

Submission to the Senate Select Committee on Women's Health

Women's Health East

October 2026

Executive summary

Women's Health East (WHE) is the regional women's health service for Melbourne's Eastern Metropolitan Region (EMR). We work with health services, local governments, and community organisations to improve women's health through gender equality, prevention, and health equity.

Our message to the Committee is simple. Good clinical care is necessary, but it is not enough. Women's health outcomes are shaped by what care costs, whether women are believed, whether they can find and understand the system, whether services are accessible to them, and whether they are safe at home. Gender inequality and family violence are health determinants, and this inquiry should treat them that way.

We ask the Committee to recommend three priorities:

1. **Postpartum care that lasts.** Extend care beyond the six-week check, with affordable, Medicare-supported access to pelvic health physiotherapy and mental health support.
2. **Pain that is believed and treated.** Invest in women's pain research, workforce training on gender bias and disability inclusion, and affordable multidisciplinary care.
3. **Help to find the way in.** Fund community-led navigation and bicultural workforce models and connect health settings to family violence support.

Scope. This submission addresses the terms of reference on postpartum care and its cost and accessibility, women's experience of pain and medical misogyny, existing policy, and data. It does not address assisted reproduction or medical device regulation, where other organisations are better placed to advise. Our full recommendations are on page 3.

Melbourne's east: averages hide inequality

The EMR covers Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and Yarra Ranges. It is home to more than 554,000 women and girls¹. Around 37 per cent of residents were born overseas², and in Monash the figure is more than half³.

The east is often seen as affluent. Regional averages hide the women for whom that is not true. Women in the region tell us the barriers are cost, long waits, fewer bulk-billing providers, transport, and referral pathways that are hard to work out. These land hardest on women with disability, women experiencing family violence, Aboriginal and Torres Strait Islander women, women who are recent migrants, and women who are insecurely housed or isolated. Often, it is the same women carrying several of these at once. That is the lens for everything that follows.

¹ ABS Census 2021

² ABS Census 2021

³ ABS Census 2021

Postpartum care shouldn't end at six weeks

Pregnancy and the postpartum period are recognised periods of heightened risk for the onset or escalation of family violence, with significant impacts on the physical and mental health of both mother and child⁴.

Postpartum care is still treated as a short clinical window, usually closing with a check at around six weeks. Many women live with the physical and emotional effects of birth for months or years. Women and service providers in the east tell us it is hard to access pelvic health physiotherapy, mental health support, continence services and specialist care. Where services can be found, they often come with significant out-of-pocket costs.

That cost is itself an economic impact of birth. It also carries over into women's capacity to return to work, their financial security and their long-term health. For women facing the barriers described above, the gap is widest.

The answer is not more one-off appointments. Effective postpartum care joins up physical health, mental health, allied health, family violence support and community connection, and links maternity, primary care and community services so that a woman doesn't have to find her own way between them.

Women's pain: being believed is part of treatment

Women describe delayed diagnosis, dismissed symptoms and treatment that doesn't match the pain they are in.

The Victorian Government's *Bridging the Gender Pain Gap* report, released in November 2025⁵, examined this in depth. WHE urges the Committee to build on that work rather than repeat it, and to focus on what only the Commonwealth can do: Medicare funding, national research priorities and health workforce education.

Women with disability face a double bind. Women with Disabilities Victoria has documented women not being believed, symptoms being minimised, and concerns being put down to disability without being investigated⁶. This is diagnostic overshadowing, and it sits on top of gender bias and ableism. Inaccessible information, communication barriers, physical access problems and exclusion from decisions about their own care follow women with disability across sexual and reproductive health,

⁴ Australian Institute of Health and Welfare 2026, Pregnant people, Family, domestic and sexual violence data, viewed 6 October 2026, <https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/pregnant-people>

⁵ Safer Care Victoria / Victorian Government, *Bridging the Gender Pain Gap: Inquiry into Women's Pain Report*, November 2025

⁶ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.(2022). Overview of responses to the Violence and abuse of people with disability at home issues paper. https://disability.royalcommission.gov.au/system/files/2022-03/Overview%20of%20responses%20to%20the%20Violence%20and%20abuse%20of%20people%20with%20disability%20at%20home%20Issues%20paper_0.pdf.

preventive care, pain management and postnatal care. They are also more likely to experience violence.

Disability inclusion is not a specialist add-on. It should be a requirement for every women's health program and funding decision, with accessible information, supported decision-making, workforce capability and inclusive design built in from the start.

Affordability is only part of the challenge. Women's health outcomes are shaped by broader economic and social factors. As UN Women Australia notes, women's health is closely linked to the conditions in which women live and work.⁷

Multidisciplinary care, combining physiotherapy, psychology and specialist input, is widely recognised as best practice for persistent pain⁸, and it is also the model that costs women the most out of pocket. Women are overrepresented in part time, and casualised workforces, meaning the appointment juggle comes with an economic cost too. It can mean taking unpaid time off work, arranging childcare, or juggling caring responsibilities. When this is combined with rising out-of-pocket costs, women may delay care or go without treatment altogether.⁹

Family violence is a health issue

In 2024–25, police recorded more than 10,800 family violence incidents across the EMR¹⁰.

Violence is a major contributor to ill health for women¹¹, including chronic pain, mental ill-health, reproductive coercion, pregnancy complications, housing instability and financial insecurity.

Pregnancy and the postpartum period are recognised times when violence can begin or escalate¹². For many women experiencing violence, a health service is one of the few places they see a trusted professional. That makes maternity services, GPs and community health clinics part of the family violence response and requires specific skills in managing disclosures and supporting survivors. We need reliable pathways from those settings into family violence and community support. Preventing violence against women is a women's health strategy.

⁷ UN Women Australia 2025, Six uncomfortable truths about women's health, viewed 5 October 2026, <https://unwomen.org.au/six-uncomfortable-truths-about-womens-health/>

⁸ Australian Physiotherapy Association (APA) 2024, *Physiotherapy and women's pain: An overview of evidence-based physiotherapy care*, Australian Physiotherapy Association, viewed 30 September 2026, https://australian.physio/sites/default/files/submission-2024-07/APA_Appendix_A_Inquiry_into_Womens_Pain_July_2024.pdf

⁹ Australian Bureau of Statistics. (2025). Access to health services. ABS. <https://www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/healthy/access-health-services>

¹⁰ Crime Statistics Agency Victoria, 2024–25

¹¹ Australian Institute of Health and Welfare (AIHW) 2026, *Health outcomes*, AIHW, Canberra, viewed 30 September 2026, <https://www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/health-outcomes>

¹² Australian Institute of Health and Welfare (AIHW) 2026, *Pregnant people*, AIHW, Canberra, viewed 30 September 2026, <https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/pregnant-people>

What works: trusted people in the community

WHE's work with Hakha Chin women in Melbourne's east shows what community-led care can do. The Hakha Chin community has been settling in Melbourne's east for more than 20 years, with many families arriving as refugees from Myanmar and building strong community networks across the region. Women faced language barriers, limited health literacy, unfamiliarity with the health system and uncertainty about where to go.

From 2024, WHE has worked with bicultural workers and community partners to provide education, navigation and support to reach cervical screening, breast screening and other general health appointments. Thirty-nine women were supported to access screening. Knowledge of where to get care increased, women were connected with ongoing primary care, and they reported greater confidence using the health system.

While a small program, the successful ingredients are clear: trusted relationships, a bicultural workforce, culturally safe health care in-language and someone to help with the next step. Applied to postpartum care, that would mean a navigator who supports women from pregnancy through the first year, helping them book pelvic health physiotherapy, find mental health support, understand contraception options and know where to go when something feels wrong. Applied to pain care, it would mean help getting through referral pathways that women are too often left to work out alone.

Recommendations

WHE recommends that the Committee call on the Commonwealth Government, working with states and territories where noted, to:

Postpartum care

1. **Extend the postnatal care pathway** from six weeks to at least 12 months, with scheduled contact points covering physical health, mental health, pelvic health and contraception.
2. **Fund affordable access to postpartum pelvic health physiotherapy and mental health support** through Medicare.
3. **Strengthen integration** between maternity, primary care, allied health and community services, including through regional women's health services.

Women's pain

4. **Fund research on women's pain** and make it a national research priority.
5. **Make multidisciplinary pain care affordable** for women, including access to physiotherapy, psychology and specialist services.
6. **Strengthen workforce training** on gender bias, trauma-informed care and disability inclusion, in pre-registration education and ongoing professional development.

Equity, disability and family violence

7. **Make disability inclusion a condition of funding** for women's health programs, covering accessible information, supported decision-making and inclusive design.
8. **Fund place-based navigation, including bicultural workforce models**, delivered through regional women's health services and community partners.

9. **Fund pathways between health settings and family violence services** and recognise gender inequality and family violence as determinants of women's health.

Data

10. **Collect and publish women's health data** at regional level, disaggregated by disability, cultural background, age and experience of family violence, so that health inequities are visible and can be effectively addressed. Consider including endometriosis in future national data collections, including the Census and Australian Bureau of Statistics health surveys, to improve understanding of its prevalence, diagnosis patterns, treatment access and social and economic impacts.

Conclusion

Across Melbourne's east, one pattern repeats: women's health follows access. If the Committee does three things, extends postpartum care beyond six weeks, takes women's pain and the bias around it seriously, and funds trusted community navigation, it will reach the women most likely to be missed.

WHE would welcome the opportunity to provide further information.

Emma Clark

Manager, Communications and Engagement, Women's Health East

Emma@whe.org.au

0411557529