T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Gender Responsive Budgeting

Melbourne—Tuesday, 10 December 2019

Members

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WITNESSES

Ms Kym Peake, Secretary,

Ms Amity Durham, Deputy Secretary, Strategy and Planning Division, and

Ms Marg Burge, Director, People and Culture, Department of Health and Human Services.

The DEPUTY CHAIR: Welcome to the public hearings of the Public Accounts and Estimates Committee Inquiry into Gender Responsive Budgeting. I am Acting Chair this morning. All mobile telephones should now be turned to silent. All evidence taken by this Committee is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you go outside and repeat the same things, including on social media, those comments may not be protected by this privilege. You will be provided with a proof version of the transcript for you to check. Verified transcripts, PowerPoint presentations and handouts will be placed on the Committee's website as soon as possible. I now invite you to make a 10-minute opening statement to the Committee, which will be followed by questions from the Committee.

Ms PEAKE: Thank you very much for the opportunity to speak to you today about how public financial management can advance gender equality. I would like to begin by acknowledging the traditional custodians of the land on which we meet today and pay my respects to their elders, past and present.

Visual presentation.

Ms PEAKE: What I would like to cover today for the Committee in my opening statement is really, firstly, to touch on why gender responsive budgeting matters to us as a department and our understanding of applying a gender lens to our budget planning advice and implementation; secondly, to inform the Committee of our progress in applying gender analysis to those functions, in particular to reduce the burden of disease and poorer health outcomes for women and gender-diverse persons, to address the social determinants of health and wellbeing for women and girls and to tackle structural barriers to gender equality both as an employer and as a steward of significant Health and Human Services systems; and then finally, just to offer some brief reflections on how we might think about strengthening and embedding these practices across the department and Government going forward.

So if I start with a little bit of the why: for us, gender responsive budgeting really matters because we know that there are significant disparities in how men, women and gender-diverse people access and experience our services, but also that Victorians are affected by gendered health and wellbeing inequalities. For example, two to three times more women than men experience mental health problems like depression and anxiety, and we know that harmful stereotypes about sexuality and body image play a part in that. The gender pay gap and inequality at work puts women at higher risk of physical and mental illness, as well as housing insecurity, and gender-based violence and harassment affect how and when women access and use public services and public spaces. We also know that men are more likely to engage in risky behaviours, like drinking too much alcohol, that put them at greater risk of harm and injury, and they are less likely to go to the doctor or seek help when they need it. Gender norms and stereotypes means health outcomes for LGBTI people are often worse than non-LGBTI people. Background, disability, location and economic status also impact health and wellbeing.

So for us, gender responsive budgeting is largely focused on improving the design of government initiatives and prioritisation of government investments for women and gender-diverse people, really in recognition of the greater disparity in outcomes for those groups. We recognise that without a really deliberate focus, policy and budget design can actually be gender-blind rather than gender-neutral, skewing benefits to people with greater access to decision-making processes, resources and economic and social opportunities. I do think it is really critical that we do not just move to a more compliance-oriented, tick-the-box approach to gender responsive budgeting, but rather establish a custom and practice of providing good advice on how budget choices will contribute to gendered outcomes, how we can leverage major government initiatives to advance gender equality and where we should really target investment to tackle gender-related issues and inequalities.

At the moment I would suggest we probably do the latter more systematically than the former, but even then I am not sure that we systematically apply the whole-of-government guide to gender impact analysis you have

just been talking about, in particular to focus on how gender intersects with other factors such as cultural background, age, disability and sexual identity in how a service or program might be used or experienced by different groups or individuals; to use different sources of evidence to understand those gender impacts, so behavioural insights as well as more formal forms of evidence and direct feedback from diverse groups and stakeholders; in how we hold ourselves to account by measuring the anticipated and then the actual gender impact of government actions and investment decisions; and then finally, how we use these sorts of tools to challenge our own internal biases and pay attention to whether gender responsive budgeting processes are really becoming embedded in our advice to Government.

If I move to the next slide, I think within DHHS we have made the most progress in identifying targeted investment requirements to gendered health and wellbeing outcomes. If we start with health, if we look at the burden of disease in Victoria the three disease groups with the highest fatality include cancer, cardiovascular disease and injuries. In addition, mental and substance use disorders and musculoskeletal conditions have the highest non-fatal burden, with women having the greatest share of total burden of neurological conditions like dementia, and musculoskeletal conditions. If I can just touch briefly on some of our responses to that burden of disease, we know that breast cancer is the most commonly diagnosed cancer for women, which is why around $23 million is invested each year in breast cancer screening, with around 270 000 women screened in 2018–19. It was why in September the Government announced up to $1.8 million for new 3D breast screening technology to speed up diagnosis and reduce invasive procedures. Just last week I presented a paper to my counterparts at the Australian Health Ministers Advisory Council and reached agreement on a review of the funding model for breast screening to better respond to population growth and changing demographics.

We know that family violence is a major risk factor that eclipses all others for women aged 18 to 44 years. Through injuries, mental health effects and other impacts it amounts to a huge 5.1 per cent of disease burden for that group—so women aged 18 to 44—which has really been underpinning our responses to the royal commission and the about $2 billion worth of investment that the department and Family Safety Victoria are responsible for leading implementation of. This includes the $448 million for the Orange Door safety support and safety hubs, $20 million over four years for therapeutic support for victim survivors, $300 million in the last few years in housing-related services for victims escaping family violence, $11 million in training for maternal and child health workforces and providing an additional consultation by MCH to women at risk of experiencing family violence, targeted initiatives for women with a disability and Indigenous communities, better family violence service responses for LGBTI people, and work that has been led through the Royal Women's and Bendigo Health about really raising awareness and confidence in health practitioners in our health services identifying and responding to family violence.

Of course illness is not the only reason the health system is there, and we are also very focused on the specific health needs of women, including reproductive health services, maternity services and support to care for babies and young children. Some of the specific investments that have been geared towards those particular needs in reproductive health are: the 2016–17 state budget delivered $6.6 million over four years for the implementation of the *Women's Sexual and Reproductive Health* strategy—I will flick through this pretty quickly, but I can leave more detail for you; for maternal and child health, by 2020 we will reach 15 per cent of families with children from birth to 3 years through a more intensified MCH service for mothers with additional risks or needs or experiencing mental health challenges; and in recognising that trans and gender-diverse people often experience poorer health and wellbeing because of the discrimination they have faced in their everyday lives we have also invested in specific trans and gender-diverse health initiatives, including statewide training programs, community-based clinics and a peer support program.

If we move through to the next slide, I think we have also done a reasonable job at really looking at targeted investments to address the social determinants of health and wellbeing applying for women and for gender-diverse people. We know that social determinants account for about 80 per cent of health outcomes and that women experience greater economic and housing insecurity, especially women with a disability and older women, and we know that a mother's social and economic opportunities—influenced by her health, employment, education and income—are really significant predictors of the lifelong outcomes of her children. That evidence base on social determinants has informed our advice to Government about targeted policy and investment decisions, including the creation of a new priority access category on the Victorian Housing

Register for people aged 55 or over and partnerships with Women's Housing Victoria to support vulnerable older women to access housing faster.

We are working closely with the Commonwealth on service models under the NDIS, particularly in relation to supported accommodation and the *Victorian State Disability Plan*, to maximise economic and social participation by women with a disability and their carers.

We have introduced a range of parenting programs. The maternal and child health line received nearly 100 000 calls in 2018–19, but we have also updated the MCH service guidelines to really promote more intersectional, inclusive and responsive services in line with the gender impact assessment guidelines from the centre as well as providing a range of supports for financial inclusion and capability, with the Good Money program perhaps being the cornerstone of that work.

As well, we have introduced targeted initiatives for young women in our out-of-home care system, knowing that if we are going to break into generational cycles of participation in the statutory care system, supporting young women to leave care with better parenting capabilities and access to employment, education and housing is really important, as well as partnering with the Department of Jobs, Precincts and Regions on job opportunities for disadvantaged jobseekers.

Moving then through to our role as not only delivering particular services and programs but also through our role as steward and employer addressing some of the structural drivers of gender inequality, we have obviously had an important role in implementing the Government's commitment to women's leadership on boards. Women currently represent 57 per cent of director positions across the State's public health services and hospitals, which is up from 45 per cent in 2015. We have also been working with peak bodies across social services to support industry and workforce development and women's leadership opportunities—and we might come back to this one—as well as working with health services and peak bodies around tackling sexual harassment in our health services. Whilst it is still early days, we have seen in our health services bullying rates reduced from 20 per cent in 2017 to 15 per cent in 2019, and respondents to the People Matters surveys are showing sexual harassment reporting down from 10.5 per cent of respondents in 2018 to 9.2 per cent in 2019.

Within the department itself we have also taken a range of measures which are listed up there, including launching our all jobs flex policy and family violence leave for all staff. For example, since the introduction of our family violence leave provisions in 2016, 72 employees of the department have accessed 265 periods of family violence leave, totalling 823 days of leave. We have been tracking key workforce metrics on gender composition of our overall staffing and executive through subcommittees of our executive board, as well as supporting parents preparing for and returning from parental leave, with 150 staff participating in a pilot initiative this year, alongside supporting women's recruitment, progression and leadership through programs that we deliver in partnership with ANZSOG, structured mentoring opportunities for 128 women in the last year, unconscious bias training for recruitment selection panels and a more supportive pathway into employment for women who have just exited or just escaped family violence experiences, as well as again actions internally on the prevention of sexual harassment, including management training, communication, updating and adoption of the whole-of-government sexual harassment policy and methods to really help people to feel confident about coming forward and having complaints heard. Then finally, we have provided support for our gender diverse staff, including through trans awareness training and a trans and gender-diverse transition policy for managers.

Finally, within the department we have been doing a body of work around how to upskill our staff in applying a gender lens to the analysis and advice that we provide and in the ways in which we can leverage the levers we have available to us to advance gender equality, including upskilling staff in social procurement strategy; developing and supporting the use of our internal designing for diversity framework; also—I think you have heard from DPC—two of our divisions participating in a pilot for the whole-of-government gender impact assessment toolkit; and really through our annual cycle of strategic and investment planning, looking at using data and analytics in a more sophisticated way, as well as feedback loops from the users and providers of our services to make sure we do have an increased focus on intersectionality, priority populations and outcomes, better capability in service design, place-based work and capturing client voice and linking our administrative data to data on experience and outcomes to measure and evaluate the impact of assessments and inform our bids to Government as well as then applying a gender lens to our ongoing monitoring of impact.

Coming to the last slide, I think I would reflect that we have provided more advice on those targeted investments to really address gaps in outcomes than we have on how we could leverage significant government programs and initiatives to further gender equality. I think that is a space where we could do more. For example, across Health and Human Services this could include embedding our focus on female representation on boards into our social procurement policies that are applied to our significant infrastructure program or working across the department to better combine our health promotion programs with our housing renewal projects to reduce falls for women associated with musculoskeletal conditions as one of the major burdens of disease for women.

To return to my earlier comment about avoiding a tick-box compliance mentality, based on my experience to date in DHHS I do think a more systematic adoption of gender responsive budgeting requires both technical and cultural change. I would suggest adopting more mature gender responsive methodologies and capabilities more quickly across the department, but also across government more generally, if we do take an applied approach. We can focus on a few priorities, both for that targeted investment and for leveraging major government initiatives, and through the practice of applying gender budgeting tools to our planning analysis design and implementation build some of those foundational enablers, whether it is the sorts of metrics we should use and the sorts of tools we should use in gender impact assessments, so that we can then spread those learnings and make gender responsive budgeting BAU across government rather than something that we have come to at the end of a big preparation or implementation process.

The DEPUTY CHAIR: Thank you, Secretary. I will lead off the questions. I would make the observation you spoke of the gender lens and 'tick-box' as the things you try to manage that issue. You also made the observations that generally Health and Human Services are quite good at targeting funding for disease based on gender issues, and I think the evidence is out there that we have gone a long way in recent decades towards making a difference there. In my previous life I had a long stint in hospital administration, and at that time and now in this current role as a Member of Parliament the one issue that Health and Human Services to my mind has still not been able to deal with successfully is around compassion and empathy. The concern that I see through my office time and time again is that if two people have the same condition and one can tick more boxes, they will get a different level of treatment than the one who does not tick boxes. That is always a frustration and a concern for me, because it will often take a phone call and the statement of the bleeding obvious about a person, 'Why were they treated this way?', and then the problem can be easily fixed. With gender budgeting, I guess the concern I would have is if we then create another lens, in your words a 'gender lens', that we look through for a problem, and then an Aboriginal and Torres Strait Islander lens and a refugee lens and all the other lenses that we are continually putting on in order to make us a better service, we are actually potentially fragmenting the service. So my question is: are we creating so many lenses that we could just have a whole-of-person lens and say, 'How is the best treatment for this person available? Can we sit down and listen to the person?'. Because I think the health and human services industry by its very nature is full of people who have done a lot of research and a lot of study and they are very good at analysing facts and figures, but sometimes you just have to listen to the person's problem.

Ms DURHAM: Yes.

The DEPUTY CHAIR: And that would be my concern. When I was listening to you talk, I was thinking, 'Oh, great, another box that will need to be ticked in order for someone to be looked after in our health services'.

Ms PEAKE: Look, I think your starting point is absolutely right—that empathy and kindness have to be at the heart of a good relationship between either a clinician or a practitioner in social services and the person who is coming forward to receive a service, but I would say that actually the toolkit that DPC have prepared does not ask you to slice a person up into different characteristics. It really does apply an intersectional approach to say, 'What's going on for this person in their life? What's the context of the life of this person that is going to impact on their confidence to approach a service, their experience of engaging with this service and the sort of outcomes that they are going to be seeking?'. In other words, if you are an Indigenous woman, if you are a woman with a disability or if you are an older migrant woman with language barriers, to be kind and empathetic there is actually more to delivering the service than, as you say, the technical proficiency of saying, 'You have this condition and this is the medical treatment that you require'. Increasingly the conversations that

we are having with all of our clinicians and practitioners are around how you understand a person in the context of their life and how you tailor customised service responses accordingly.

I think the family violence work is really, really interesting in that regard. You have a clinician who has a duty of care and a responsibility to provide really high quality health services but increasingly is more alive to 'What are the risk factors for this woman outside of the hospital that are going to impact on her recovery, that are going to impact on her ability to maintain a treatment regime that is recommended on discharge, and what might the other services and supports be that we could connect her with that will enable her health outcomes to be achieved?'.

So in fact I would say that applying a gender lens but also one embedded within that broader intersectionality of the factors that contribute to experience and outcomes will enable there to be a better service, a more holistic service, whole-of-person service provided and better connections between the different range of health and human services that we are stewards of.

The DEPUTY CHAIR: So when we talk of gender budgeting in health and human services, we are not going to see a situation where various service providers, whether it is in the community services or at the acute end, are going to be looking to fulfil budgets in terms of, 'We haven't seen enough of this type of person or that type of person so let's prioritise them'.

Ms PEAKE: I think it is much more about saying if there are people who are not accessing a service, why are they not accessing a service, and how do we need to adapt our service to make sure that we are inclusive and responsive? Again, I use the example of migrant women who are now reaching the 60 and 70 age cohort, many of whom are reverting back to the language that they grew up with. And so, again, a lot of our health services have been mindful, particularly in the north, that actually there is a group, a really high-needs group, who are only hitting the hospital at the emergency department because they are not well engaged with primary care, and when they come into the emergency department they have a much more negative experience because they find the communication and understanding what is going on quite complex. And so having interpreters and having different types of spaces and having different pathways of care with primary care is a direct consequence of really thinking about who is in their catchment, who is the population they are serving and how might services need to adapt accordingly.

Ms RICHARDS: Thank you so much again for the evidence; that was really insightful. I am actually wanting to segue from the Deputy Chair's insights. I was reading and delighted to hear about the $23 million for screening for breast cancer. I am interested in that evidence you gave around the intersectionality of people who are experiencing perhaps another level of disadvantage because of their cultural background. I am wondering if you have any insights, especially in light of what is going on in other jurisdictions, about how we can add that lens, that gender responsive lens, particularly over breast screening rates for our culturally diverse women. That is something that I am interested in because we have had some analysis recently that shows that some areas of Victoria have lower screening rates and they perhaps might also be places where there are women who experience extra barriers to accessing preventative screening or screening anyway. So I am interested in whether you can use breast screening particularly to highlight how the department is making sure that we get the care we need to people who are most at risk.

Ms PEAKE: Thank you. I think there are a few ways to this. One is just really how you raise awareness of the benefits of the screening and how to access the screening, thinking all the time about not just how you provide information in different languages but also what are the channels to get that information out, partnering with a broad range of community groups that might be ethno-specific or might be places that we know in local communities that people feel comfortable to spend time, to make those resources more readily available. It is then a question of how the screening is actually done, where and how it is done. So increasingly we are looking at models where, whether it is screening or treatment, it is back out in the community rather than asking people to come into a more medicalised-feeling place. And then the discussion that we had at the health ministers advisory council on Friday was making sure that the actual funding models have a component in them that reflect an extra period of time that might be needed to be spent with someone, a follow-up that might be required, so that there is a cultural component or an equity component that is built into the funding model. I think at the moment a lot of the business models for GPs and for specialists are pretty fee-for-service and

episodic rather than building a relationship with a patient and spending a bit more time. That is not just about Commonwealth programs; it is also about how we design some of our funding models as well.

Ms RICHARDS: And are there other jurisdictions we can look to, not just in Australia but overseas, where perhaps they are doing it really well, that we could learn some lessons from in terms of that gender responsive budgeting lens overlaid with those other social determinants of health?

Ms PEAKE: Yes, certainly I think in some of the Scandinavian countries they have had much more of a population health approach. We have still got a health system that has been premised on responding to infectious disease and trauma but increasingly we are needing to respond to chronic disease and preventative population-level health. Look, I would not say there is anywhere in the world that has completely cracked this nut, but I do think with some of the Scandinavian countries where there is a bit more of a culture of thinking about the whole population, there are lots of rich learnings for us about some of those methods of engagement, methods of partnering with patients and methods of combining social prescription with medical treatment.

Ms RICHARDS: Fascinating. Thank you.

Ms STITT: I found it very refreshing to hear you talk about not going down a compliance tick-the-box road and giving us some really concrete examples and powerful examples of why gender responsive budgeting really matters in your department, because at the end of the day we are trying to tackle gender inequality. Can you give me a few examples of how you are tackling the culture in your department in making sure that, not just at a senior level but across the department, people understand the importance of making this part of everything we do?

Ms PEAKE: Yes. Look, this will sound like a slightly technical answer, but one of the things we have done over the last couple of years is really put our outcomes framework and key results at the forefront of how we work across the department so that we are really focused on who we are designing services for and how we will know if what we are designing is actually having an impact. That has led to—and Amity might want to talk a little bit more about this—us really using data and analytics very differently to link up all of our different administrative systems so that we know a lot more about service usage and who is not using our services, which then just begs lots of questions so we then go in with more structured methodologies for engaging with people who are our clients and our patients to better understand their experience, what outcomes matter to them and, if there are people who are missing out, why are they missing out?

The last bit then is the sort of management training that we are doing to really reinforce that how we work in the department, how we focus on people, the recipients of our services, but also how we can complement each other by working together across the department and across Government, is really then enshrined in the values and leadership behaviours that we are going to hold ourselves to account for. So it really does come from the inputs that we make use of, the way that we work with patients and clients and service partners through to the leadership values and the sort of code of conduct, if you like, that we are going to set for ourselves about how we are going to do our work.

Amity, I might just get you to reflect a little bit. I think one of the things that has been transformational has been how we have been using data that tells you a story about people, so it is not just facts and figures but draws out the journeys people take through service systems to really change the way we are designing.

Ms DURHAM: In our department we started with our own datasets—about 30 datasets—and those are service usage across our health but also our social services. We are able to link those and then have de-identified datasets that we can use for analytic and planning purposes. As Kym said—and we are probably about 12 months in—we have also begun to link, on behalf of the whole of government, with other departments' data, like justice and education. It enables us to look at different scales. So we can look at whole-of-population level but we can also start to segment our clients into different groups with different needs and have a look at what the service usage profile looks like. That can give us insights into both service access but also outcomes, because we can see service pathways, for example, starting with school attendance through to school results. We can see out-of-home care and child protection experience, and then we can start to see impacts in terms of health—mental health, emergency department service usage, justice contacts—and really start to plot out what pathways look like. In this context we can also take a gender lens to that and then sort of

deep dive into different groups within our clients to have a look at what both access experience and also outcomes look like. We are using this to inform our identifications of need and where we target our investment and effort, but we can also use the finer grain analysis to inform some of that service model development, as Kym said. So when we then talk to service providers or talk to our clients we can start to share some of those early insights, test them, but also add to it with some rich client experience information so we are designing services that are more tailored, more person centred, and more able to achieve better outcomes.

Lastly, we can use the linked data in terms of measuring impact as well. We are starting to use that with our evaluations of programs. We can actually identify clients who have received a certain service and see what changes that has enabled in their service use over time. So, for example: did we reduce emergency department presentations? Did we see an increase in access to mental health services if there is identified need? Or did we reduce criminal justice contacts? So it is a really powerful tool that we can use both to assist gender responsive budgeting but also that big shift Kym is talking about in our department—about using evidence data in how we make decisions and assess our own performance.

Ms PEAKE: Sometimes it is completely intuitive. And actually it is as important, if not more important, to be really connected out in the field, getting the feedback loops from people who are using our services about what matters to them. But sometimes that data analysis actually gives you insights that we just have not intuitively or through experience understood as precisely before. So, for example—and this is actually a male example rather than a female example—the analysis that Amity's teams did really pointed to the fact that we were seeing an increase in young men with autism who were not getting NDIS plans and who were ending up being relinquished by their parents and entering the statutory out-of-home care system. Because of their behaviours it was really difficult to find foster carers or kinship carers who had that kind of support and expertise to care for them. We could provide quite specific data on the numbers of young boys who were coming in to resi care and we were then able to negotiate with the Commonwealth a cost-sharing arrangement for new models of care and accommodation for that group, which hopefully means that more people can actually stay at home and have respite care so parents are not feeling the need to relinquish, but where there are young people who are in resi care there is a more fit-for-purpose service model that is then available for them.

Ms STITT: I think you were part of the trial for the gender responsive budget tool. What are your key take-outs from that?

Ms PEAKE: We trialled it in two divisions. One was in out-of-home care and the other was in the Office for Youth, which has now moved into DPC. In the out-of-home care space it really elucidated for us that we did not have policies on entry into care that were very focused on young people who identified as LGBTI, and so we were sort of putting trauma over trauma on them. That has led to a different approach to how we engage with young people and coming into care. The other piece that it really elucidated was that comment I made during my opening remarks—about the intergenerational transfer of young women who had not had role modelling around parenting then becoming parents and not feeling very confident and capable about parenting their own children—so building much more into our out-of-home care services that focus on your future as an adult, how you will form relationships. We certainly provided some feedback too about what were parts of the methodology that were really easy to use and where were bits where it did feel a little bit clunky, and I think it has been a good process of continuing to evolve and improve the toolkit, but overall our staff said that it was a really positive experience and it got them to ask some slightly different questions.

Ms VALLENCE: Hello, team. Thank you for your presentation. I have got probably two main questions, and firstly I would like to agree with Ingrid there around not taking that compliance box-ticking approach, because this should be something that is cultural, that just should be embedded—something that we do anyway—in the culture of any organisation or workplace. Obviously a couple of years ago the Government had their Victorian gender equality strategy, which required looking through a gender lens for policies and budgets, and through your presentation today you have already identified areas using this gendered lens that informs your thinking, what you are doing through your service provision, targeted investments in DHHS and investment dollars in budgets past that you have mentioned for breast screening and other issues. So in your view why do we need this new law?

Ms PEAKE: I think two things: one is that whilst I think there are great examples of how we have focused on and sought to address particular inequities in outcomes, as I touched on in my comments, I do not know that

we have systematically looked at those questions of intersectionality and looked at the different forms of evidence that can contribute to really understanding what is going to have the most impact, taking account of what has been the context for either particular people missing out or there being higher rates of a particular need for subpopulations. So I think this law and these toolkits will just provide us with the tools and guidance to help us keep maturing and strengthening our analysis and our methodologies.

The second thing that I would say is that—again as I tried to touch on—where I do not think we have been as focused is working across Government to think about, when there is a big major initiative, how do we know what the experience of implementation is going to look like, how do we model that and then how do we test that for women? One of my favourite stories recently, it is not an Australian example actually but in Sweden—I think it was Sweden—they had an approach to snowploughing each year. The approach that they had taken, which was very rational, was to say, 'We will focus on the big arterial roads to snowplough and we will put less attention onto the side roads', and then when they started applying a more focused gender lens, they realised that they were having an increase in hospitalisations of women who were having falls because—this is generalising—at higher rates men were driving into work on the main arterials and women were driving to work but on the way were dropping the kids at child care or doing the shopping, doing various things, so the roads that they were walking on or driving on were the ones that had not been snowploughed. If you just took a macro view, that would not really be identified. By virtue of having done that analysis, they changed the pattern of how they applied their snowploughing and they had a massive decrease in emergency department presentations.

Ms VALLENCE: In that example and also in the examples that you have presented you are presenting a state of affairs where DHHS is already looking through this gendered lens, is already doing this work, is already thinking around how you deliver services in this way and seek investment dollars through the budget. So it is still not clear to me why a new law—what would a new law do to change? How will it make a difference if you are already doing this work? How will it make a difference?

Ms PEAKE: I think in that second example—we do not do snowploughing, obviously—I do not think that we bring the same attention to thinking about what the connection is between built form, urban design and outreach from health services for older women who are living at home to reduce falls, for instance.

Ms VALLENCE: So do you think by having a law, and therefore a compliance regime and a compliance framework—going back to that box-ticking exercise which you at the top said you are not doing, having a box-ticking exercise by having a law and a compliance regime, and presumably possible penalties for departments that are perhaps not doing this, that were referred to in the last presentation—do you think that is a path we should be going down?

Ms PEAKE: I guess there is a bit of an assumption in the way you have asked me that question that the approach to implementation will be more technical and less cultural and adaptive. I guess my reflection would be that having responsibility in law is powerful for the public service because we do refer to legislation to really look at our obligations and responsibilities, but how you implement that legislation, I think, should be really applied so that it should be embedded in the doing. It should be learning by practice about what are the big initiatives, and if we really deep dived into them and asked some different questions than we traditionally ask about transport projects or new building regulations, about how they will play out in practice, and you actually ask some of those gendered impact questions, you might come up with quite different solutions. That snowplough example shows how that might occur. But I agree with you that it should not be just: you have acquitted the legislation by putting a form on the top of your budget bid that says you have done a gender impact analysis. It is really all the tools and guidance and cultural change about how you ask different questions and do different forms of analysis.

Ms VALLENCE: Given our aspirations that this is cultural anyway I query why we need a new law to do it. My other question is quite different. You mentioned in your answer to one of my colleagues previously around, through health services, trying more and more to develop a relationship with the person that you are providing the service to—so perhaps a woman or anyone. You are trying to get away with, I think the example you mentioned was GPs having the 15-minute sessions and it is hard to make a relationship with the person that they are seeking to help, so it is about developing relationships in health care. With my own child and my experience in the hospital system, with the government's move away from having dedicated doctors for a child

who has an ongoing issue and moving—I am talking about my child but I understand this is happening in other areas—to super clinics and therefore not having dedicated doctors to see that patient through their needs over time, how then do you see that this is developing relationships?

Ms PEAKE: Sorry, just so I understand the question, in terms of super clinics are you talking about GP clinics or are you talking about—

Ms VALLENCE: The example I am using is in the Royal Children's Hospital, but understanding and talking with other people who are also accessing healthcare services in the hospital system who used to have a doctor that they would be able to build a relationship with, now increasingly they are unable to do that. They go for their annual assessments and there is a super clinic, so there is not a doctor. It is like going to the deli and picking a number. How do you see that that is going to help in this gender responsive approach if through your application you are actually going to super clinics? To me it would seem that you cannot actually develop relationships with the patient.

Ms PEAKE: Again, I would probably make two comments. Definitely the direction that health is heading is to have more integrated models of care in the community that really involve a team. So it has your GP, your specialist and then your acute care really having more seamless interaction. Actually what I think you will see more and more in the future, rather than there being more sort of handover points without a warm handover, is actually a pathway of care, and cancer is the best example of how we have designed optimal care pathways where that is not the experience. The second thing I would say, in support of that, is obviously then the use of technology and information systems so that, for example, if you are living in Wangaratta, you do not have to come to Melbourne to see a specialist but you can actually have a telehealth consultation—so you are with a doctor who has a relationship with you but then can have that specialist input. I am sorry you had that experience, but I do not think that is the model of care that is emerging.

Ms VALLENCE: It is not just me; I know many people are experiencing less in this regard, but anyway.

Mr RICHARDSON: Just a quick one, Kym. Thank you for your presentation——the wraparound and the discussion on gender responsive budgets. Just a question that we put to the Department of Premier and Cabinet related to sexual harassment and the worrying figures out of VAGO's report: do you see that the gender responsive budgeting around the 3 per cent reporting of the public service that are coming forward, out of 21 000 that are impacted, could have an impact on increasing the rate of people coming forward, and how would the department's budgets be looked at in terms of addressing that real cultural problem?

Ms PEAKE: I can certainly see a link between the more that we are talking about respect for women—the more that we are talking about the importance of tackling gender inequality—and the more we create environments where there is not a tolerance for inappropriate behaviours. A lot of our People Matter surveys would say the experience of sexual harassment often is in the form of inappropriate jokes and inappropriate comments. So we create an environment where there is more respect and that helps prevent some of the incidents of sexual harassment.

Then, secondly, I think that the focus on structural drivers of gender inequality definitely means that we are paying more attention in our internal allocation of resources to looking at what we can do to reduce those structural drivers. Whether that is the pay gap, whether that is the experience of sexual harassment or whether it is the experience of returning from maternity leave and missing out on progression, there is a whole range of structural determinants. I think this sort of budgeting approach—the sorts of questions we are asking ourselves—will lead us to make better decisions about how to use our discretionary internal resources.

Mr RICHARDSON: Is that a key element, I guess, of the Bill as well that is coming forward and how that complements the budget allocation as well? Is that a driver that the Department of Health and Human Services will put forward?

Ms PEAKE: Yes, definitely. It really comes back to Ms Vallence's questions about how the legislation is a sort of driver of cultural change more broadly.

Mr RICHARDSON: Fantastic.

The DEPUTY CHAIR: We thank you, Secretary Peake and directors, for your time this morning.

Witnesses withdrew.