverse conditions

> The diagnostic criteria [for autism] does not adequately recognise the ways in which females express their autism.
>
> **[Woman, 25-34y, metro]**

  - Heart disease, stroke

> We know that women are more likely to present with “atypical” features of a heart attack, and “atypical” features of whatever else - this is because we haven’t had an active, sustained effort to actually establish what the “typical” is for female anatomy and physiology … it leads to poorer outcomes in terms of physical and mental health, directly or indirectly by impacting upon access to and engagement with health professionals.
>
> **[Medical Professional]**

  - Pulmonary embolism

> The biological conditions that cause blood clots are autosomal inherited; men and women are affected equally … But I was on the pill, therefore the pill was considered wholly at fault … there was no reason at all to even think about ordering a test for a genetic clotting disease … My clot was used (mis-used!) in statistics to prove that the pill causes clots … women on contraception are simply more likely to be screened for DVT or PE than those not.
>
> **[Woman, 25-34y, metro]**

  - End of life care

> Truly, to die at home, one needs a wife. Research into the gendered experiences of dying is required to advance health dying in our community and recognise the different experiences of dying of men and women.
>
> **[Medical Professional]**

- Conditions which are more common in men, but still experienced by women:
  - Haemophilia in women

> Gaps in research and barriers to appropriate care for women and girls with bleeding disorders have occurred due … a commonly held but mistaken belief … that only males have haemophilia and that females carry the gene change without symptoms. However … 20-30% of female haemophilia carriers have reduced factor levels and bleeding symptoms, and may be diagnosed with haemophilia.
>
> **[Advocacy Organisation submission]**

### 5.3.2 Limited translation of evidence into practice:

Even where research evidence exists, over half of the health professionals, researchers and consumer advocates who responded to the survey did not believe research was incorporated into guidelines, implemented into clinical practice, or implemented into policy (Figure 27).

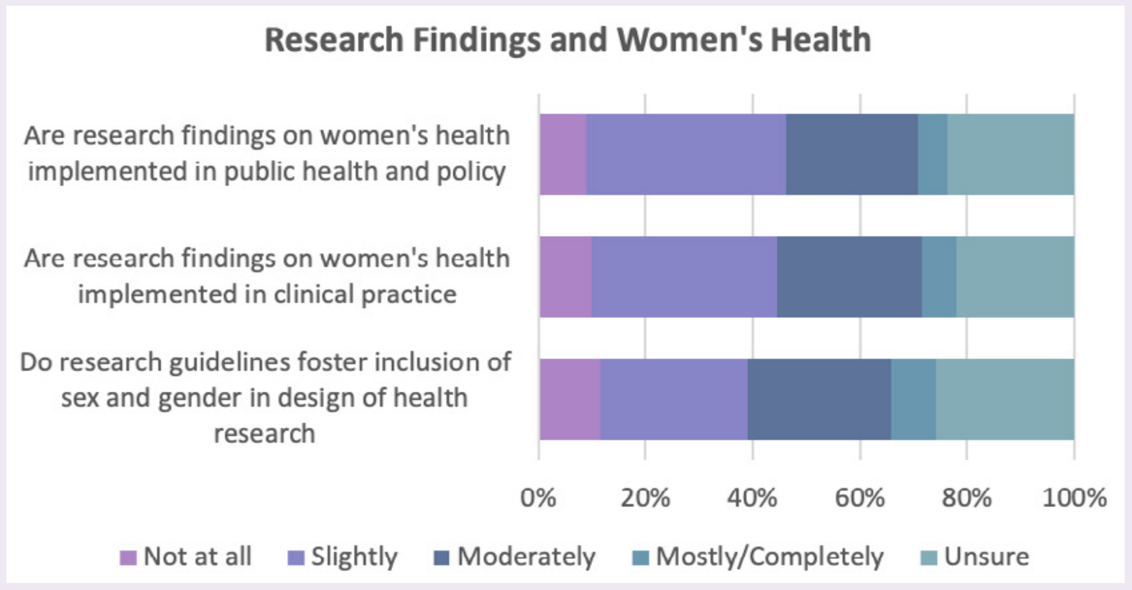


Figure 27: Perceptions about women's health research.

The lack of translation into practice was attributed to limited:

- Researcher capacity to communicate findings in accessible ways to key audiences.

> Science communication should be encouraged, as should continuous professional development for health care practitioners. Too many are not across the latest research, which contributes to archaic ideas being perpetuated.
>
> **[Researcher]**

- Access to latest evidence.

> From the perspective of community-led health promotion, it is often difficult to access research which is not open access and easily available online.
>
> **[Advocate]**

- Health workforce opportunity to conduct research, and equitable access to professional development leave (including in female dominated professions, such as general practice, nursing and midwifery).

> I believe that GPs… have time to take in all the information that is being presented to them. Many (but not all) of the doctors I've seen over the years are really just doing what they were taught to do at university.
>
> **[Peer worker]**

> Research could be more widely distributed in professional development seminars and courses; fees could be ssubsidised by scholarships and grants available for application.
>
> **[Nurse/Midwife]**

- Engagement with consumers and other marginalised voices.

> Barriers are the tokenistic inclusion of consumers … they are not given due respect or voice within the process. Small changes may occur, but they are usually inconsequential or too small to impact the bigger agenda … Consumer groups lobby the health departments, but hit walls constantly, only to see [a health professional society] … waltz in being favoured and responded to.
>
> **[Researcher, Advocate]**

> Peak consumer bodies should be engaged in research in the Australian context for POTS. Women consumers, who represent 90% of this population should be at the forefront of development of research methodology and identification of key outcomes.
>
> **[Researcher, Nurse/Midwife, Advocate]**

- Vested interests and lack of political will to implement changes.

> Deeply embedded paternalistic and discriminatory attitudes towards women and female-dominated health professions … acts as a barrier to the translation of research evidence into clinical practice. For example … continuity of midwifery carer services.
>
> **[Health Professional Society submission]**

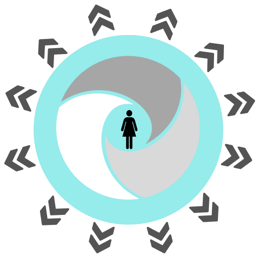
- Funding to implement evidence-based practice change, scale up and sustainability.

> Not enough money is put into the implementation of new strategies. It is assumed that the health care will implement a strategy with the current clinical resourcing, this is impossible when staff are already at capacity with clinical demands.
>
> **[Allied Health]**

- Funding precarity for community-led health and wellbeing programs.

> From the perspective of community-led health promotion … the fast-paced nature of grant cycles and funding applications can mean that it is difficult to conduct the background research required for evidence-based approaches, and there may not be adequate funding available to deliver evidence-based programs (e.g., where it is primarily small grants which are available).
>
> **[Advocate]**

## 5.4. Intersectional perspectives



Gender bias in healthcare – interpersonal, structural and in the evidence-base – intersected with other aspects of participants' identities to amplify impact on their experiences and health outcomes. While participants' responses continued to fit the overarching thematic map they also recounted experiences that highlight concurrent intersectional discrimination. It is important to note that some participants felt that the survey design could not adequately capture the complexity of their intersectional perspectives.

> This survey does not allow for meaningful input, given the complexity of my conditions. In order to provide improved access to health services and medical care for women, you need to assume that intersecting factors need analysis. Simple, either or, or drop-down menus, do not reflect or allow for input of this complexity.
>
> **[Woman, 55-64y, regional]**

Nonetheless, participants highlighted many aspects of intersectionality in their experiences.

**Age**

> Older women are really invisible. Older people in general are so dismissed.
>
> **[Advocacy Stakeholder submission]**

**Disability**

> [I'm] unable to access adequate women's health care such as pap smear, breast scan and gynaecologist due to my disability and access issues.
>
> **[35-44 years, woman with a disability, metropolitan]**

**Rurality**

> Women living in rural and remote locations experience geographic inequality … For example … difficulties accessing emergency contraception.
>
> **[Industry Stakeholder submission]**

### Sexuality

> I was to have a melanoma removed from my face … The surgeon … said to me in a sarcastic tone, “Why would it matter anyway you aren’t trying to get a guy?” He believed that since I am a lesbian my face can be mutilated with no consequence.
>
> **[55-64 years, woman with a disability, LGBTQI+, regional]**

### Gender

> Contamination of records based on ‘assigned sex at birth’ - this permeates referrals, prescriptions, the title ‘Mr’ being added to my name, and is often difficult to remove/correct… it is usually easier to just seek new providers.
>
> **[25-34 years, Trans woman, Metropolitan]**

### Culturally and Linguistically Diverse

> Immigrant and refugee women … are less likely … to take health related action when ill and have amongst the lowest rates of participation in breast and cervical cancer screening
>
> **[Industry Stakeholder submission]**

### Socio-economic status

> Women are more likely to experience bias due to social determinants that arise specifically due to gender [including] poverty restricting access and choice, [and] older and women being poorer.
>
> **[Advocacy Stakeholder submission]**

### Body weight

> [I’m] always seen as a fat woman … I was told that I was just fat for my whole life by GPs and told over and over to lose weight WHATEVER medical issue I was seeking treatment for.
>
> **[55-64 years, woman, metropolitan, participant’s emphasis]**

### Caring responsibilities

> The health of primary carers is significantly impacted by their caring role. Women are 2.5 times more likely than men to be a primary carer.
>
> **[Advocacy Stakeholder submission]**

In the following subsections, additional discussion and illustrative quotations are provided where participants made explicit links between aspects of their identity.

### 5.4.1 Disability

People with a disability were much more likely to report experiencing gender-based bias or discrimination than those without disability (Figure 28).

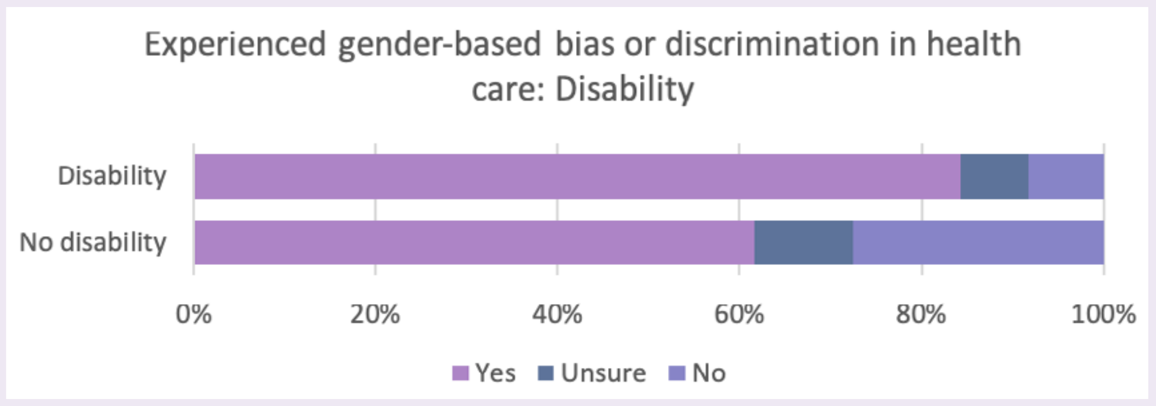


Figure 28: Experiences of gender-based bias or discrimination in healthcare by people with or without a disability.

People with a disability who had experienced gender bias, also reported more negative experiences (compared to people with no disability who had experienced gender bias) on each investigated aspect of their healthcare:

- Less choice and less satisfaction with all aspects of health services (except for choice of medicines, which was similar)
- Less likely to feel their care was appropriate, affordable, or accessible
- Less satisfied with the amount of information shared
- Less confident about speaking up
- Less likely to feel that their opinions were heard and considered in the decision-making process
- Much more likely to feel unsafe in a healthcare setting
- Much more likely to feel they were treated very or extremely differently in a healthcare setting due to their gender.

The free-text responses for and on behalf of people with lived experience of disability aligned with the overarching thematic map. For some participants, their disability was the health condition that was dismissed or disbelieved, resulting in delayed diagnosis and access to supportive care.

> I experienced a pattern of middle aged/elderly white men dismissing my symptoms as being 'too sensitive', 'emotional', 'hormonal'. I wasn't any of those. I was experiencing symptoms of a progressive brain disorder, Schizophrenia. If I hadn't been dismissed for years, I may have received the appropriate treatment earlier … which may have lessened the current cognitive losses I currently suffer.
>
> **[Woman with lived experience of disability, 35-44y, metro]**

Conversely, other participants included accounts illustrating how other health conditions were dismissed and disbelieved due to the combination of their disability and gender bias in healthcare.

> On numerous occasions … because I have PTSD, physical illnesses … are overlooked or not treated as fully. [Instead] put into the category of its all in her head or I am exaggerating.
>
> **[Woman with lived experience of disability, 55-64y, rural]**

Consistent with the overarching thematic map, participants with lived experience of disability also described how ableism could further impact the accessibility of health services.

> When a deaf person signs something [about chest pain] … interpreter can interpret this in a million ways - pulsing, tightening, spasming, on and off, throbbing, sparking pain. Remembering that the doctor ALWAYS believes and listens to the interpreter and assumes that they are doing a perfect job. … This leads to misdiagnosis, etc.
>
> **[Policymaker, Peer worker]**

### 5.4.2 First Nations Australians

People identifying as First Nations Australians were slightly less likely to report experiencing gender-based bias or discrimination in healthcare than other people. Comparisons between the two groups were somewhat limited due to the small number (61) of First Nations respondents.

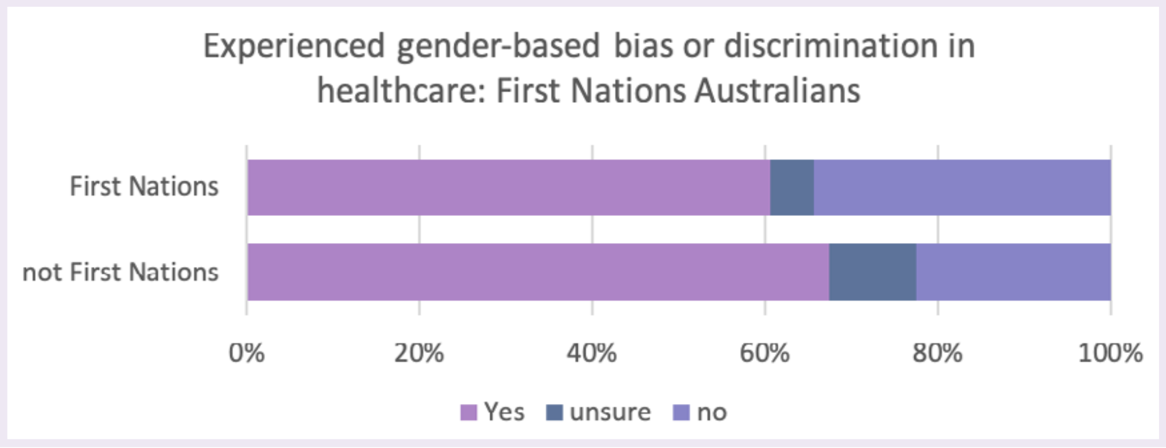


Figure 29: Experiences of gender-based bias or discrimination in healthcare, by First Nations status.

Nevertheless, compared to other people who experienced gender bias in healthcare, First Nations people who experienced gender bias in healthcare also reported:

- Slightly less choice and less satisfaction about healthcare services
- Less feelings of safety in healthcare settings
- Similar responses to questions about appropriateness, affordability, and accessibility of services
- Similar levels of satisfaction with information sharing
- Similar levels of confidence in speaking up
- Similar likelihood of feeling that their opinions were heard and considered in decision making
- Similar likelihood of feeling that they were treated very or extremely differently in a healthcare setting due to their gender.

In their free-text responses, First Nations participants reported experiences of being dismissed and disbelieved that were consistent with the overarching thematic map, but in some cases were also able to describe these experiences as a reflection of racist assumptions and stereotypes.

> I take medication which is known to cause liver damage. For about 12 years I've had abnormal LFTs [liver function tests] and every time a doctor sees results I'm advised to stop drinking. I don't drink but they never believe me because I'm an Aboriginal woman.
>
> **[First Nations woman, 45-54y, regional]**

First Nations participants also reported disrespectful and demeaning interactions with healthcare professionals that raised similar questions about racism.

> [The doctor] diagnosed me with PCOS and advised that in combination with the endometriosis I was likely to be infertile … but at the same time recommended I have a baby to 'cure' my endo. I was obviously mortified by that notion as a single low income First Nations teenager … I wondered at that time if it was because of my race, because of my physical appearance, because of my age, or because of my gender.
>
> **[First Nations woman, <18y, metro]**

In some cases, First Nations participants noted the importance of drawing upon local community solutions and services, when faced with mainstream services that are not culturally safe or acceptable.

> She felt she wasn't … respected as an Aboriginal they did not look at her nor listen… She kind of gave up on [mainstream] services and now involved with local Aboriginal community for healing.
>
> **[Participant responding on behalf of a First Nations woman, 45-54y+, regional]**

Some First Nations participants also identified the positive impact that trusted advocates, including Aboriginal Health Workers and family members, had had on their healthcare experiences.

> I've also had really wonderful health care but only after advocating from a loved one.
>
> **[First Nations woman, 25-34y, metro]**

### 5.4.3 Culturally and Linguistically Diverse

The #EndGenderBias survey asked participants if they were born in Australia, and if they spoke a language other than English at home. Participants were defined as culturally and linguistically diverse where they were born outside of Australia, New Zealand, the United Kingdom, Canada, the United States and South Africa (all English-speaking countries), or where they spoke a language other than English at home.

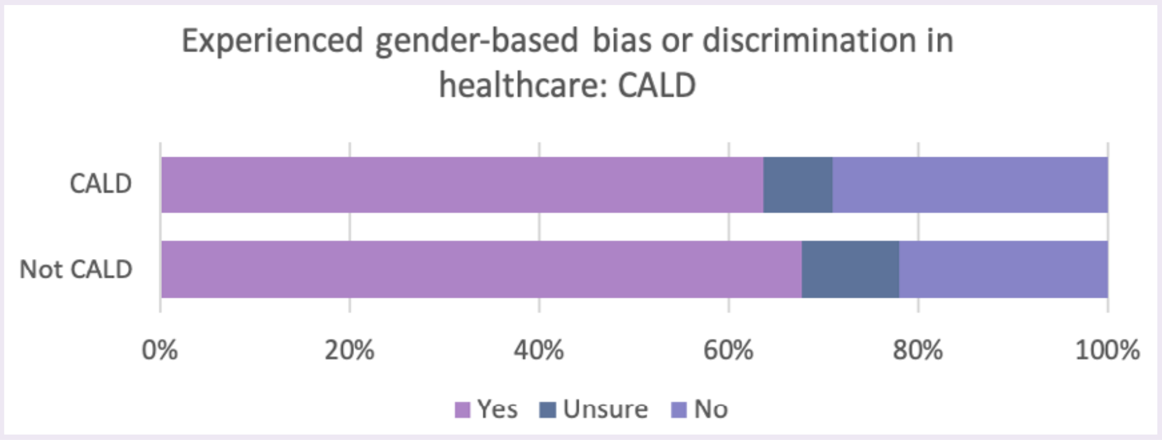


Figure 30: Experiences of gender-based bias or discrimination in healthcare for participants classified by cultural and linguistical diversity.

Culturally and linguistically diverse people were slightly less likely to report experiencing gender-based bias or discrimination in healthcare than other people (Figure 30). Both groups reported similar experiences of:

- Choice about various aspects of healthcare
- Satisfaction with services
- Appropriateness, affordability, and accessibility of services
- Satisfaction with information sharing
- Confidence in speaking up
- Feeling their opinions were heard and considered in decision making
- Feeling safe in a healthcare setting
- Being treated differently due to their gender.

While culturally and linguistically diverse participants' free texts comments only rarely identified the intersecting impact of gender and cultural background, stakeholder submissions highlighted how linguistically diverse women could be excluded from decision making in dehumanising ways, exacerbated by cultural stereotypes.

> Health providers refusing to use interpreters when engaged with women not proficient in English and instead relying on women's partner/adult children … a refugee woman petrified about an upcoming surgery [because she] … did not know what the procedure [was] … the specialist [only] spoke to her husband … migrant and refugee women being assumed incompetent to look after themselves because they don't speak a word of English; assumptions about some women (e.g., Muslim women) having less agency or being less empowered.
>
> **[Advocate]**

Other stakeholders noted differences in access to healthcare, with likely implications for their health outcomes.

> Immigrant and refugee women … are less likely … to take health related action when ill and have amongst the lowest rates of participation in breast and cervical cancer screening.
>
> **[Health Professional Society Submission]**

Consistent with the overarching thematic map, some culturally and linguistically diverse participants' responses linked their experiences of being dismissed and disbelieved, with both their gender and cultural background.

> The Radiology staff scoffed at the order for a CT stan, saying that I was walking and looked fine, I did not look pale … If I were a whiter person, I probably would have been considered 'pale' but, my olive skin confused the healthcare staff … Women won't look pale if they are naturally a few shades darker than a typical English descent patient.
>
> **[Culturally and linguistically diverse woman, 25-34y, metro]**

> I have been suffering from chronic pain for the past 13 years (9 of them in Australia). I used to have good care and treatment in [another country] … but since I came to Australia I was never taken seriously … I see Australian men being treated for conditions much simpler than mine, and being taken seriously, having tests I never had, and receiving treatments I was never offered.
>
> **[Culturally and linguistically diverse woman, 35-44y, metro]**

Culturally and linguistically diverse participants also described the impact of demeaning and disrespectful interactions.

> [Following a mistake with a request repeat prescription] He [doctor] brought me straight out into the waiting room, called me some very unpleasant things and humiliated me in front of a packed waiting room … As a fat, foreign, 'problematic' woman, I have been made to feel responsible for male medical professional reputation and to cover over their failings by apologising for bothering them.
>
> **[Culturally and linguistically diverse woman, 45-54y, regional]**

Consistent with the overarching thematic map, culturally and linguistically diverse participants also described added dimensions to their efforts to reclaim agency.

> I've had to learn to advocate for myself to get proper treatment … Gender bias affects how seriously we are considered. I am also a woman of colour, so I always dress up when I go see a doctor to make sure I'm taken seriously. Gender bias and racism leads to even worse outcomes for some women so I hope that's considered as a priority.
>
> **[Culturally and linguistically diverse woman, 35-44y, metro]**

### 5.4.4 LGBTQI+

In the #EndGenderBias survey, participants had the option to self-identify as lesbian, gay, bisexual, queer or other diverse sexuality, herein described as LGB+. Participants also had the option to self-identify as transgender or gender diverse, as well as being separately asked to select their gender (with the options of man/male, woman/female, non-binary or to provide a different preferred term). Participants were included in this sub-analysis where they responded affirmatively to either or both questions. When discussing the responses of sexuality and gender diverse groups collectively, we use the umbrella term LGBTQI+.

People who identified as LGBTQI+ were much more likely to have experienced gender bias or discrimination in healthcare than people who did not identify as LGBTQI+ (Figure 31).

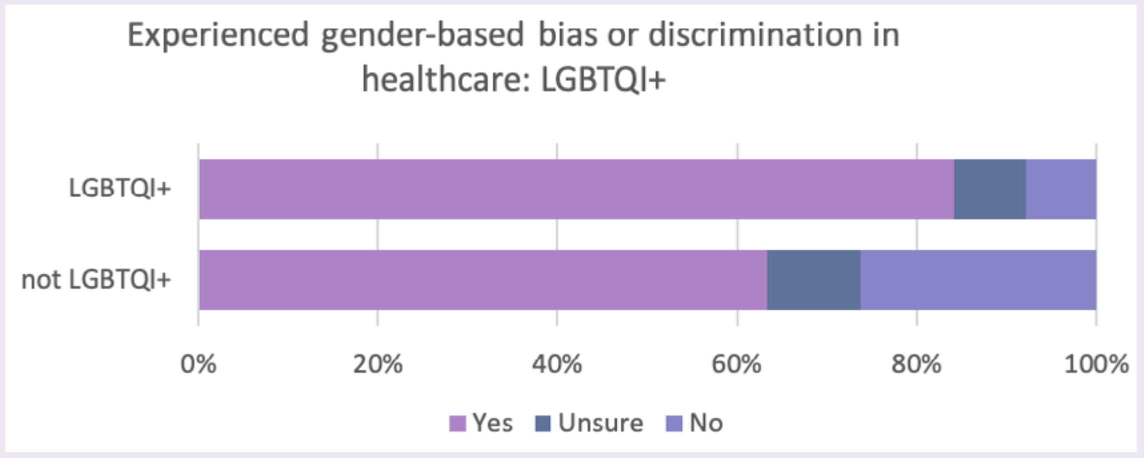


Figure 31: Experiences of gender-based bias or discrimination in healthcare, by LGBTQI+ identification.

Compared to non-LGBTQI+ participants, LGBTQI+ participants were:

- Less likely to feel their care was affordable or accessible
- Less likely to feel confident about speaking up
- More likely to report feeling unsafe in a healthcare setting
- More likely to feel they were treated differently due to their gender.

Both LGBTQI+ participants and non-LGBTQI+ participants reported similar levels of:

- Choice and satisfactions with health services
- Appropriateness of care, of satisfaction with the amount of information shared
- Satisfaction with having their opinions heard and considered in the decision-making process.

Consistent with the overarching thematic map, LGB+ participants free text responses described feeling dismissed and disbelieved by healthcare professionals, and in some cases attributed this to their sexuality.

> GP did not take my health concerns seriously and treated me in a disrespectful manner. GP did a test only when I insisted, and then criticised my life choices based on their own assumptions that were not true (… assumed it was an STI). After finishing taking antibiotics I came back to seek advice as I developed thrush. The same GP laughed at me and kicked me out of her office.
>
> **[LGB+ woman, 35-44y, metro]**

For some LGB+ participants, such experiences that contributed to delays in diagnosing (and therefore accessing treatment for) health concerns.

> I had suspected for some time that I fit the picture of ASD, but … I was told … my experience of depression from a very young age was the reason I still thought and felt differently. This was further compounded… by my sexuality 'which tends to make people a bit mixed up' (a direct quote).
>
> **[LGB+ person, 55-64y, rural]**

Gender diverse participants also described additional experiences of being dismissed and disbelieved in their quest to access gender affirming healthcare.

> Growing up in the 90's, gender dysphoria was not recognised, nor spoken of … The general explanation that was provided by health professionals was "Hormones. She's just a teenage girl and is acting out because her father isn't around. She'll grow out of it." … I had breast reduction surgery twice and still live in regret as … I didn't follow my true desire of top surgery, instead ... followed health professionals advice on what to do with my body because I was 'sure to regret it' otherwise.
>
> **[Non-binary person, 25-34y, metro]**

Participants who identified as LGB+ also described disrespectful and demeaning treatment.

> I was to have a melanoma removed from my face … The surgeon … said to me in a sarcastic tone, "Why would it matter anyway you aren't trying to get a guy?" He believed that since I am a lesbian my face can be mutilated with no consequence.
>
> **[LGB+ woman with a disability, 55-64y, regional]**

> Early in my transition… before I could even explain my situation he [GP] interrupted me, told me that he was uncomfortable with hearing any more or helping in any way due to his religion and then asked me to leave.
>
> **[Trans woman, 25-34y, metro]**

For some gender diverse participants, disrespectful or demeaning treatment, or fears about such treatment, led them to be cautious about disclosing their gender identity to healthcare providers, while others found explaining made little difference.

> They are afraid to disclose their preferred name and pronouns for fear it will result in discrimination. Also it is frustrating that sometimes professionals wearing ally pins or otherwise involved in trans inclusive programs are some of the worst offenders for offensive comments and misusing name and pronouns.
>
> **[Participant responding on behalf of gender diverse person, 18-24y, regional]**

> When presenting as male after my transition from female-to-male, I was denied service at [tertiary hospital in capital city] for matters relating to emergency gynaecological medical care because I did not present at female. After multiple attempts at explaining my situation (in a crowded waiting room), I was sent to a local hospital that then referred me back to [the tertiary hospital] for specialist medical care.
>
> **[Trans man, 25-34y, metro]**

Gender diverse people's experiences of disrespectful and demeaning treatment extended along the continuum identified in the overarching thematic map.

> During cancer I was forced to de-transition, the pain of which is indescribable … Have been denied cancer screening while in remission. Have been told as I walked through the door "You are transgender, I will not write any scripts for you" Have been told "I don't treat 'you people' you need to find a LGB doctor".
>
> **[Trans woman, 45-54y, metro]**

> Urologist making assumptions about what was best for me during a minor urological procedure on the basis of me being 'male' and removing tissue without my consent despite specifically discussing NOT doing this prior. I didn't experience genital dysphoria until after this procedure.
>
> **[Trans woman, 25-34y, metro]**

Some LGB+ participants also emphasised how knowledge gaps amongst healthcare professionals could also lead to being denied important healthcare.

> Last year … I asked for self-test cervical cancer screening kit … My doctor asked if I was sexually active, to which I responded I was, but was not having penetrative intercourse. She then asked for details, and I explained that I had only had sexual intercourse with other women. Then she told me "Oh well, then you don't need one of those tests." I was confused because I had received a letter in the mail [about cervical screening] … Later, I went home and did my own research … I do not understand why my doctor, who was also female, had this knowledge gap about women's health.
>
> **[LGB+ woman, 25-34y, regional]**

Many LGB+ and gender diverse participants singled out specific health services or healthcare professionals as having made a positive impact on their health and wellbeing which, consistent with the broader thematic map, often stemmed from being listened to and taken seriously. Participants often linked their positive experiences to accessing female healthcare professionals, and emphasised the impact that even one individual could have.

> I have had and currently have amazing female GP's who are caring and diligent with their care of me. They listen to me and are never dismissive or rude. They are always happy to have my wife in attendance if need be and visa-versa.
>
> **[LGB+ woman, 55-64y, regional]**

> [One particular nurse] very empathetic. Felt I could open up about my sexuality and the challenges I was having with body image. It only takes one. One person to send you to the depths and one person to re connect you with humanity again.
>
> **[LGB+ woman, 55-64y, regional]**

For both LGB+ and gender diverse participants, the accessibility and affordability of "queer friendly" doctors created an additional barrier to accessing health services.

> I find it difficult even in [capital city] to find understanding, queer-friendly doctors. I am more often than not acting as a straight woman or as if I have a male partner so as to not enter into a conversation I don't want, or to not hear any prejudice as I have in the past.
>
> **[LGB+ woman, 25-34y, metro]**

> There are amazing, queer-supportive, trauma informed healthcare workers, but they are the ones who do the work to educate themselves. And they are invariably booked out… and expensive.
>
> **[LGB+ woman, 25-34y, regional]**

Gender-diverse participants noted accessibility and affordability barriers to gender-affirming care. Access to permanent contraception and/or hysterectomy was singled out as particularly challenging.

> Access to life saving gender affirmation surgery procedures are specifically excluded for Transgender patients from Medicare while the exact same procedures are included for cisgender ones. Significant lack of knowledge on gender affirmation treatment by GP's and no availability of other alternatives without multi year waitlist. No affirmation surgery available in [state].
>
> **Gender diverse person, 45-54y, metro]**

### 5.4.5 Age

Younger people were more likely to report experiencing gender-based bias or discrimination in healthcare than older people (Figure 32).

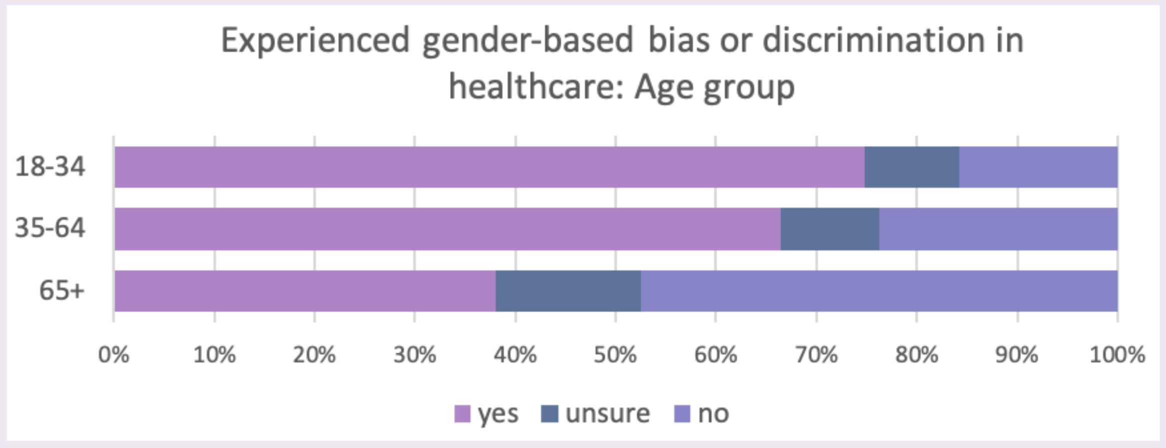


Figure 32: Experiences of gender-based bias or discrimination in healthcare, by age group.

Nevertheless, people in all age groups gave similar responses to questions about choice about various aspects of healthcare and satisfaction with services.

Younger people were more likely to report feeling they were treated differently in a healthcare setting due to their gender.

People aged 65+ were most likely to rate their care as affordable. They were also more likely to feel confident about speaking up and having their opinions heard and considered in the decision-making process. They were more likely to feel safe in a healthcare setting.

Analysis of the free-text responses of younger and older participants highlighted the importance of different issues at each life stage. Younger participants' experiences of gender bias in healthcare were more closely related to issues such as menstruation and endometriosis. For participants aged 25-34 years, experiences were closely related to childbearing, while for participants aged between 35 and 54 years, experiences of gender bias were most closely related to menopause care. Beyond this, participants described experiences that were consistent with the overarching thematic map and intersected with their age.

Amongst younger participants, being dismissed and disbelieved meant symptoms were too readily attributed to disordered eating, or stereotypical 'teen' behaviours.

> My daughter was having some eating and digestion problems and the hospital staff seemed to assume she was a typical teenage girl with anorexia and just told me to 'feed her' … They also told her to stop scrolling on her phone at night (which she wasn't) … They … seemed to imply that all my daughter's issues were psychological (befitting a teenage girl) rather than genuine and physical. The gaslighting was appalling … She was later diagnosed … with gastroparesis, severe erosive reflux, gastritis and lactose intolerance.
>
> **[Participant responding on behalf of a woman, >18y, metro]**

Older participants linked their experiences of a repeated pattern of being deprioritised and disbelieved to the invisibility of older women.

> My mother had recently had a complete oopherectomy-hysterectomy for endometrial cancer … She presented at a large public hospital with symptoms of elevated temperature, dehydration and severe abdominal pain. … [The doctor's] response was along the lines of "you have a UTI, we can't admit everyone who presents with a UTI" … My mother then proceeded to firmly/assertively tell him she didn't think it was a UTI and felt it was perhaps related to her recent treatment, and had he looked at her medical history? At this point he responded that she "didn't need to raise her voice" … A short while later a different doctor [found] a large infection near her bowel which required surgery to drain. The first treating dr was very dismissive of her experience, her medical history and her determination to stand her ground.
>
> **[Participant responding on behalf of a woman, 75-84y, metro]**

Particularly for participants with deficits associated with age, the intersection of age and gender led their exclusion, and the exclusion of their loved ones, from decision making about their care.

> Mum was admitted to [hospital] after she fractured 2 lumbar vetebrae … They seem to be conveniently using her deafness and memory loss to avoid giving her, or our family essential information. Now this treatment may be mainly age related but I don't think they'd treat a man that way.
>
> **[Participant responding on behalf of a woman, 85+y, metro]**

Some participants particularly noted the impact of gender bias in aged care, including the lack of trauma-informed approaches.

> Aged care facilities that privilege male residents needs because they're louder, more demanding … I asked my mum what she wanted me to look for when looking at aged care facilities all she wanted was "a lock on the door" & it was extraordinarily hard to find.
>
> **[Participant responding on behalf of a woman, 85+y, metro]**

> Sexual assault of older women is a fact that the community, including health services, find difficulty believing … around 50 assaults occur each week in residential care yet it is not compulsory to report the 'incident' and neither is it required to report to police.
>
> **[Advocacy Organisation Submission]**

### 5.4.6 Experience of violence or abuse

People who had experienced violence and/or abuse were more likely to:

- Experience gender-based bias or discrimination in healthcare (Figure 33)
- Feel they were treated differently in a healthcare setting due to their gender
- Report less choice and satisfaction with health services.

They were less likely to:

- Report their care was appropriate, affordable, or accessible
- Feel confident about speaking up
- Feel their opinions were heard and considered in the decision-making process
- Feel safe in a healthcare setting.

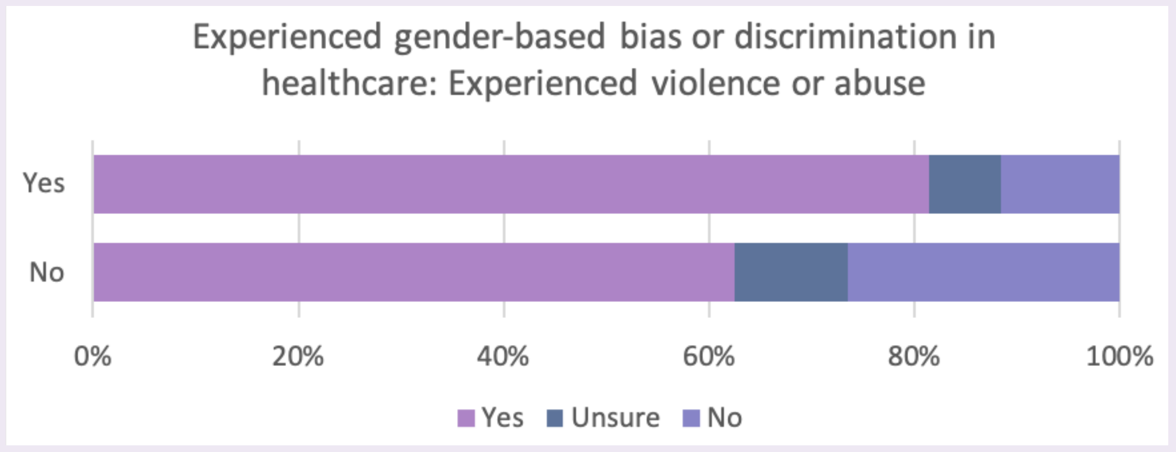


Figure 33: Experiences of gender-based bias or discrimination in healthcare by experience of violence or abuse.

### 5.4.7 Body weight

Although the #EndGenderBias survey did not inquire about body weight, numerous participants perceived that their body weight intersected with gender bias in their experiences of healthcare. While participants' responses continue to align with the overarching thematic map, the number of responses that singled out that additional impact of "fat phobia" was noteworthy.

For some participants, their body size had been blamed for a variety of health concerns, curtailing proper investigation of other explanations.

> I'm 48 years old and broken, because people assumed I was just a fat lazy woman, and didn't listen to the fact that I was gaining weight because I was in so much pain.
>
> **[Woman, 55-64y, metro]**

> I'm constantly experiencing medical gaslighting regarding how much pain I'm in, and every symptom I've had for anything is assumed to be pregnancy, menstruation or anxiety, and the solution is always to just lose weight.
>
> **[Non-binary person, 18-24y, metro]**

In other cases, participants described disrespectful and demeaning treatment, explicitly connected to their body weight.

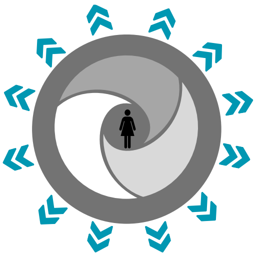
> [Doctor] was disgusted. He tried to stop the [cardiac stress] test right there … The tech said she could do the test but the doctor ordered her to stop. He was angry at me. As he left the room he came and towered over me and spit out very loudly that they could not do the test because I was too fat and strode out of the room. I never did get the test.
>
> **Woman, 55-64y, regional]**

> A male GP slapped my butt cheek before administering my [long-acting contraception injection] and then asked me "Have you always been this fat?".
>
> **[Woman, 35-44y, regional]**

Consistent with the overarching thematic map, participants described how being listened to and believed, and building a positive relationship with a trusted healthcare professional had been a turning point in their health.

> My new GP is amazing - she is thorough, takes her time and follows up on my concerns … She does not dismiss your concerns and has, on more than one occasion made a point to tell me what is causing a particular [issue] for me - knowing that for a many years I was dismissed for being overweight.
>
> **[First Nations woman, 45-54y, Metro]**

## 5.5. Gender bias has far reaching impacts in women's lives



The combined impact of encountering gender bias in healthcare was far reaching in participant's lives. Flowing from the experience of being dismissed, disbelieved and delayed, participants described impacts on every aspect of their lives.

> In the 20 years [it took to get diagnosis and treatment] I lost so much, I was always anxious and trying to problem solve my mysterious health problems … I had a fulltime job in attending medical appointments… I lost confidence in my body, I lost enjoyment in sex due to pain and discomfort, and this impacted by romantic relationships. I felt a lot of shame.
>
> **[Woman, 45-54y, metro]**

In some cases, participants described how their experience of gender bias in healthcare had locked them out of options in perpetuity.

> By the time I found out that my lived experience was possibly autism, I was already locked out from support. I lived years in poverty, homeless, because I couldn't hold a job. I have one now, but who knows how long that will last. The cost for diagnosis is permanently out of reach for me.
>
> **[Non-binary person, 25-34y, regional]**

Participants also recounted how delays led directly to worse health outcomes, with lasting impact.

> My health would be significantly better, and my function would be significantly better if I had had access to equitable care. I might now be working, socialising and enjoying hobbies, rather than being housebound, unable to drive, unable to sit upright for anything other than necessities and severely disabled.
>
> **[Woman, 55-64y, metro]**

> One year down the track [after missed diagnosis], the endometriotic lesions are tethered to my bowel … it's a very complicated surgery and there is a risk of ending up with a colostomy bag.
>
> **[Woman, 35-44y, regional]**

Some participants recounted "near misses" where, despite being dismissed, their health concerns had turned out to be immediately life threatening.

> I presented to the emergency ward in hospital numerous times with intense migraines and pulsatile tinnitus. I was told I had a common migraine (which is apparently very common in women!) and sent home with Panadol … Eventually Dr agreed to CT scan saying he did not recommend the procedure because “I had a typical migraine” … It was a Spontaneous artery dissection and [I] was lucky to be alive!
>
> **[Woman, 45-54y, regional]**

In other cases, participants believed that the concerns dismissed by healthcare professionals had led to the death of a loved one.

> I presented at the obstetrician’s office at 19 weeks for the first consultation … I was very thankful to be able to see the obstetrician and talk to him about recent pain I had been experiencing … the obstetrician dismissed my concerns. He overestimated my “low risk” prognosis (based on family history) & significantly underestimated that I could be suffering pregnancy complications. Instead … he would see me one week later where we could go over that (but by one week later my son had died [stillborn; HELLP Syndrome]).
>
> **[Woman, 35-44y, regional]**

Many described feeling “worthless”, “abandoned”, “ashamed” and “tossed aside” by society. They were often acutely aware of “clogging up the system”. This pattern of dismissal led some participants to internalise self-doubt.

> The dismissiveness of the medical staff, who concluded that I did not need to be admitted, led to me questioning whether my pain was real or imagined.
>
> **[Woman, 25-34y, metro]**

> OK so it’s not bad enough to warrant an emergency visit, I’m not vomiting or passed out and I don’t have a temperature, it’s just pain. I don’t want to waste anyone’s time, not least health services; perhaps this is my own gender bias, to fear being a drain on the system, to fear taking up space.
>
> **[Woman, 35-44y, metro]**

For many participants, managing their health condition required significant engagement with healthcare providers. This brought financial and time burden, sometimes impacting on career and educational opportunities.

> I’m relying on pain relief medication while paying out of pocket for pelvic floor physio and dietician appointments to see if I can help myself deal with pain while waiting for surgery [for endometriosis]… there’s also the financial impact of private health cover premiums, then the cost for the hospital excess, the anaesthetist, travel to a Melbourne hospital, daily pain relief, medication to lighten the heavy blood flow, visits to pelvic floor physio, dietician appointments, costly iron infusion due to low iron. The oral contraceptive the surgeons want me to take is not on the PBS so costly to take long term.
>
> **[Woman, 35-44y, regional]**

For some participants, the far reaching impact of their experiences of gender bias in healthcare, especially in the context of ongoing dismissal by health professionals had led them to give up.

> It has been 4 years and I still experience these issues … but I am so exhausted and time poor, and doctors are so expensive, that I just don't have the energy to explore it any further.
>
> **[Woman, 25-34y, regional]**

**Reclaiming agency**: Faced with the far reaching impact of gender bias, many participants responded by taking steps to reclaim agency in their healthcare. Many participants described overcoming the barriers they encountered in formal healthcare by accessing support online.

> I have suffered so many symptoms over a period of about 6 years, that can all be accounted to peri menopause and menopause, yet not one Dr I spoke to over those years even suggested it as a possibility. I have completed some minor research and joined a Facebook group in the last 2 weeks and have received more information from that, than I ever have from any of the Drs I've seen in 6 years.
>
> **[Woman, 55-64y, metro]**

Participants also believed that their experienced had shaped them into strong advocates for their own health and wellbeing, which included continuing their search for trusted healthcare professionals.

> My positives come from my ability to self-advocate and find health professionals that listen. There are good ones out there!
>
> **[Woman, 35-44y, rural]**

> Being older and more experienced speaking to and working with health professionals also helps, I wasn't able to advocate for myself strongly when I was younger.
>
> **[Woman, 25-34y, regional]**

Although participants were empowered by these actions, their own self-advocacy efforts were often met by negative reactions from healthcare professionals.

> However most doctors are appalled when I said I was on the [online] forums for my support … They are all amazing resources with ACTUAL CURRENT information … They have in fact saved my life. All my questions were answered, and I knew I was not alone.
>
> **[Woman, 45-54y, metro, participant's emphasis]**

> My friends and I regularly talk about how to behave in medical appointments. We know that if we reveal we understand our conditions or how the medications work that we will be accused of drug seeking or a hypochondriac. However, if we don't then we waste our time, money + often get prescribed the contraceptive pill.  Last GP appointment I told the doctor that I had already tried the treatments they had suggested … I was ignored and then ushered out of the room. Sometimes I ask: "Could you please write in my clinical notes that you refuse to investigate or provide a referral?" When this happens the GP usually becomes angry, belittles and shames me.
>
> **[Woman, 35-44y, regional]**

Evidencing that their experiences were ultimately rooted in gender bias, participants observed differences in their care when they were accompanied by a trusted male advocate.

> Pain was only taken seriously when my husband explained things, despite me saying the same things previously and being minimised, treated as drug seeking.
>
> **[Woman, 25-34y, metro]**

# 6. How the #EndGenderBias Survey was conducted

Council members, stakeholder organisations, consumer groups and professional bodies were asked to share information about the survey and encourage survey participation through social media, newsletters, posters, etc. An information kit in 17 languages was available to support promotion activities.

The online survey was developed by the Department of Health and Aged Care in conjunction with the Council, with results analysed by the Australian Women and Girls' Health Research Centre at the University of Queensland. The survey was structured in three parts:

- People reporting their own experiences (Section A; 2,570 completions)
- People reporting the experiences of another person (Section B; 86 completions)
- Stakeholder experts were invited to report their perspectives (Section C; 497 completions).

Each section included closed response items on socio-demographic characteristics, health conditions and experiences of the health system. There were also 23 open ended questions that provided a wealth of insights into experience of gender bias.  Many people responded in more than one section, reflecting their multiple roles. To protect the privacy of respondents, only the major categories have been reported here and some response options have been aggregated.

Expert stakeholders could respond either individually or on behalf their organisation. Nurses (28%) were the largest group in the individual responses, followed by researchers (23%), allied health professionals (20%), doctors (19%), health advocates (13%), policy makers (11%) and health administrators (8%). Amongst organisational responses, disability groups (27%), pregnancy organisations (25%) and groups representing low socio-economic people (25%) were all well represented, followed by LGBTQI+ groups, culturally and linguistically diverse groups, and organisations representing rural and remote areas and First Nations Australians.

All open-ended responses and stakeholder submissions were analysed thematically. In Part A (own experience) and Part B (someone else's experience) responses to at least one open ended question were received from 1,989 and 67 participants respectively. In Section C, 418 responses were recorded to at least one open-ended question. Participant responses to later questions often referred back to their earlier responses, and participants often referred to their own and other people's experiences in responding to questions in both Section A and B. Therefore, data from all open-ended questions in Section A and B was analysed together. Also, responses to open ended questions in Section C that related to stakeholders' perceptions of women's experiences of gender bias were analysed with the relevant Section A and B data. Questions about research (from Section C) were analysed separately.

The qualitative analysis was conducted by two members of the research team, using Leximancer. Leximancer is a text mining software that can be used for parts of thematic analysis. We used Leximancer to identify the clusters of concepts that were most common across participant responses, and used this to direct our closer analysis of these. Two researchers reviewed the Leximancer concept map, and we collaboratively generated themes from these, iteratively going between the participant responses, the concept map and the thematic map – including a search for disconfirming data. The final thematic map was the result of this consensus-based approach.

For the intersectional sub-analyses, the free-text responses of participants from each sub-group were reviewed against the thematic map, and illustrative quotations purposively selected. Fewer participants provided free-text responses than answered the closed-form questions. The sub-analyses included responses from or on behalf of:

- 601 people with lived experience of disability
- 41 First Nations people
- 414 Culturally and Linguistically diverse people
- 514 LGBTQI+ participants (comprised of 493 who identified as LGB+, 119 trans and gender diverse people and 98 participants who identified as diverse in terms of both their gender and sexuality)
- 45 responses from participants at each end of the age spectrum (comprised of 12 people aged over 75 years, and 33 people aged under 24 years).

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