Final Print

NSW Youth Parliament

Inclusion of Women in Medical Research Youth Act 2025

Bill Proposed By: Women's Affairs Committee

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I certify that this public Bill, which originated in the Youth Legislative Assembly, has finally passed the Youth Legislative Assembly of New South Wales.

Hamani Tanginoa, Youth Parliament Coordinator

NSW Youth Parliament

Inclusion of Women in Medical Research Youth Act 2025

Act no. 2, 2025

A Bill for

An Act to improve the inclusion of Women as subjects, in the Medical Research field, and other purposes.

I have examined this bill and find it to correspond in all respects with the bill as finally passed by the Youth Legislative Assembly.

Lian Sequeira, Youth Governor of the NSW Youth

Explanatory Note

Summary
The object of this Bill is to improve disproportionate adversity which women and females face in the medical field; societal stigma perpetuating such deplorable overrepresentation will be mitigated through education, facilitating an increase of funding and effective research into relevant medical conditions and safety considerations.

This Bill comes at a time when women and females face disproportionate and systemic discrimination within the health sector, significantly impacting diagnostic criteria, treatments, and outcomes that women experience in consideration of medical health and safety and contributing to women's perspective towards institutions and society. This has also had immense repercussions, as health struggles mean that women cannot participate in society to their fullest extent, perpetuating institutionalized discrimination that cyclically reinforces the deficient treatment of women in society.

This Bill aims to firstly improve the status of women's healthcare, by deconstructing stigma in the patient, the patient's community, and in medical workers. Education is key in this as it is societal change that drives political will and tangible results. Through mechanisms keeping medical workers accountable, the medical industry will improve, and subsequently will lead to more research and funding. This research and funding will contribute to a higher quality of women's healthcare and thus in conjunction with improving societal attitudes, the quality of women's healthcare will be improved holistically. This applies to both physical and mental health, as well as clinical or safety trialling.

Ultimately the status of women's health must be improved to address unacceptably entrenched societal stigmas, research, and funding, contributing to the holistic improvement of women's status and experiences within society.

Overview of provisions
Part 1 sets out the Short Title, Commencement, Objects and Definitions of the Act.

Part 2 sets guidelines and requirements of the Medical and Physical Health Sector by mandating improved education of students and healthcare workers and establishes frameworks underpinning the importance of nuanced representation of women in all sections of this bill and the medical field. Part 2 creates mandated diagnostic criteria and questionnaires, sensitivity training and implementation of an anonymous report line to improve stigma and patient invalidation within the women's health sector. It also sets medical training and safety research to dispute gender-based disparities within women's safety trials.

Rationale

Throughout New South Wales, women are not receiving the care and safety precautions that they are entitled to. Many departments of women's safety and health are not being accounted for, ranging from the medical industry to the automotive industry. Although issues like these have started to be addressed, there is still evident sex-based bias and male centrism within the medical industry, and whether intentional or unintentional, this bias is largely a cultural issue and is still an extremely damaging phenomenon.

In the medical industry, many women go undiagnosed because of the lack of female symptoms within the diagnostic criteria and overall awareness of sex-specific features within different medical issues, ultimately resulting in a lack of diagnoses and, thus, a subsequent absence of adequate treatment. Despite significant advancements in medical science, women in New South Wales continue to face disproportionately poorer health outcomes due to systemic gender bias embedded in research design, safety standards, and clinical practice. The National Health and Medical Council (NHMRC) has acknowledged that women have historically been excluded from clinical trials, a practice that persisted well into the 1990s in Australia, leading to diagnostic gaps, poor treatment efficacy, and increased adverse effects for women. Even now, women remain underrepresented in medical studies and leadership in these fields, with male researchers being more likely to receive senior grant funding, and sex-disaggregated data rarely mandated. In NSW, the state’s research ethics and governance frameworks do not explicitly require consideration of sex or gender in study approval, contributing to continued underdiagnosis and misdiagnosis of women, particularly in areas such as cardiac care, pain management, and reproductive health. These trends underscore a dangerous failure to treat sex and gender as critical variables in healthcare research and practice, resulting in a systemic disregard for the specific needs and safety of half the population.

A recent Australian Government survey, the #EndGenderBias survey, revealed that two out of three women in Australia have experienced discrimination in healthcare (Department of Health and Aged Care, 2024). This survey, involving nearly 3,000 participants, highlighted that many women feel dismissed, disbelieved, or stereotyped when seeking medical care. Common issues that these women indicated on the survey include: having symptoms or pain minimised, being labelled as "hysterical," and receiving inadequate treatment recommendations. The findings underscore systemic gender bias in the healthcare system, prompting the 2024 National Women's Health Summit to address these disparities and improve health outcomes for women. In 2021, 16.20% of women aged 15-24 admitted to not seeking medical care from a specialist because of costs, compared to only 7% of men of the same age. To address these issues at a federal level, the Albanese government has announced significant additions to the Pharmaceutical Benefits Scheme (PBS), aiming to improve women's access to essential reproductive health treatments. Health Minister Mark Butler emphasised that these changes aim to address decades of inaction in women's health, potentially saving women and their families thousands of dollars over their lifetimes, hopefully making women's healthcare more accessible and allowing for a push for women's health to be taken more seriously.

Moreover, concerning women’s general safety, those most likely to be affected by blunt force injury in a car accident are women, predominantly because of the lack of female inclusion in

the testing of safety features of cars. Female drivers are consistently over-represented in intersection side impact crashes, but it is only recently that female body types have been taken into consideration when considering vehicular safety. However, there is no suitably advanced small female side-impact dummy available currently. In the testing of side impacts with poles or other narrow objects in car accidents, young males are heavily over-represented, with the 50th percentile male dummy being used for this crash testing. While there have been many ongoing international projects and initiatives to develop an adequate female-based dummy for crash testing, male-based dummies are still consistently used. However, on a positive note, the dummies used for crash tests have specified injury thresholds that are based on a combination of data from both male and female subjects. So, while a dummy may be designated for the safety of the personal measurements of males, the performance limit, such as the impact acceleration that is likely to result in skull fracture, is not specifically either male or female, thus somewhat promoting a non-biased development of vehicular safety.

Mental health and neurodivergence are also a focal point of our research and Bill development, as, similar to crash testing, the basis for many mental health and neurodivergent diagnoses is developed purely based on males. In Australia, research consistently shows that women, girls, and gender-diverse people are often underdiagnosed or misdiagnosed with conditions such as ADHD, autism, and even mood disorders because diagnostic frameworks were originally built around male-centric symptoms and behaviours. The Australian Bureau of Statistics (ABS) found that while 21% of Australians experience a mental health disorder, the pathways to diagnosis and treatment differ significantly by gender, also highlighting that girls are frequently diagnosed later in life, often because their symptoms present differently, being more internalised or less disruptive, and therefore are less visible under current diagnostic models. The 2024 establishment of UNSW's Centre for Sex and Gender Equity in Health and Medicine reflects the growing recognition of this entrenched inequity, with data showing girls are three times less likely to be diagnosed with ADHD than boys due to male-centric diagnostic models (Schulz, 2020). This gender bias in mental health frameworks has real-world impacts, significantly affecting access to early intervention, appropriate support, and even legal protections under disability and discrimination laws.

With the underrepresentation and studies of women, there is a lack of evidence-based policies, treatments, and safety measures that reflect women's needs and experiences, thus resulting in systemic inequities across physical healthcare, mental health, and safety standards. Therefore, to fix these issues, a prioritisation of gender-sensitive reforms and inclusive research must be established.

Reference List

Department of Health and Aged Care. (2024, March 14). *Department of Health and Aged Care.* Retrieved from 2 out of 3 Women Experience Discrimination in Healthcare: www.health.gov.au/ministers/the-hon-ged-kearney-mp/media/2-out-of-3-women-experience-discrimination-in-healthcare-0

Schulz, J. (2020, April 20). *University of New South Wales.* Retrieved from Australia has an ethical and economic obligation to reform medical negligence.: https://www.unsw.edu.au/law-justice/our-research/impact/australia-has-an-ethical-and-an-economic-oblig ation-to-reform-medical-negligence

The Youth Legislature of New South Wales enacts—

Part 1 Preliminary

1 Name of Act

This Act is the Women in Medicine and Health Act 2025.

2 Commencement

The Act commences on January 1, 2026.

3 Objects

The objects of this Act are to—

(a) establish better and more relevant diagnostic criteria for health issues affecting women,

(b) encourage medicine practices without the indoctrination of gender bias through mandatory sensitivity training,

(c) implement better education methods around women's healthcare, beginning at a primary school level,

(d) eradicate the stigma and patient invalidation around women's health concerns and medical conditions,

(e) enforce consequences for medical negligence and gender bias if imposed by healthcare professionals,

(f) extinguish gender-based disparities within health, medical, and safety trials.

4 Definitions

In this Act—

Diagnostic criteria are a set of signs, symptoms, and tests used to accurately identify as many people with a specific condition as possible, when such symptoms vary from person to person.

female refers (exclusively in this bill) to those who have anatomy specific to someone assigned female at birth, specifically reproductive organs and hormones which do not pertain to typical male anatomy or male diagnostics.

female anatomy refers to physical features relating to sex, including chromosomes, genitals, hormones, reproductive organs and/or sexual anatomy.

gender bias is a disproportionate weight in favour of or against someone due to gender, conscious or unconscious bias alters perceptions and understanding, hence affecting interactions and decision making.

medical negligence is a failure of duty of care or prevention of loss/injury, due to which the patient suffers physical or psychological harm as a direct consequence.

stigma is the cultural and societal imposition of a negative trait or designation to an individual or group, deemed to differentiate from social norms as perceived by dominant consensus, often resulting in reduced status, discrimination, segregation, and enforcement of stereotypes that limit opportunities and enforce prejudice.

woman refers to the societal construct of gender and a person identifying as a *woman*.

Note— The *Interpretation Act 1987* also contains definitions and other provisions that affect the interpretation of this Bill.

Part 2 Improved Education on Issues Applying Generally to Females and Women

5 Improved Education of Healthcare Workers

(1) Education on issues applying to females and women will be mandatory for all healthcare workers and healthcare degrees.

(2) It shall be implemented into the existing framework within the medical system, where consistent education is already mandatory

(3) The representation of women and females must not be reductive and consider women's health based on:

(a) ethnicity and culture; and

(b) socioeconomic status; and

(c) gender; and

(d) sexuality

(4) The nature of the education must—

(a) centre the lived experiences of women and females within the healthcare system to humanise their experiences.

(b) provide factual and up-to date information that is based on research performed on females and women. If data is not based on, or differentiated by the categories of woman or female, potential biases must be clearly analysed and communicated; and

(c) have a clear correlation to women's or female health- ergo, information must clearly strive to improve women's health, rather than be general advice that has some correlation to women's health.

(5) The duration of the education must conform to at least one of the following criteria—

(a) consists of 10% of existing education frameworks that medical professionals follow; and

(b) 10 hours of learning are to be completed every two years of practice for all practicing medical practitioners

6 Improvements for Primary Education

(1) The curriculum for primary education in New South Wales must include age-appropriate content that—

(a) promotes respectful attitudes toward healthcare and medical Professionals; and

(b) encourages open, confident communication about personal health and wellbeing; and

(c) introduces basic concepts of gender-specific health needs to reduce stigma and support early understanding of women's health

7 Improvements for Secondary Education

(1) With secondary education, actions will be made to—

(a) surround attitudes towards medical care more technically, as implemented through the PDHPE, Biology, Community and Family Studies, and Society and Culture syllabi; and

(b) aim to educate students on the types of ailments that women and specifically females face.

8 Improvements for Tertiary education

(1) Tertiary education, both professional (TAFE or similar) and university education, in degrees of medical practice or research, must—

(a) include a mandatory class or unit, equivalent to at least 5% of total course load covering female health issues such as—

(i) endometriosis, PMDD and other menstrual irregularities; and

(ii) breast, cervical and ovarian cancers; and

(iii) medical conditions for which women are at higher risk and present notably different symptoms; and

(b) for all medical diagnostic education, teach sex variations in symptom presentation; and

(c) demonstrate, for all published faculty and thesis research, that sex and gender differences have been accounted for in research design; and

(d) revise curricula at least once every 10 years

(i) in consultation with a professional and teaching body of at least 50 members, containing 50% or more women

(ii) make changes in medical understanding of women's health based on peer-reviewed, sufficiently proven or reproduced studies where appropriate

Part 3 Considerations for Culturally and Linguistically Diverse Persons (CALD), First Nations, Socioeconomic, Gender and Sexuality

9 CALD and Aboriginal and Torres Strait Islander Considerations

(1) For culturally and linguistically diverse women and females, translation support will be provided for those who are not comfortable with English, if requested.

(2) For Aboriginal and Torres Strait Islander females and women, culturally sensitive healthcare must be provided if requested, this includes care based in community that is holistic and place based, and additional funding for Aboriginal Community Controlled Health Organisations to provide additional care.

10 Gender and Sexuality Considerations

(1) Considerations for gender and sexually fluid females and women must be implemented; this includes but not limited to—

(a) acknowledging that women and females of different gender and sexualities experience further societal stigma and may need specific healthcare; and

(b) females with non-cisgender identities or women with non-cisgender or intersex anatomy must be given appropriate healthcare to address specific needs and health differences; and

(c) medical professionals must consider a wide variety of circumstances surrounding reproductive health needs due to a diversity of sexualities.

11 Socioeconomic Considerations

(1) Socioeconomic considerations must be embedded in healthcare provision, which include but are not limited to—

(a) acknowledging that some women and females continue to experience socioeconomic disadvantage due to factors of constrained financial autonomy, persistent familial responsibilities, and structural economic barriers contributing to restrictive access to healthcare, whilst recognising the existing framework of the NSW Women's Strategy 2023-2026; and

(b) expansion of infrastructure, such as free telehealth services in low-income and regional areas for female-specific conditions to combat patients who may not have the time or resources to travel for medical help; and

(c) further financial support for women who may be unable to afford medical care, or are single parents; and

(d) proactive targeting of public and under-resourced schools for medical education programs, with tailored community liaison strategies to educate women and females on the importance of women and female-sensitive healthcare; and

(e) Provision of culturally appropriate health literacy resources distributed through community centres, housing commissions, and schools; and

(f) funding for local women's health advocates and peer educators in disadvantaged communities; and

(g) collaboration with non-profit organisations and local councils to identify access gaps and co-delivery services

Part 4 Addressing Stigma and Patient Invalidation within the Women's Health Sector

Division 1 Improving Diagnostic Criteria and Treatment

12 Establishment of Effective Diagnostic Criteria and Treatment

(1) Diagnosis and treatments must derive information from reputable source, and procedures for diagnoses must include but not limited to—

(a) avoiding stigma, through sensitivity training against gender bias.

(b) considering women of different backgrounds, these include:

(c) CALD

(d) Aboriginal and Torres Strait Islander

(e) Gender

(f) Sexuality

(g) Socioeconomic Status

(2) Treatment must be effective and to serve the individual rather than treat the 'problem', ensuring that autonomy and holistic wellbeing of a woman or female must be respected, which can be done by—

(a) requiring talking through all solutions with professionals and those with lived experience; and

(b) requiring documenting thoughts and concerns of patients; and

(c) ensuring that treatments are checked consistently; and

(d) providing economically sustainable solutions as patients may have financial restraints; and

(e) ensuring accessibility, including but not limited to—

(i) through the use of the internet for those in rural and regional communities

13 Training and Implementation Requirements for Diagnostic and Medical Artificial Intelligence Models

(1) All artificial intelligence or computer learning diagnostic tools must—

(a) with the exception of male-exclusive health issues, use at least 50% (± 3%) women's data for model training; and

(b) be taught to distinguish sex specific symptoms and how to identify them; and

(c) before release into public use

(i) be trained on at least 5,000 data points; and

(ii) pass clinical research trials with an accuracy of 95%; and

(d) remove all personal identifiers from data where possible, without affecting accuracy of results; and

(e) only be used for preliminary evaluation, and requires verification by an expert medical professional before implementing treatment plans or official diagnoses; and

(f) be used only with the informed written consent of patients as a diagnostic tool

Division 2 Gender-Based Disparities within Women's Safety Trials

14 Medical Training

(1) All New South Wales institutions delivering courses, training and education not covered by clauses 5, 6, 7, and 8 for purposes of professional, corporate or citizen first aid and/or CPR training must—

(a) use CPR manikins and simulation tools of both female and male thoracic anatomy, including breast tissue and rib cage structure for all training exercises; and

(b) supplement robotic cardiac models and physiological simulations based solely on male circulatory dynamics with sex-diverse models that represent how cardiac issues present differently in females; and

(c) make clear how symptoms of cardiac arrest are often atypical in women; and

(d) teach sex variations in symptoms and their identification for all key conditions covered by the course

15 Safety Research

(1) All safety trials conducted for the approval, regulation, and assessment of—

(a) motor vehicles sold or operated in New South Wales; and

(b) amusement rides, including roller coasters and other high speed attractions, must include crash test dummies and simulation models that reflect diverse female anatomical characteristics to inform the development of advanced, gender-inclusive injury prevention technologies, which includes but not limited to variations in—

(i) weight; and

(ii) height; and

(iii) muscle mass; and

(iv) spinal alignment

(2) Injury risk assessments must include sex-disaggregated data, particularly highlighting differential risks related to—

(a) whiplash, chest injuries, and abdominal trauma in vehicle collisions; and

(b) the performance of restraint systems on female occupants in both vehicle and amusement ride environments, such as—

(v) seatbelts; and

(vi) harnesses

(3) Governmental agencies, including Transport NSW, Fair Trade NSW, and SafeWork NSW, must—

(a) conduct biennial reviews on the inclusion and representation of women in safety testing frameworks, and publish findings to the public; and

(b) conduct consultations with women across diverse demographic axes, including but not limited to cultural, racial, and socioeconomic backgrounds, to effectively recommend changes based on current research and testing data

(4) To ensure this division is effectively implemented, regularly reviewed, and kept in line with advancements in gender-based injury research, the Minister for Health must consult with—

(a) experts in biomechanics and injury prevention; and

(b) women's health and safety non-government organisations; and

(c) industry stakeholders and;

(d) testing labs

(5) The Minister for Women must table an annual report in Parliament reviewing the implementation of this division, assessing whether the Minister for Health has met all requirements under this bill.

Division 3 Medical Research

16 Funding

(1) Research receiving funding through the NSW government or affiliated grants must submit a written demonstration, to be approved by the funding body, of the consideration and inclusion in research design

(a) biological sex differences including, as appropriate

(i) anatomy and physical proportions; and

(ii) endocrine systems; and

(iii) reproductive health and anatomy; and

(iv) gendered social beliefs and behaviours where relevant

17 Research and New Treatments

(1) Clinical trials for new treatments and pharmaceuticals to be prescribed to more than one sex or gender group must study and publicly document findings on—

(a) the effectiveness of the treatment on each group; and

(b) side effects which may be more prevalent in, or specific to one sex or individuals taking hormones in some form; and

(2) The release of new pharmaceutical treatments pertaining to women must—

(a) on their packaging or instructions, clearly and visibly provide information obtained from sections 1 (a) and (b) of this clause

Produced for The Y NSW Youth Parliament