Australian Pain Society

Women And Girls Need Timely, Equitable Access To Whole Person Pain Care

Submission by the Australian Pain Society
Select Committee on Women's Health

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Foreword And Introduction

On behalf of the Australian Pain Society (APS), I welcome the opportunity to submit to the Senate Inquiry into Women's Health.

APS is Australia's leading multidisciplinary society for clinicians, researchers and educators working in pain. Our vision is that all people will have optimal pain management throughout life. Through education, research collaboration and evidence-informed advocacy, we strengthen clinical practice and contribute to better pain policy. As the Australian chapter of the International Association for the Study of Pain, we connect Australian expertise with international research and practice.

Our membership includes medical practitioners, nurses and nurse practitioners, allied health professionals, researchers and educators. Members work across hospitals, private practice, community services, universities, research institutions and government organisations, bringing perspectives from direct patient care through to health system improvement.

APS leadership and governance

APS is governed by an elected Board with representation from every state and territory and supported by a Secretariat. Its leadership brings expertise across clinical practice, research, professional education and multidisciplinary service delivery.

Current senior office bearers include:

- **Bernadette Smith, President** — senior psychologist and Managing Director of Pain Solutions, Tasmania.
- **Dr Laura Prendergast, President-Elect** — senior psychologist, Persistent Pain Management Service, Northern Health, Victoria.
- **Dr Duncan Sanders, Treasurer and Scientific Program Committee Co-Chair** — pain management physiotherapist and Senior Lecturer at the University of Sydney; Managing Pain Clinic, Gold Coast.
- **Jacintha Bell, Secretary** — occupational therapist, Lifeworks Occupational Therapy, Western Australia.

Our contribution to this inquiry

This submission draws on the Society's comprehensive clinical, research and educational expertise, including contributions from our recently formed **Pelvic Pain Special Interest Group**. The group provides a dedicated focus on pelvic pain within APS's broader multidisciplinary work, connecting specialist expertise with women's healthcare experiences and access to appropriate care.

Our central message is that persistent pain must be recognised and treated as a pain condition in its own right. Women and girls deserve to be heard, believed and offered timely, whole-person care. We ask the Committee to prioritise early intervention, equitable access to multidisciplinary care, a workforce trained in contemporary pain science, and research and outcome measurement that reflect women's priorities.

Improving pain care for women and girls will strengthen pain care for all Australians. APS would welcome the opportunity to appear at a hearing and provide further evidence and information to assist the Committee.

Bernadette Smith MAPS MSciMed (Pain M'ment)
President, Australian Pain Society

Australian Pain Society Key Message: Women And Girls Need Timely, Equitable Access To Whole Person Pain Care

Women bear a greater burden of pain than men, experiencing higher rates of both chronic and everyday pain and greater prevalence of many painful health conditions. Yet evidence shows their pain is less likely to be taken seriously and is more often delayed in diagnosis and undertreated, highlighting a persistent gender pain gap (Laughey et al., 2025). This gap is not confined to pelvic pain. Many persistent pain conditions are more common in women, including migraine, fibromyalgia, temporomandibular disorders, irritable bowel syndrome and musculoskeletal conditions such as osteoarthritis and back pain (Venkataraman et al., 2026). These conditions frequently co-occur, so a woman with pelvic pain may also live with headache, bowel or widespread pain. This submission uses persistent pelvic pain as a detailed example, but its recommendations apply to women living with any persistent pain.

Persistent pain is a health condition in its own right. This includes persistent pelvic pain, whether or not it is associated with endometriosis. It often begins in adolescence, is too often dismissed as normal, and affects every part of a woman's life. This submission uses persistent pelvic pain as a detailed example, but its recommendations apply to women living with any persistent pain.

Among people experiencing socioeconomic disadvantage, persistent pain is more common, and often more disabling (Blyth et al., 2001). Access to multidisciplinary pain care is uneven. Women in rural and regional areas, Aboriginal and Torres Strait Islander women, culturally and linguistically diverse communities, women with disability and those on low incomes face additional barriers of cost, distance and a lack of culturally safe services (AIHW, 2023). Whole-person care therefore means addressing these social determinants of health as part of pain care, not treating them as outside its scope.

Persistent pain, across all conditions and diagnoses, responds best to timely, whole-person, multidisciplinary care that listens to the woman, understands her pain in the context of her life, and offers her real choices. Australia possesses an established framework through the National Strategic Action Plan for Pain Management, providing a national foundation for pain care across all populations. However, delivering meaningful outcomes for women and girls requires dedicated funding and systematic implementation that explicitly addresses sex and gender differences in pain. Good pain care for women is good pain care for everyone: broad, holistic, individualised and built on shared decision-making. Investing in it for women and girls will strengthen pain care for all Australians.

APS Recommendation 1. Recognise persistent pain as a condition in its own right, and fund whole-person care that addresses the social determinants of health.

The Australian Government should recognise persistent pain in women and girls, including persistent pelvic pain, as a health condition in its own right, and fund implementation of the National Strategic Action Plan for Pain Management with a sex and gender lens. Funding and models of care should address the social determinants of health through bulk-billed or publicly funded multidisciplinary pathways, telehealth, interpreters, culturally safe services and links to social, employment and financial supports, prioritising women who face the greatest barriers to care.

Our Five Priority Recommendations

Of the 24 recommendations in this submission, APS calls on the Committee to prioritise these five areas for immediate action:

Recognise persistent pain as a pain condition in its own right.
Persistent pain, including pelvic pain, whether or not associated with endometriosis, should be recognised as warranting timely, whole-person, multidisciplinary care that addresses the social determinants of health consistent with the National Strategic Action Plan for Pain Management.

(Recommendations 1 and 3).

Make multidisciplinary care the standard, not the exception.
Allied health should be funded as a core part of publicly funded pelvic pain services, and Medicare reformed so that pain medicine and allied health care are adequately rebated, with session numbers that reflect clinical need.

(Recommendations 7, 11 and 12).

Intervene early, and listen first.
Severe period pain that affects a girl's or woman's functioning should be assessed and managed without waiting for a diagnosis, and care should be whole-person, patient-centred and trauma-informed from first presentation.

(Recommendations 3, 4, 5 and 6).

Build a pain-literate health workforce.
Contemporary pain science, including sex and gender differences in pain, should be strengthened in training across every health discipline.

(Recommendation 9).

Measure what matters.
A sustainable national pain outcomes data collection, with sex-disaggregated and pelvic pain-specific measures, would show which treatments and models of care work for women.

(Recommendations 22 and 23).

Terms of Reference Addressed

This submission addresses the following Terms of Reference of the Senate Select Committee on Women's Health, with a particular focus on persistent pelvic pain:

(i) The ways in which women and girls experience recurrent, severe, or long-lasting pain conditions;

(j) Women's experience in seeking appropriate healthcare responses to pain, including experiences of medical misogyny;

(k) Barriers to effective pain management, including the range and affordability of available treatments;

(n) The regulation of medical devices used in women's healthcare treatments, including risk assessments, monitoring and reporting;

(o) The role of relevant regulators and other agencies in responding to complaints regarding medical devices; and

(p) Any related matters.

Victoria's Inquiry Into Women's Pain

Victoria's Inquiry into *Women's Pain report, Bridging the Gender Pain Gap (2025)*, identified unmet healthcare needs, gaps in research and representation, gender bias in healthcare and barriers to accessing care. It made 27 recommendations across seven key areas: women's health research; policy strengthening; training and professional development; cultural change and public awareness; models of care; building our specialist workforce; and affordable and accessible healthcare.

The table below summarises the focus of these recommendations rather than reproducing them verbatim.

	Priority area	Focus
1	**Women's health research**	Strengthen research funding, sex- and gender-specific approaches, clinical standards and clinician resources.
2	**Policy strengthening**	Develop a women's pain action plan, embed lived experience in policy, improve feedback and complaints processes, and strengthen workplace support.
3	**Training & professional development**	Improve communication training, establish consistent pain training requirements, strengthen women's health education and provide specialist advice for clinicians.
4	**Cultural change & public awareness**	Address gender bias and stigma, establish an online pain information directory, improve accessible and culturally appropriate information, and expand school education.
5	**Models of care**	Enable person-centred care, strengthen referral pathways and care coordination, improve information sharing, and expand access to non-surgical care, allied health and peer support.
6	**Building the workforce**	Support recruitment and retention, enable full scope of practice, and align training placements with workforce and community needs, particularly in regional and rural areas.
7	**Affordable & accessible healthcare**	Advocate for Australian Government action on costs and access, and increase Victorian investment in specialist women's health and pain services.

APS Recommendation 2. Adopt the Victorian Inquiry recommendations nationally.

APS supports these recommendations and urges their national adoption (APS Recommendation 2). In extending Recommendation 3.3 nationally, APS encourages a focus on sex and gender differences in pain, not only women's health, and in all health disciplines, not only medicine (see ToR (k)).

Source: Victorian Government, Bridging the Gender Pain Gap: The Inquiry into Women's Pain Report 2025, pp. 28–34. Recommendation summaries are paraphrased.

Addressing The Terms Of Reference

(i) The ways in which women and girls experience recurrent, severe, or long-lasting pain conditions

1. Pelvic pain starts early, is common, and is too often treated as normal.

Most girls and young women have period pain. In a national survey of 4,202 Australians aged 13–25, 92% reported period pain. Around half had missed at least one class or lecture in the previous three menstrual cycles. Most reported trouble concentrating in class during menstruation: 77% of those at school and 70% in tertiary education. Higher pain scores were strongly associated with more absenteeism and poorer academic performance. Yet most would not tell teaching staff, including 60% of school students and 83% of tertiary students (Armour et al., 2020a). Data from the Longitudinal Study of Australian Children confirm that menstrual pain in adolescence commonly disrupts school and everyday activities (Cameron et al., 2024).

APS emphasises that reducing diagnostic delay is only part of the response. Period pain that interferes with school, work or daily activities warrants timely assessment and active management. Girls and young women should not have to wait for a confirmed diagnosis of endometriosis or another condition before receiving care that takes their pain seriously and addresses its impact.

2. Adolescence is a critical window.

In early childhood, boys and girls have similar rates of chronic pain and similar sensitivity to pain in experimental studies. From around age 12, girls show higher rates of chronic primary pain and greater pain sensitivity than boys (Fillingim et al., 2009; Boerner et al., 2014; Hagy et al., 2025). Chronic pain becomes markedly more common in girls between ages 12 and 14, and girls are more likely than boys to report pain at multiple sites and at higher intensity (Perquin et al., 2000).

Adolescent period pain is not a passing inconvenience. A large UK population-based cohort found that dysmenorrhoea in adolescence is associated with an increased risk of chronic pain in adulthood (Reid-McCann et al., 2025). Australian longitudinal data link adolescent menstrual pain with poorer mental health in adolescence and early adulthood (Cameron et al., 2025). Effective early care is therefore an opportunity to prevent persistent pain and disability in adult life, not only to relieve pain in the moment.

3. Persistent pelvic pain must be recognised and treated as a pain condition in its own right

Persistent pelvic pain is complex and often involves several overlapping conditions, including endometriosis, irritable bowel syndrome, bladder pain syndrome, vulvar pain and pelvic floor muscle pain. Changes in how the nervous system processes pain, including increased sensitivity known as central sensitisation, can contribute to ongoing symptoms. Assessment and treatment must therefore consider the whole person and the multiple factors contributing to her pain.

Pelvic pain also rarely occurs in isolation. Many women with persistent pelvic pain also live with other persistent pain conditions, such as migraine, fibromyalgia, temporomandibular disorders and back pain, many of which are themselves more common in women (Venkataraman et al., 2026; Maixner et al. 2016). Shared changes in how the nervous system processes pain help explain why these conditions so often occur together, and why care focused on a single organ or diagnosis can miss the whole picture.

Women with persistent pelvic pain without endometriosis can experience a similar impact on their lives to those with endometriosis (Armour et al., 2020b). The extent of endometriosis does not reliably indicate pain severity, and surgery does not consistently resolve persistent pain. While surgery may be appropriate for some women, it should form part of an individualised care plan that addresses other contributors to pain and supports function and quality of life.

This whole-person approach is supported by the Faculty of Pain Medicine's statement on persistent pelvic pain and endometriosis and the November 2025 joint statement on best-practice management of endometriosis and pelvic pain. The joint statement brings together five major professional bodies representing gynaecology, surgery and multidisciplinary pain care across Australia and New Zealand: the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Australasian Gynaecological Endoscopy and Surgery Society (AGES), the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (FPM), the Australian Pain Society (APS) and the New Zealand Pain Society (NZPS). Together, they support timely access to coordinated, multidisciplinary care that responds to women's needs and experiences.

4. Pelvic pain affects relationships, employment and financial security

Persistent pelvic pain can affect every aspect of a woman's life. An Australian online survey of 409 respondents, published by Armour and colleagues in 2020, documented substantial impacts on relationships, education and employment among women both with and without a confirmed diagnosis of endometriosis. Respondents described difficulties with intimate relationships and friendships, disruption to work and, in some cases, losing their job because of pelvic pain (Armour et al., 2020b).

> In a related economic study, researchers from Western Sydney University and UNSW estimated annual costs of Int$20,898 per woman with endometriosis.

These estimates included healthcare, carer and productivity costs and were expressed in international dollars adjusted for purchasing power, using 2017 prices. Lost productivity accounted for 75–84% of total costs. Among respondents with endometriosis, productivity costs were approximately 12.5 times higher for those reporting severe pain than for those reporting minimal pain (Armour et al., 2019). These findings strengthen the case for care that improves pain, function and participation in work and daily life.

APS members working in public pelvic pain services report seeing these pressures regularly. Women describe missing work, reducing their hours or being unable to pursue their preferred employment. Some have exhausted their sick leave and worry about paying rent when their next period is due. These clinical observations highlight why effective pain care must consider financial security and employment alongside symptoms.

5. The psychological and social burden of pain is substantial, and closely linked to pain severity.

Years of severe, often dismissed pain commonly bring anxiety, hypervigilance, low mood and loss of trust in healthcare. Experiences of trauma, including medical trauma, are common among women attending pain

services. Trauma does not cause pain, but stress and threat responses are protective in the same way pain is. They can amplify pain and must be understood and addressed with care. Social circumstances such as insecure work, housing and income, distance from services, and limited family support shape both the experience of pain and the capacity to access care (see Recommendation 1). These findings are not unique to young women with pain; the Senate Community Affairs References Committee's 2024 inquiry into issues related to menopause and perimenopause highlighted the 'quiet' struggle perimenopausal women face with balancing debilitating symptoms such as pain and their social roles such as work and caring for children.

A de-identified example from a public pelvic pain clinic illustrates the importance of understanding pain within the context of a woman's circumstances and life:

> A young woman in her twenties has had pelvic pain for more than a decade, alongside bladder and bowel symptoms, back pain and sleep disruption. She has seen many clinicians, had a laparoscopy that found little endometriosis, and holds down a job she is afraid to leave because her employer tolerates her absences. With no sick leave and little family support, her greatest fear each month is not the pain itself but losing her housing. Her pain cannot be understood, or effectively treated, without understanding her circumstances.

Her experience is not uncommon and highlights why the APS is calling for care that addresses the clinical needs and the social and economic circumstances that shape a woman's ability to access treatment, remain in work and treat the whole person, not just the symptoms. Patient-centred care starts with listening (Slater et al., 2022). That means hearing what the woman is experiencing, what matters most to her and what she fears, and learning from her about her life. Her pain is understood in the context of her body, her history, her relationships, her work and her social circumstances, and her care is planned with her, not for her. A multidisciplinary team, bringing together medical, nursing and allied health care, is how that understanding becomes effective treatment.

6. Persistent pain after birth is common, but not normal.

Pain is one of the most common physical consequences of pregnancy and birth, yet it is rarely named in postpartum policy. In 2023, more than 280,000 women gave birth in Australia, and 41% gave birth by caesarean section (AIHW, 2025). Persistent pain after childbirth is a recognised clinical condition, but it is rarely looked for. A meta-analysis found persistent wound pain in around 15% of women three months after caesarean section and 11% at 12 months or longer (Weibel et al., 2016). With more than 115,000 caesarean births a year in Australia, that suggests well over 10,000 women each year may still have pain a year later. Persistent perineal and pelvic pain also occurs after vaginal birth, particularly after perineal injury or instrumental delivery (Komatsu et al., 2020).

Pregnancy-related pelvic girdle pain affects around one in five pregnant women and persists after birth for some (Wu et al., 2004). Postpartum pain with intercourse, back pain, and pain associated with pelvic floor injury are also common, and often go unreported because women assume they are a normal part of recovery or are told so. Persistent pain after birth affects a woman's ability to care for her baby, return to work, resume sexual relationships and consider future pregnancies. As with adolescent period pain, postpartum pain should not be treated as something women must simply endure.

7. Pain after birth is a predictor for persistent pain and depression.

The severity of acute pain after birth matters beyond the first few days. A prospective study of more than 1,200 women found that severe acute pain after childbirth predicted both persistent pain and postpartum depression, whereas the type of delivery did not (Eisenach et al., 2008). A history of other persistent pain and severe acute postoperative pain are among the strongest predictors of persistent pain after caesarean (Komatsu et al., 2020).

These findings have two implications. First, good acute pain management after birth is not only about comfort; it is an opportunity to reduce the risk of long-term pain and to support maternal mental health. Second, women at higher risk can be identified, including those with existing persistent pain conditions such as persistent pelvic pain or endometriosis, and their pain should be planned for during pregnancy, not as a postpartum after thought.

APS recommendations: ToR (i)

APS Recommendation 3. Develop national guidance and a model of care for persistent pelvic pain beyond endometriosis.
The Australian Government should fund national clinical guidance and a model of care that ensures severe menstrual pain affecting daily functioning is assessed and actively managed without waiting for a confirmed diagnosis. Investment in pelvic pain care must also support women and girls whose pain is not caused by endometriosis, including those with persistent postpartum pain.

APS Recommendation 4. Prioritise early intervention for adolescents with significant period pain.
Governments should fund school-based menstrual health and pain education, alongside accessible primary care pathways, to support timely assessment and management and reduce the risk of persistent pain continuing into adulthood (consistent with Victorian Inquiry Recommendation 4.4).

APS Recommendation 5. Embed whole-person, patient-centred care from the first presentation.
Care for women and girls with persistent pain should begin with listening to and learning from each person, understanding her pain in the context of her life, and planning care with her through shared decision-making and a multidisciplinary team (consistent with Victorian Inquiry Recommendation 5.1).

(j) Women's experience in seeking appropriate healthcare responses to pain, including experiences of medical misogyny

1. Women's pain is too often disbelieved and dismissed.

Women and girls consistently report that their pain is minimised, normalised or attributed to psychological causes without adequate assessment. Among Australians with endometriosis, dismissal of pain by doctors was the most commonly reported reason for delayed diagnosis (Mosterd et al., 2025). Although average diagnostic delay in Australia has fallen, it remains around eight years from symptom onset (Armour et al., 2020b). Women describe the experience in their own words:

> "...it's just to a point where it's just how much pain do I really have to be in before I'm really like taken seriously in this?" (Chakraborty et al., 2026)

> "Told I was just experiencing heavy periods, it's normal. Pain all the time is normal for a woman. Put down. Made to feel stupid. ...Many medical appointments have left me very sad, depressed, frustrated and at times just wanting to no longer be here."
> 52-year-old woman; Mosterd et al., 2026)

APS recognises that medical misogyny can be embedded in health systems as well as expressed through individual attitudes and behaviours. Expectations that women should endure pain, gendered judgements about how they describe their symptoms, historical under-research of female biology, and services organised around short consultations and single-organ specialties can all contribute to pain being overlooked or inadequately treated. Addressing these failures requires both respectful clinical interactions and structural change in research, workforce education, funding and service design.

2. Distressing healthcare encounters can undermine trust and future care

In a recent Australian mixed-methods study, 80% of women with endometriosis reported at least one distressing endometriosis-related healthcare encounter. Harmful communication was reported by 64%, and distressing medical procedures by 30%. Among those who experienced a distressing encounter, 80% said it affected their subsequent healthcare-seeking (Mosterd et al., 2026). One woman described a pelvic examination before surgery:

> "It was an extremely de-humanizing experience. The surgeon was teaching a medical student and used my pelvic exam/my body as a teaching moment/instrument, but did not ask for my consent to do so, and did not ask about my comfort during the procedure despite reporting severe chronic pelvic pain." (32-year-old woman; Mosterd et al., 2026)

These experiences highlight why respectful communication, consent and attention to comfort are fundamental to safe care. APS supports making person-centred, empathetic and trauma-informed communication a core

clinical practice requirement. This includes obtaining explicit consent for intimate examinations and procedures, obtaining separate consent for student involvement, checking comfort throughout, and ensuring the person can ask to pause or stop at any time. This approach is consistent with Recommendation 3.1 of the Victorian Inquiry.

3. Dismissal can drive women away from care

The effects of dismissive or distressing encounters can extend well beyond the consultation, undermining trust and leaving women feeling that seeking help is futile or unsafe. Clinicians in pelvic pain services report seeing women who have stopped seeking care for prolonged periods after a dismissive consultation; for example, being told to "just add paracetamol" when presenting in crisis.

Assessing complex, long standing pain requires time to listen, understand the person's circumstances and develop a shared care plan. A standard 15-minute consultation may be insufficient, particularly when pain affects multiple aspects of a woman's health and daily life.

Disengagement can delay assessment and treatment, leaving women without support as pain and its impacts persist or worsen. When trusted care feels inaccessible, women may also turn to unproven treatments and misinformation in their search for relief (see ToR (n), point 5). Rebuilding trust requires respectful communication, sufficient consultation time and continuity of care.

4. Women want to be heard, understand their pain, and have meaningful choices

Women consistently say they want to be heard, believed and validated, to understand what is happening in their bodies, and to be offered treatment options. An Australian priority-setting partnership with people living with chronic pain captured this in a guiding principle for health professional training: "Listen to me, learn from me" (Slater et al., 2022).

Assessment is an opportunity to begin building trust and supporting recovery. Taking time to hear a woman's story, understand her concerns and explain how the nervous system and other factors contribute to pain can help her make informed decisions about multidisciplinary care. Clinicians report that women receiving this explanation often ask why no one told them earlier.

The Royal Women's Hospital in Melbourne offers a practical example. A gynaecology waiting list of approximately three and a half years prompted the development of an early-intervention multidisciplinary program for women aged 18–40 with a normal ultrasound. Participation is voluntary. A nurse contacts women soon after referral, providing an early opportunity for them to be heard and supported. Over six to 12 months, participants receive structured pain education, pelvic health physiotherapy, psychology and dietetic care, with appointments arranged to accommodate work commitments.

The program provides support while women await further care and helps those who may subsequently undergo surgery to better understand their pain and treatment options. Supported by the Victorian Government, it is being evaluated with the University of Melbourne using data from the electronic Persistent Pain Outcomes Collaboration (ePPOC). APS supports evaluating this model's potential for national expansion, informed by outcomes and adaptation to local needs (Recommendation 12).

5. Culturally safe and inclusive care must be part of every pelvic pain service

Person-centred care must also be culturally safe. Ahpra describes culturally safe practice as requiring ongoing reflection on practitioners' knowledge, attitudes, behaviours and power, to deliver accessible and responsive healthcare free of racism. Cultural safety is determined by those receiving care, not by the clinician (Ahpra and National Boards, 2020).

Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds, women with disability and LGBTIQA+ people can face additional and intersecting barriers to pelvic pain care. These may include cost, distance, language barriers, inaccessible services and previous experiences of racism or discrimination. Services must recognise and respond to these distinct needs rather than assume that one approach will work for everyone.

Pelvic pain care often involves intimate examinations and discussions about menstruation, sex and the body. These require sensitivity to each person's cultural context, communication needs, identity and preferences. When people do not feel safe, respected or understood, they may delay seeking help or disengage from care.

APS supports embedding cultural safety and inclusive practice in the training of every discipline involved in pain care. Pelvic pain services and health information should be co-designed with the communities they serve, consistent with Recommendations 4.3 and 5.1 of the Victorian Inquiry.

APS recommendation: ToR (j)

APS Recommendation 6. Embed person-centred, trauma-informed and culturally safe care in training, practice and service design.

Ahpra, the National Boards, professional colleges and education providers should make person-centred, trauma-informed and culturally safe communication a core training and practice requirement across all health disciplines. This must include obtaining explicit consent and ensuring ongoing attention to the person's comfort during intimate examinations and procedures.

Pelvic pain services and health information should be co-designed with the communities they serve to reflect their needs, experiences and priorities (consistent with Victorian Inquiry Recommendations 3.1, 4.3 and 5.1).

(k) Barriers to effective pain management, including the range and affordability of available treatments

1. Multidisciplinary care is recommended but not routinely funded or available.

Best-practice care for persistent pain including persistent pelvic pain is multidisciplinary, bringing together medical, nursing and allied health expertise, underpinned by contemporary pain science. This approach is supported by the September 2025 joint statement from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Australasian Gynaecological Endoscopy and Surgery Society (AGES), the Faculty of Pain Medicine (FPM), the Australian Pain Society (APS) and the New Zealand Pain Society (NZPS), as well as the Faculty of Pain Medicine's statement on persistent pelvic pain.

In practice, publicly funded pelvic pain services are frequently led by gynaecologists and general practitioners, without allied health care funded or required as a core component of the team. This creates a gap between the multidisciplinary care endorsed by these professional bodies and the care women can access.

Even when publicly funded pelvic pain services include allied health care, a dominant biomedical health system creates additional barriers to access. For example, the South Australian Women's and Children's Hospital (WCH) offers a physiotherapy-led pelvic pain service with a current wait time of around six weeks from referral to first visit. However, a prerequisite for referral to this service is a prior consultation with a WCH public gynaecologist. Pelvic pain referrals are triaged as low priority (Category 3), and resulting wait times to see a gynaecologist currently exceed two years. By making specialist medical review the gateway to physiotherapy, the system turns a six-week wait into one of more than two years.

Limited access to multidisciplinary pelvic pain care

The Commonwealth's investment in 33 Endometriosis and Pelvic Pain GP Clinics is a welcome step towards improving access to primary care. However, there is no clear dedicated funding for the allied health care to which these clinics refer patients (Department of Health, Disability and Ageing, 2025a). Women may therefore receive an assessment and referral but still be unable to afford the recommended treatment.

Women need access to treatments matched to their symptoms, circumstances and preferences, including pelvic health physiotherapy, psychological support and pain education, alongside medicines or surgery where appropriate. Evidence for the effectiveness of laparoscopic surgery in reducing endometriosis-associated pain remains uncertain (Bafort et al., 2020). Funding arrangements must support informed treatment choices and access to multidisciplinary care throughout the treatment pathway.

Multidisciplinary care in practice

The Royal Women's Hospital Chronic Pelvic Pain Clinic illustrates this approach through structured multidisciplinary care. Its team brings together pain medicine, nursing and allied health expertise to assess

contributors to pain, support daily functioning and help women manage their symptoms. This model demonstrates why access to coordinated care must extend beyond an initial medical consultation.

Growing demand for services

Hospitalisations for endometriosis rose by 23% over the past decade, from 145 to 180 per 100,000 females, compared with a 4.7% increase across all female hospitalisations (AIHW, 2023). These figures highlight increasing hospital use associated with endometriosis. They do not establish which treatments women received or whether those treatments were appropriate, but underscore the importance of planning accessible services across primary, community and hospital care.

2. Non-surgical pathways should be available from the outset.

APS supports expanding non-surgical management and referral pathways as part of a comprehensive care pathway, consistent with the RANZCOG Australian Living Evidence Guideline: Endometriosis (2025) and Recommendation 5.5 of the Victorian Inquiry. The guideline supports starting treatment on a clinical or working diagnosis, without first requiring laparoscopy, unless there are signs of advanced disease. A properly powered randomised controlled trial of surgery for superficial endometriosis (ESPriT2) is due to report, and APS encourages the Committee to consider its findings carefully.

Non-surgical pathways do not replace surgery. They make sure women understand their pain and have real choices. The Royal Women's Hospital early-intervention program (see ToR (j)) works as "prehabilitation": women who later choose surgery do so knowing what to expect and how to manage their pain if surgery does not resolve it. Choice matters. Around 30% of women offered the program prefer to proceed directly to surgical review, and services should respect that. Shared decision-making also applies to hormonal treatment. Women should be offered a range of options and supported to choose, and their experience of side effects should be systematically recorded so that future advice is better informed (see ToR (o), Recommendation 19).

3. Workforce shortages and gaps in pain education limit access to care

Access to contemporary pelvic pain care depends on a workforce with the skills and capacity to deliver it. A national survey identified 74 persistent pain services, only two of which were dedicated pelvic pain services. Some public waiting times were three years or longer, people experiencing the greatest disadvantage waited longest, and medical staffing had not kept pace with demand (Hogg et al., 2021). Shortages of pain-informed allied health clinicians, including psychologists and pelvic health physiotherapists, further limit access, particularly outside metropolitan centres.

These gaps begin in professional education. Contemporary pain science receives limited attention in most undergraduate health curricula. Clinicians may therefore enter practice without sufficient preparation to explain pain, recognise persistent pain or support whole-person management (Faculty of Pain Medicine, 2026).

Every registered health practitioner should have a working knowledge of contemporary pain science appropriate to their role. Education across all health disciplines should address sex and gender differences in pain, rather than confining this content to women's health teaching in medical courses. It should also explicitly

cover pelvic pain and pain during pregnancy and the postpartum period—areas that remain under-served in pain education and research.

Strengthening both foundational education and continuing professional development is essential to building a workforce capable of delivering timely, evidence-informed care. This approach is consistent with Recommendations 3.2, 3.3 and 6.1 of the Victorian Inquiry.

4. Rural and remote women need care closer to home

Women in rural and remote Australia face substantial barriers to multidisciplinary pelvic pain care. Long distances, travel and accommodation costs, time away from work and family, and limited local specialist services can make recommended care difficult to access or sustain. Lower rates of endometriosis-related hospital care in remote areas should not be assumed to indicate lower need; they may also reflect barriers to accessing services (AIHW, 2023).

Existing models offer opportunities to strengthen local care. Pain Revolution's Local Pain Educator program trains and mentors rural clinicians in contemporary pain science so they can support their communities (Grant et al., 2026). Building this local capability is important for both early intervention and ongoing care.

Regional networks could connect tertiary pelvic pain services with rural GPs, nurses and allied health clinicians through telehealth, shared care and visiting specialist services. These arrangements should support local clinicians to deliver coordinated care close to home, with clear referral pathways when specialist assessment or treatment is needed.

Affordability of pelvic pain care

5. Allied health is largely user-pays.

From 1 July 2025, two new Medicare items funded longer gynaecology consultations of 45 minutes or more for complex conditions such as endometriosis and pelvic pain (MBS Online, 2025; Department of Health, Disability and Ageing, 2025b). APS welcomes this. However, no equivalent reform was made to pain medicine specialist consultations or to the allied health components of multidisciplinary pelvic pain care.

Under a GP Chronic Condition Management Plan, a woman can claim a Medicare rebate for only five allied health sessions per calendar year, shared across all disciplines. Those five sessions might need to cover pelvic health physiotherapy, psychology and dietetics combined, at a rebate well below typical fees with average out of pocket costs for most allied health service of $55 per appointment while gap payments for psychology services are often substantially higher (Ducket et al., 2022).

> For a woman who has used up her sick leave and is worried about rent, these costs often decide whether she gets care at all.

Pelvic health physiotherapy is central to recovery from pelvic floor injury, perineal pain, pelvic girdle pain and pain with intercourse. Yet outside hospital-based services for women with recognised severe injury, it is largely user-pays. The NSW Select Committee on Birth Trauma (2024) recommended that the NSW Government fund postpartum physiotherapy for women with birth-related pelvic floor injury. APS supports a national approach.

The economic consequences extend beyond healthcare spending. Chronic pelvic pain costs an estimated Int$16,970–20,898 per woman annually, predominantly through lost productivity, with pain severity identified as the strongest driver of cost (Armour et al., 2019). These findings strengthen the case for investing in accessible, evidence-informed care that improves function and participation in daily life. Funding should reflect clinical need, with outcomes and cost-effectiveness evaluated to guide ongoing investment.

6. Medicare session caps do not fit chronic pain.

The main route to rebated psychology is the Better Access initiative, which provides up to ten sessions per calendar year under a Mental Health Treatment Plan. The rebate from 1 July 2026 is $101.55 for a registered psychologist and $149.05 for a clinical psychologist. Better Access was designed for mental health conditions, not persistent pain. Requiring women to be framed as having a mental health disorder to access pain psychology can reinforce the message, described under ToR (j), that their pain is "all in their head". Ten sessions a year is also often not enough for the complexity and duration of chronic pain treatment. APS supports dedicated, adequately rebated allied health items for people with persistent pain, with session numbers that reflect clinical need, consistent with Recommendation 7.1 of the Victorian Inquiry.

7. The public–private divide.

Women who cannot afford private care face long public waits. National data show public pain service waits of three years or more in some services, with the most disadvantaged waiting longest (Hogg et al., 2021). At the Royal Women's Hospital, the gynaecology waiting list reached around three and a half years after the COVID-19 pandemic. Most endometriosis-related hospital care (68%) is delivered in private hospitals (AIHW, 2023). This divide also leaves women vulnerable: families may pay $20,000 or more out of pocket for private procedures with little evidence behind them (see ToR (n), point 5), while evidence-based multidisciplinary care is unfunded or unavailable. Indirect costs matter too. Programs offered during working hours are inaccessible to women with no sick leave who fear losing their jobs.

8. Investment in specialist multidisciplinary women's pain services.

APS supports increased investment in specialist multidisciplinary women's pain services, consistent with Recommendation 7.2 of the Victorian Inquiry. That investment should prioritise early-intervention models, flexible scheduling outside working hours, and bulk-billed or publicly funded pathways for women experiencing disadvantage (see Recommendation 1).

APS recommendations: ToR (k)

APS Recommendation 7. Fund allied health as a core component of pelvic pain services.
The Australian Government should fund allied health care as a core component of publicly funded pelvic pain and endometriosis services, including the Commonwealth Endometriosis and Pelvic Pain GP Clinics. Access to the multidisciplinary team each woman needs should be a funded service requirement, rather than left to individual service discretion (consistent with Victorian Inquiry Recommendation 5.6).

APS Recommendation 8. Ensure women can access and choose multidisciplinary treatment pathways.
Every woman referred for pelvic pain should have access to non-surgical, multidisciplinary care, including early intervention and preparation before surgery where appropriate. Women should be supported to make informed choices, with surgery offered when clinically indicated and performed by appropriately credentialed surgeons. These pathways should align with the RANZCOG Australian Living Evidence Guideline: Endometriosis (2025) and Victorian Inquiry Recommendation 5.5.

Recommendation 9. Embed contemporary pain science in education across all health disciplines.
Ahpra, the National Boards and education providers should strengthen pain science education through undergraduate curricula, including psychology, and a brief mandatory contemporary pain science module for all registered health practitioners. Interdisciplinary pain training should explicitly address sex and gender differences in pain, pelvic pain, and pain during pregnancy and the postpartum period (consistent with Victorian Inquiry Recommendations 3.2, 3.3 and 6.1).

APS Recommendation 10. Strengthen rural and remote access through connected services and local workforce development.
The Australian Government should fund regional networks linking specialist pelvic pain services with local GPs, nurses and allied health clinicians through telehealth, shared care and outreach. Investment should include training and mentoring for local clinicians, building on programs such as Pain Revolution's Local Pain Educator program.

APS Recommendation 11. Reform Medicare to fund multidisciplinary pain care according to clinical need.
The Australian Government should extend the July 2025 Medicare Benefits Schedule reforms to pain medicine specialist consultations and the allied health components of multidisciplinary pelvic pain care. Reform should include dedicated allied health items for persistent pain, rebates that reduce out-of-pocket costs, and session numbers that reflect clinical need. Access to this care should not depend on a mental health diagnosis (consistent with Victorian Inquiry Recommendation 7.1).

APS Recommendation 12. Expand specialist multidisciplinary women's pain services with equity and early intervention at their centre.
Governments should increase investment in specialist multidisciplinary women's pain services across metropolitan, rural and remote areas, prioritising women experiencing disadvantage. Investment should support evaluation and, where outcomes justify expansion, wider implementation of early-intervention models such as the Royal Women's Hospital program. Services should offer flexible scheduling, including appointments outside standard working hours, to reduce barriers to attendance (consistent with Victorian Inquiry Recommendation 7.2).

(n) The regulation of medical devices used in women's healthcare treatments, including risk assessments, monitoring and reporting

APS supports access to safe and effective treatments and recognises that medical devices may form part of appropriate care for some women living with persistent pain. APS defers to RANZCOG and AGES on device-specific clinical and regulatory matters.

APS's central position is that regulatory decisions about devices used in pain management should be based on robust evidence of clinically meaningful benefit, with the level of evidence required proportionate to the device's risks and invasiveness. This should include well-designed clinical trials with appropriate comparators, independent long-term monitoring using prospectively collected data, and validated patient-reported measures of pain, function and quality of life. Assessment should consider both harms and benefits over time, including whether improvements are sustained and make a meaningful difference to daily life.

Device assessment should also reflect contemporary pain science and the biological, psychological and social factors that shape persistent pain. Patients' experiences and priorities should inform evaluation and ongoing monitoring, ensuring that regulatory decisions reflect the outcomes that matter to the people using these devices.

1. Diagnostic devices should inform care, not determine whether pain is believed

Imaging, particularly ultrasound and MRI, plays an important role in assessing pelvic pain and endometriosis. Its value depends on appropriately trained operators, consistent reporting standards and equitable access.

APS emphasises that a woman's pain does not require confirmation by a device or test to be recognised as real. Pain is a personal experience shaped by biological, psychological and social factors. Imaging findings alone cannot establish its severity or impact and must be interpreted alongside the woman's account, clinical history and comprehensive assessment.

A normal imaging result should not be used to dismiss pain or conclude that nothing is wrong. Women should receive an explanation of what the findings do and do not show, alongside continued assessment and appropriate care. Diagnostic devices should support an integrated, whole-person approach, with access to multidisciplinary care guided by clinical need.

2. Lessons from transvaginal mesh: regulation must include long-term care

The experience of transvaginal mesh highlights the importance of timely regulatory action, transparent information and sustained support when devices cause harm. Reforms have included removing transvaginal mesh products for pelvic organ prolapse from the Australian Register of Therapeutic Goods (ARTG), introducing patient implant cards and establishing the Australian Pelvic Floor Procedure Registry. These measures support informed consent, traceability and long-term monitoring.

However, regulatory reform alone does not meet the needs of women already experiencing harm. Women affected by mesh continue to present to pain services, requiring access to coordinated assessment, treatment and ongoing support. Helplines and legal avenues for compensation cannot substitute for timely, publicly funded healthcare.

APS encourages the Committee to examine both the achievements and the gaps in the response to mesh, including the timeliness of regulatory action, registry coverage, access to specialist services and funding for ongoing care. These lessons should inform the regulation of other implantable devices used to manage pelvic pain, including neuromodulation devices. Safeguards must extend beyond approval and implantation to long-term monitoring, prompt responses to emerging harms and accessible care for those affected.

3. Implanted pain devices need a national registry, model of care and procedural standards

In April 2024, APS joined the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (ANZCA) and Chronic Pain Australia (CPA) in calling for three reforms to support safe, high-quality care for people receiving implanted pain devices:

- **A national pain device implant registry** to monitor safety and patient outcomes and support evidence-based practice.
- **A national model of care for implanted pain treatments** to define who should provide these treatments, which patients are likely to benefit, and the assessment, treatment and follow-up services required.
- **Clear training and credentialing standards** for clinicians performing pain implant procedures, addressing the lack of standardised procedural training identified in the joint statement.

  (Faculty of Pain Medicine, Australian Pain Society and Chronic Pain Australia, 2024)

A national registry would enable systematic, long-term monitoring of outcomes that matter to people living with persistent pain, including sustained pain relief, function and quality of life, alongside complications and other harms. Consistent, transparent reporting would strengthen informed consent, guide treatment selection and provide regulators and funders with evidence about benefits and risks in routine practice. For devices used in pelvic pain, APS supports reporting outcomes by sex and treatment indication so that women's experiences and outcomes are visible.

A national model of care should embed multidisciplinary assessment before implantation and coordinated follow-up afterwards, bringing together medical, nursing and allied health expertise. Women should be supported to understand the potential benefits, risks, uncertainties and alternatives, and to make decisions consistent with their goals. Access to ongoing multidisciplinary pain care should continue whether or not a device is implanted.

4. Pain management for IUD insertion must support informed choice

Intrauterine devices (IUDs) are highly effective, long-acting reversible contraceptives. Levonorgestrel-releasing devices are also widely used to manage heavy and painful periods. Pain during insertion can range from none to severe and is difficult to predict, making an individualised approach essential (RANZCOG, 2024).

Victoria's Inquiry into Women's Pain heard accounts of inadequate pain relief during procedures such as IUD insertion and recognised that painful healthcare experiences can discourage future care-seeking. Recommendation 1.3 called for clinical guidelines and consistent best-practice guidance and tools for managing women's pain, including during IUD insertion.

Women should receive clear information before the procedure about potential pain, available pain-management options and what each option involves. Planning should take account of their preferences, previous experiences and concerns. Options may include supportive communication and pacing, local anaesthetic and other forms of analgesia or sedation where clinically appropriate. Consent should be ongoing, with women supported to ask for a pause or to stop the procedure.

APS strongly supports Recommendation 1.3 and encourages its adoption nationally, with guidance developed with pain specialists, gynaecologists, general practitioners and women with lived experience.

APS recommendations: ToR (n)

Recommendation 13. Establish national imaging standards and embed whole-person care in device guidance.
The Australian Government should fund the development and implementation of national minimum standards for performing and reporting complex gynaecological imaging, in partnership with professional colleges, peak bodies and people with lived experience. Guidance for diagnostic and treatment devices should reflect a biopsychosocial, multidisciplinary approach. Results must be interpreted alongside each woman's account of her pain, with normal findings prompting continued assessment and appropriate care rather than dismissal.

Recommendation 14. Establish a national pain device implant registry with long-term outcome reporting.
The Australian Government should establish and fund a national pain device implant registry, as called for by the Faculty of Pain Medicine (ANZCA), APS and Chronic Pain Australia. The registry should record long-term pain, function and quality-of-life outcomes, complications, revisions and removals, with results reported by sex. Its development should draw on lessons from the Australian Pelvic Floor Procedure Registry, alongside support for that registry's full national implementation.

Recommendation 15. Establish a national model of care and procedural standards for implanted pain treatments.
The Australian Government should develop a national model of care for implanted pain treatments, including clear training and credentialing standards for clinicians performing implant procedures. The model should require multidisciplinary assessment before implantation, informed shared decision-making, and coordinated follow-up and support afterwards.

APS Recommendation 16. Require evidence and ongoing monitoring when devices or procedures are used for new pain indications.
The Therapeutic Goods Administration, Medical Services Advisory Committee and Australian

Commission on Safety and Quality in Health Care should, within their respective roles, require robust evidence of clinically meaningful benefit and acceptable risk when established devices or procedures are proposed for new indications in women's pain care. Ongoing monitoring should assess benefits, harms and long-term outcomes to protect women from costly treatments of unproven benefit.

APS Recommendation 17. Develop national guidance on individualised pain management for procedures such as IUD insertion.
The Australian Government should work with clinical experts, health services and women with lived experience to develop consistent national guidance on procedural pain management, including IUD insertion. Guidance should support clear information, individualised pain-management options, informed consent and shared decision-making, extending Recommendation 1.3 of Victoria's Bridging the Gender Pain Gap report nationally.

(o) The role of relevant regulators and other agencies in responding to complaints regarding medical devices

APS is not a regulator and does not seek to comment on the detailed operation of any single agency. Our members, across medicine, nursing, psychology, physiotherapy, occupational therapy, pharmacy and research, often support women over the long term, including when a device-based treatment has not worked as hoped. This gives them a valuable perspective on how complaints and concerns can be responded to well.

1. A clearer, more connected pathway.
Several agencies including the TGA, Ahpra and the National Boards, state and territory health complaints entities, hospitals, health insurers and the Department of Health, Disability and Ageing share responsibility for responding to device-related concerns. Each plays an important role. A single, clearly signposted entry point, supported by cross-referral and information-sharing between these bodies, would make it easier for women to raise a concern and be confident it reaches the right place. Feedback to people who report, and the inclusion of patient and clinician perspectives in device safety monitoring, would further strengthen trust in the system.

2. Capturing chronic pain, quality-of-life outcomes and side effects.
Complaint and monitoring pathways could be enhanced to capture the longer-term outcomes that matter most in persistent pain, such as sustained pain relief, function and quality of life, alongside acute adverse events. The same applies to side effects of hormonal treatments and hormonal devices, which are common, but which are not collected in a consistent way; at present the main route is for individual women or clinicians to report each one to the TGA. The national pain device implant registry APS has called for (see ToR (n), point 3), and national surgical outcome reporting (see ToR (p)), would strengthen this further: when a concern is raised, regulators could consider it alongside systematic outcome data rather than individual reports alone. Published timeframes and public reporting of outcomes would give patients and clinicians greater confidence. 3. Concerns about practice that is "within the rules". Regulators most readily act on clear breaches. Concerns about low-value care, such as repeated procedures of limited benefit, or devices used for indications without evidence, are harder to raise and rarely reach regulators. Patients often do not know what is normal or expected, misinformation is common, and notifications about practice that falls within current rules may not be acted on. Systematic outcome data and the ability to identify patterns of concern, rather than relying on individual complaints alone, would help regulators and health services respond earlier.

APS recommendations: ToR (o)

APS Recommendation 18. Create a single "no wrong door" pathway for medical device concerns.
The Australian Government should establish a single "no wrong door" entry point for medical device concerns, with formal cross-referral and information-sharing between the TGA, Ahpra, state and

territory health complaints entities and the Australian Commission on Safety and Quality in Health Care, published timeframes for responding and public reporting of outcomes, so that women can raise a concern easily, see that it has been acted on, and so that patterns of concern, not only individual complaints, can be identified.

APS Recommendation 19. Make adverse event reporting simple, inclusive and responsive.
The TGA should make adverse event reporting simple and actively encourage it from consumers and all health professionals, including allied health, and including side effects of hormonal treatments and devices, and give feedback to those who report, so that insights from community care inform medicine and device safety.

APS Recommendation 20. Include lived experience and multidisciplinary pain expertise in device review.
The TGA should include people with lived experience of persistent pain and multidisciplinary pain clinicians in device advisory and post-market review processes, so that decisions reflect patient experience and pain science.

APS Recommendation 21. Connect people with device-related pain to multidisciplinary care.
The Australian Government should fund multidisciplinary care pathways for people experiencing ongoing pain related to a medical device, so that responding to a concern also connects women with the care they need.

(p) Any related matters

1. A sustainable national pain outcomes system is essential to improving women's care

Across the Terms of Reference addressed in this submission, a common need emerges: reliable national data on whether care improves outcomes for women living with pain. Device registries (see ToR (n)) are one component. Understanding the effectiveness of care for persistent pain, including pelvic pain, endometriosis, and persistent postpartum pain, requires consistent outcome measurement across medical, surgical, nursing and allied health treatments.

Since 2013, the electronic Persistent Pain Outcomes Collaboration (ePPOC), an initiative of the Faculty of Pain Medicine hosted by the University of Wollongong, has supported outcome measurement in specialist pain services across Australia and New Zealand. It collects standardised patient-reported measures of pain severity, pain interference, mood and function, enabling services to compare outcomes and improve care.

With ePPOC due to cease on 31 October 2026 following the end of its funding, Australia risks losing a major source of systematic pain outcomes data just as this inquiry seeks stronger evidence to improve women's pain care. A sustainable national successor is needed to preserve this capability and address gaps in coverage. APS, as the multidisciplinary peak body, is working with the Faculty of Pain Medicine, Chronic Pain Australia, the Australian Pain Solutions Research Alliance and Painaustralia to bring the sector together to identify practical solutions.

Australia has collected national maternity data through the National Perinatal Data Collection since 1991. This registry captures what happens at birth, including caesarean rates and perineal injury, but not whether women are still in pain months later. Without that information, services cannot tell whether pain after birth is being prevented or treated well. Longitudinal data on postpartum pain should be collected, either via the National Perinatal Data Collection or ePPOC, and should include validated measures of pain, function, and quality of life after birth.

Victoria's Bridging the Gender Pain Gap report identified limited research on sex and gender differences as a contributor to inconsistent and inequitable pain management. Recommendation 1.1 called for greater investment in women's health research, including women's pain, sex and gender differences, and improved data collection. APS supports extending this approach nationally.

A national pain outcomes system should:

- **Make women's outcomes visible,** by collecting data on sex and gender and including measures specific to pelvic pain and endometriosis.
- **Use rigorous, consistent methods,** including validated, internationally recognised outcome measures aligned with national data standards, such as those maintained by the Australian Institute of Health and Welfare.

- **Connect with existing systems,** including clinical records, device registries and the Australian Pelvic Floor Procedure Registry, to support secure data linkage and minimise duplication.
- **Maintain public trust,** through independent, transparent governance, strong privacy protections and regular publication of findings.

Sustained funding for this system would enable patients, clinicians, services and governments to assess which approaches improve pain, function and quality of life, for whom, and where gaps in care remain.

2. National reporting should show whether gynaecological surgery improves women's outcomes

Australia has collected national maternity data through the National Perinatal Data Collection since 1991. An equivalent national approach is needed to consistently measure outcomes following gynaecological surgery. Currently, a limited proportion of hospitals voluntarily report gynaecology clinical indicators to the Australian Council on Healthcare Standards

Rising endometriosis-related hospitalisations (see ToR (k)) reinforce the need to understand both the care women receive and its outcomes. Hospitalisation figures alone do not show whether surgery occurred or whether treatment improved pain, function or quality of life.

National reporting should link information on gynaecological procedures and complications with validated patient-reported outcomes over time. Secure data linkage could connect hospital records with a national pain outcomes system, helping women, clinicians and funders understand which treatments provide meaningful benefit and where care needs to improve.

3. Research priorities must be set with women

Significant gaps in women's pain research leave women and clinicians without the evidence needed to make informed treatment decisions. Endometriosis has rightly received greater attention, but research investment must also address persistent pelvic pain more broadly, including pain not caused by endometriosis, alongside improvements in workforce capability and care delivery (Villegas-Echeverri et al., 2025).

International guidelines offer variable and sometimes inconsistent recommendations, reflecting fragmentation across specialties and gaps in the evidence base (Ghai et al., 2021; Mardon et al., 2022). Women continue to report care that does not meet their needs, with difficulties often beginning in adolescence (Victorian Government Department of Health, 2025; Johnson et al., 2025). Pain during pregnancy and the postpartum period also requires greater attention in research and clinical guidance.

A James Lind Alliance Priority Setting Partnership provides a structured way for people with lived experience, carers and clinicians to identify and prioritise unanswered research questions. This approach helps direct funding towards the outcomes that matter most to those receiving and providing care (James Lind Alliance, n.d.). It has been used internationally for menopause and in Australia for women and cardiovascular disease (James Lind Alliance, 2022; James Lind Alliance, 2024).

An Australian priority-setting partnership with people living with chronic pain has already informed national interdisciplinary pain training (Slater et al., 2022; Faculty of Pain Medicine, 2026). APS supports a similarly

collaborative approach to setting research priorities for persistent pelvic pain and for pain during pregnancy and the postpartum period.

APS recommendations: ToR (p)

APS Recommendation 22. Fund a sustainable national pain outcomes system that makes women's outcomes visible.
The Australian Government should fund a national pain outcomes data collection, building on ePPOC's infrastructure and expertise. It should use validated outcome measures, meet national data standards, support secure linkage with device registries and other national health datasets, and operate under independent, transparent governance. It should enable reporting by sex and gender and include pelvic pain-specific measures, so that policy and funding decisions are informed by rigorous evidence of treatment benefits, harms and gaps in care. This is consistent with Recommendation 1.1 of Victoria's Bridging the Gender Pain Gap report.

APS Recommendation 23. Mandate national reporting of gynaecological procedures and patient outcomes.
The Australian Government should mandate national reporting of gynaecological clinical indicators and surgical outcomes, including complications and patient-reported pain and function. Reporting should link with national pain outcomes data and draw on the experience of national maternity data collection to support consistent measurement and service improvement.

APS Recommendation 24. Fund research priority-setting partnerships with women, carers and clinicians through a James Lind Alliance partnership.
The Australian Government should fund, through the Medical Research Future Fund, James Lind Alliance Priority Setting Partnerships for persistent pelvic pain and for pain during pregnancy and the postpartum period. These partnerships should ensure that research investment reflects the priorities of women with lived experience, carers and clinicians.

Conclusion

The Australian Pain Society urges the Committee to translate the evidence and lived experiences presented to this inquiry into coordinated, measurable national action. This is a unique opportunity for the Federal Government to match national leadership with sustained funding and policy reform so that women and girls experiencing pain are heard, believed and supported with timely, affordable, evidence-informed care. The time has come to embed contemporary pain education across the entire healthcare workforce, equipping health professionals with the knowledge, practical skills and confidence to recognise, assess and manage pain, including sex and gender differences in its presentation and treatment. This investment must be matched by accessible multidisciplinary services, with allied health embedded in publicly funded pelvic pain care and Medicare rebates and session allowances that reflect clinical need.

Persistent pain, including pelvic pain with or without endometriosis, must be recognised as a condition warranting care in its own right. Care must address the biological, psychological and social dimensions of pain, with early assessment and support available while investigations continue. Building on the Victorian inquiry and existing clinical guidance, reform must be shaped by lived experience, address gender bias and inequities in access, and be supported by research, clear accountability and a sustainable national pain outcomes data collection. A pain-literate workforce, accessible multidisciplinary care and meaningful evaluation are essential to achieving lasting improvements in women's and girls' functioning, wellbeing and quality of life. The APS is well placed to contribute its multidisciplinary expertise to turn these recommendations into better care across Australia.

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Appendices

Appendix 1: The Australian Pain Society Pelvic Pain Special Interest Group

Interim Chair: Dr Jane Chalmers

Committee members: Dr Laura Prendergast, Dr Amelia Mardon, Dr Kelsi Dodds, Dr Marilla Druitt, Dr Karin Jones, Dr Joanne Sheedy, Bernadette Smith

Interim Chair Dr Jane Chalmers PhD, BPhysio (Hons)

Dr Jane Chalmers is a physiotherapist and Senior Lecturer in Pain Science at Adelaide University, where she leads pelvic pain research within the IIMPACT research program. Her work focuses on pain education and physiotherapy interventions for persistent pelvic pain, including endometriosis and adolescent period pain. She has recently been awarded a 2027 NHMRC Investigator Fellowship for a project to investigate the effectiveness of pain science education and other management strategies for women with pelvic pain.

Committee Member: Dr Marilla Druitt MBBS, BMedSc, FRANZCOG

Dr Marilla Druitt is a specialist obstetrician and gynaecologist with expertise in persistent pelvic pain and endometriosis, working across public and private practice, including Barwon Health's interdisciplinary pelvic pain service. She is President of Pelvic Pain Victoria and Chair of RANZCOG's Victorian State Committee. She contributed to Australia's endometriosis clinical practice guideline and Victorian Government work on women's health clinic redesign and the Inquiry into Women's Pain.

Committee Member: Dr Karin Jones MBBS, FANZCA, FFPMANZCA

Dr Karin Jones is a specialist pain medicine physician and anaesthetist, and Clinical Lead for the Chronic Pelvic Pain Clinic at the Royal Women's Hospital. She developed the hospital's award-winning CONNECT program to improve access to multidisciplinary pelvic pain care. She is Secretary of Pelvic Pain Victoria and represented the Faculty of Pain Medicine on RANZCOG's Australian Endometriosis Guideline Working Group.

Committee Member: Bernadette Smith, MSciMed (Pain Management), MAPS

Bernadette Smith is President of the Australian Pain Society and a Senior Psychologist with 20 years' experience in persistent pain management. As Managing Director of Pain Solutions in Tasmania, she provides trauma-informed psychological care within a multidisciplinary team. She is a Pain Revolution mentor and OPEN Board member. Her national advocacy focuses on pain policy and equitable access to evidence-informed care, particularly for women and rural communities.

Committee Member: Dr Laura Prendergast, DPsych (Health), MAPS

Dr Laura Prendergast is President-Elect of the Australian Pain Society and a Senior Health Psychologist with 15 years' experience in persistent pain management. She works in multidisciplinary pain services at Northern Health, including the Women's Health Hub Pelvic Pain Service, and advises the Transport Accident Commission through its Clinical Panel. Her work focuses on psychologically informed pain care and improvements in pain policy and service delivery.

Committee Member: Dr Jo Sheedy M. Psych / PhD, MAPS

Dr Jo Sheedy is a Clinical and Counselling Psychologist and qualified physiotherapist with over 20 years' experience in persistent pain management. She works at Barwon Health's Pain Management Unit, treats women with persistent pain in private practice and advises WorkSafe Victoria through its Clinical Panel. She delivers pain education and trauma-informed care training nationally and internationally.

Committee Member: Dr Millie Mardon PhD, BMedSc (Hons)

Dr Millie Mardon is a Research Fellow in IIMPACT in Health at Adelaide University, focusing on pelvic pain, endometriosis and menstrual health. She developed a consumer-informed pain science education curriculum for pelvic pain and has authored more than 30 peer-reviewed publications, contributing to policy and guideline development. She is an Early Career Ambassador for the World Endometriosis Society.

Appendix 2: Faculty of Pain Medicine, ANZCA — Statement on the clinical approach to persistent pelvic pain including endometriosis-associated pain (PS15(PM), 2025)

Supporting FPM statement

PS15(PM) sets out the Faculty of Pain Medicine's clinical approach to persistent pelvic pain, including endometriosis-associated pain. It supports early, individualised assessment and multidisciplinary management, recognising persistent pelvic pain as a condition requiring care in its own right. The related joint statement is listed in Appendix 3.

Full statement: PS15(PM) — Persistent pelvic pain and endometriosis

Appendix 3: RANZCOG, AGES, FPM, APS and NZPS — Joint Statement: Best Practice Approaches to the Management of Endometriosis and Pelvic Pain (2025)

Supporting joint statement

The joint statement brings together RANZCOG, AGES, FPM, APS and NZPS in support of coordinated, whole-person care for endometriosis and pelvic pain. It emphasises access to multidisciplinary services, workforce capability and equitable care, including for rural and remote communities.

Full statement: Best Practice Approaches to the Management of Endometriosis and Pelvic Pain

Appendix 4: RANZCOG — Australian Living Evidence Guideline: Endometriosis (2025)

Supporting guideline

RANZCOG's living evidence guideline informs the submission's recommendations on assessment, diagnosis and multidisciplinary management of endometriosis. It supports clinical decision-making across the treatment pathway and is maintained as a living resource.

Full guideline: Australian Living Evidence Guideline: Endometriosis

Appendix 5: Summary of All 24 Recommendations

Rec	Short title	ToR	Victorian Inquiry
1	Recognise persistent pain; fund whole-person care	All	—
2	Adopt Victorian Inquiry recommendations nationally	All	All areas
3	National guidance for pelvic pain beyond endometriosis	(i)	—
4	Early intervention for adolescents	(i)	4.4
5	Whole-person care from first presentation	(i)	5.1
6	Trauma-informed and culturally safe care	(j)	4.3
7	Fund allied health in pelvic pain services	(k)	5.6
8	Access to multidisciplinary treatment pathways	(k)	5.5
9	Pain science education across health disciplines	(k)	3.2, 3.3, 6.1
10	Rural networks and local workforce development	(k)	—
11	Medicare reform matched to clinical need	(k)	7.1
12	Expand specialist women's pain services	(k)	7.2
13	Imaging standards and whole-person device guidance	(n)	—
14	National pain device implant registry	(n)	—
15	Model of care and implant procedural standards	(n)	—
16	Evidence and monitoring for new pain indications	(n)	—
17	Individualised procedural pain management	(n)	1.3
18	A 'no wrong door' pathway for device concerns	(o)	—
19	Simple, inclusive adverse event reporting	(o)	—
20	Lived experience and pain expertise in device review	(o)	—
21	Multidisciplinary care for device-related pain	(o)	—
22	Sustainable national pain outcomes system	(p)	1.1
23	Report gynaecological procedures and outcomes	(p)	—
24	Research priority-setting partnerships with women	(p)	—

Victorian Inquiry numbers are the explicit cross-references in this submission; — indicates no specific numbered cross-reference.