

2026 Progress Report

The Royal Victorian Eye and Ear Hospital

Gender Equality Act 2020

Organisation name	The Royal Victorian Eye and Ear Hospital (Eye and Ear)
Total employees (as of 30 June 2025)	Total employees: 1,096 Women: 699 (64%) Men: 397 (36%)
PMS response rate	32% (2025 People Matter Survey)
Contextual information	Australia's only specialist eye, ear, nose and throat hospital. Based in East Melbourne with specialist clinics across Victoria. Serves approximately 220,000 patients annually across 100+ specialist clinics. Workforce organised across four occupational groups: Allied Health (including Audiologists, Optometrists, Orthoptists, Speech Therapists, Social Workers, Physiotherapist, Pharmacists, Technicians, Medical Photographers and Allied Health Assistants) (162), Medical (400), Nursing (304), Non-Clinical (231). 32% of survey respondents were born overseas; 43% speak a language other than English at home; 55% have caring responsibilities. Clinical Division: 79% of workforce; operates under healthcare funding models and award structures that significantly limit organisational control over pay equity and role design. Non-Clinical Division: 21% of workforce; greater flexibility to implement structural changes
Location	Metropolitan (East Melbourne) and regional Victoria

Summary: Progress Against Indicators

Indicator	Progress (Yes / No)
1. Gender Composition of Workforce	Yes
2. Gender Composition of Governing Body	Yes
3. Equal Remuneration	Yes
4. Sexual Harassment in the Workplace	No
5. Recruitment and Promotion	Yes
6. Availability and Utilisation of Flexible Work and Leave	Yes
7. Gendered Segregation Within the Workplace	Yes

Step 1: Reporting on Gender Impact Assessments (GIAs)

The *Gender Equality Act 2020* requires organisations to undertake GIAs on policies, programs, and services that have a direct and significant impact on the public.

Section 1.1: Confirming GIA Exemptions

None of these apply (go to 1.2).

Eye and Ear conducted 10 gender impact assessments during the reporting period. No exemptions apply.

Section 1.2: Describing Policies, Programs and Services Subject to a GIA

Ref #	A: Title	B: Subject	C: Description	D: Status	E: Gendered Impacts
1	Remote After Care Program (Datos Digital Solution)	Service	Implementation of the Datos remote patient monitoring platform at the Eye and Ear, enabling personalised automated care programs through interactive CareApps that gather biometrics and patient-reported outcome measures, offer self-care guidance, send alerts to the healthcare team, and support virtual visits. The platform facilitates hybrid care models for post-operative and ongoing patient monitoring.	New	Digital health solutions risk creating access barriers for patients with lower digital literacy or limited technology access, with these barriers disproportionately affecting older women, women from culturally and linguistically diverse backgrounds, and women experiencing socioeconomic disadvantage. The assessment identified the need for alternative access pathways (phone-based nurse consultations, paper-based forms), multilingual support through interpreter services, culturally sensitive design developed through consumer consultation, and gender-specific questionnaire content capturing relevant symptoms and health needs.
2	Signage and Wayfinding Rectification Works	Service	Review and rectification of wayfinding and signage on the ground floor and level 1 following feedback that wayfinding was insufficient after the hospital redevelopment. A Wayfinding and Artwork Working Group was established to prioritise signage improvements based on feedback from staff, volunteers, consumers, and patients.	Review	Wayfinding barriers affect patients differently based on gender intersecting with vision impairment, mobility, cultural and linguistic background, and age. The assessment identified that inadequate signage disproportionately affects patients who cannot easily ask for assistance due to language barriers, those with vision impairments requiring specific sign design, and older patients who may face compounding barriers of age and gender.
3	Patient Communication Boards	Service	Development of Patient Communication Boards for the Inpatient Ward in response to patient feedback about insufficient communication from staff. The boards aim to improve communication, reduce frustration, and enhance	New	Communication barriers in inpatient settings affect patients differently based on gender intersecting with vision impairment, language proficiency, and health literacy. The assessment identified that patients with vision impairments or language barriers require additional support to access information provided through visual communication boards.

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			patient safety by providing clear and updated care information.		
4	Age Related Macular Degeneration Discharge Information Sheet	Service	Development of new discharge information packs for Medical Retina patients to facilitate safe discharge of stable patients back into the community for follow-up. The packs were developed with consumer engagement to ensure information meets patient needs and is written in plain language.	New	Discharge information accessibility is affected by the intersection of gender with vision impairment, language diversity, and health literacy. Patients with age related macular degeneration have specific vision impairment considerations requiring accessible document design.
5	Glaucoma Discharge Information Sheet	Service	Development of discharge information sheets for Glaucoma patients as part of the Eye and Ear's broader initiative to improve discharge pathways and patient information provision.	New	As with other discharge information initiatives, accessibility is affected by the intersection of gender with vision impairment, language diversity, and health literacy. This initiative is at an early stage of development.
6	Specialist Clinic Mobile App	Service	Early-stage exploration of a mobile application for alerting patients about their appointments while in the hospital, replacing the current call system. Initial consultation with the Community Advisory Committee Consumer Working Group has commenced.	New	Digital appointment notification systems may create barriers for patients with lower digital literacy, limited technology access, or vision impairment. The current call system was identified as not user-friendly for patients with vision impairments. The assessment identified concerns about older patients facing barriers associated with downloading and using mobile applications.
7	Emergency Department Seating Review	Service	Review and replacement of seating in the Emergency Department waiting area, with input from staff, volunteers, and consumers on comfort, aesthetics, and accessibility of replacement options.	Review	Seating in clinical waiting areas affects patients differently based on body size, mobility, age, and disability. The assessment identified the need for seating that accommodates diverse patient needs including bariatric patients, older patients with mobility challenges, and patients using mobility aids.
8	Developing Social Stories	Program	Early-stage concept for creating social stories to help different patient cohorts access and navigate the hospital. Social stories use narrative and visual formats to prepare patients	In progress	Hospital navigation and healthcare access are affected by gender intersecting with cultural background, language proficiency, disability, and age. Social stories can be adapted to address specific barriers faced by different patient groups.

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			for healthcare experiences, reducing anxiety and improving engagement.		
9	Forget-Me-Not Flower Tool	Service	Potential adoption of the Forget-Me-Not flower tool to support patients with delirium and dementia. The tool captures key personal information (hobbies, preferences) to help staff build rapport with patients and provide person-centred care during their stay.	New	Patients with delirium and dementia are disproportionately older and may experience the intersection of gender with cognitive impairment and age. The tool aims to support personalised care that respects individual identity and preferences. The Patient Experience Committee discussed whether the tool should be used for all patients to promote equity and inclusion, while recognising its particular significance for patients with delirium and dementia.
10	Sugamadex Medication Information Leaflet	Service	Development of a patient information leaflet about the potential interaction between sugamadex administration and progesterone-based medicines, advising patients of management strategies to mitigate potential impacts to their treatment.	New	The medication interaction between sugamadex and progesterone-based medicines has direct gendered impacts, primarily affecting patients using hormonal contraception or hormone replacement therapy. The assessment recognised that this also affects gender diverse individuals using progesterone-based hormone therapy, younger patients, and patients from diverse cultural and faith backgrounds where discussion of reproductive health and contraception carries additional sensitivities.

Section 1.3: Describing Actions Taken as a Result of a GIA

Ref #	F: Actions Taken?	G: Actions Description	H: If No Action, Explain	I: Intersectionality Considered	J: Intersectional Inequality Actions
1	Yes	Alternative access options maintained including phone calls with nurses and paper-based forms. Interpreter services provided for patients requiring them. Consumer liaison and consumer group representatives from diverse genders and cultural backgrounds consulted to ensure culturally appropriate and accessible materials. Questionnaire reviewed and revised to capture gender-specific symptoms, experiences, and health needs related to the Eye and Ear conditions and post-operative recovery, with input from clinicians specialising in gender-specific health.	N/A	An intersectional lens was applied by acknowledging that gender intersects with other identity dimensions to create unique experiences of inequality. The assessment identified specific intersectional risks for First Nations People (systemic racism and historical trauma compounding health disparities), older adults (ageism combined with gender stereotypes creating technology access barriers), people with disabilities (distinct access, communication, and healthcare challenges), culturally and linguistically diverse communities (language barriers and cultural differences compounding marginalisation), gender diverse individuals (gender identity shaping health needs and requiring inclusive language), and individuals from lower socioeconomic backgrounds (poverty limiting technology and healthcare access with disproportionate effects on women and gender diverse individuals).	The Eye and Ear plans to collect detailed patient demographic data (gender, age, ethnicity, disability status, language spoken at home) to analyse potential disparities. Consultation with community organisations representing diverse populations to ensure the system meets all patients' needs. Personalised resources and assistance based on individual patient needs. Promotion of culturally safe environments respecting diverse identities and experiences.
2	Yes	Worked with volunteers to identify common pain points for patients seeking wayfinding assistance. Vision impaired consumers engaged in co-design of the project. Interpreters and patients from culturally and linguistically diverse backgrounds consulted, highlighting the need for	N/A	An intersectional lens was applied by acknowledging that gender intersects with other identity dimensions. The assessment identified risks for older adults (ageism combined with gender stereotypes affecting sign placement and design), people with disabilities (particularly vision impairment and	Co-design with vision impaired consumers. Consultation with interpreters and culturally diverse patients. International best practice toilet signage guidelines addressing vision impairment, cultural diversity, and gender diversity simultaneously.

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		<p>universal iconography and clear, simple signage. International best practice guidelines adopted for toilet signage for vision impaired, culturally diverse, and gender diverse individuals, with primary emphasis on vision impaired patients' ability to navigate independently, followed by accessibility for culturally diverse patients. A follow-up survey will be circulated after installation to assess effectiveness.</p>		<p>wheelchair users affecting sign positioning and size), culturally and linguistically diverse communities (language barriers and cultural differences requiring universal iconography), and gender diverse individuals (gender identity shaping wayfinding needs, particularly for toilet signage).</p>	
3	Yes	<p>Prototypes developed through surveying inpatients, with input from volunteers and the Patient Experience Committee. Board design simplified based on feedback from patients, staff, volunteers, and consumer advisors. Three-month trial on the Inpatient Ward with feedback captured by volunteers. Staff education provided on completing boards with patients and updating them as needed. Consumer feedback highlighted the need for consistent staff engagement and training, particularly for patients with vision impairments or language barriers, which will be incorporated into future staff education. Plans to improve physical design (perspex covers, whiteboard markers) to enhance accessibility.</p>	N/A	<p>The assessment considered the intersection of gender with vision impairment and language diversity, recognising that these compounding factors affect patients' ability to access care information. Consumer advisors specifically identified that patients with vision impairments or language barriers require additional staff engagement to benefit from the communication boards.</p>	<p>Staff education to include specific guidance on supporting patients with vision impairments and language barriers to access board content. Ongoing consumer feedback mechanisms to identify accessibility gaps.</p>

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4	Yes	Consumer engagement ensured information is clear, concise, and written in plain language. Design specifically considered vision impaired individuals who use assistive readers, ensuring layout compatibility. Plans for multilingual dissemination to address language diversity.	N/A	The assessment considered the intersection of gender with vision impairment and cultural and linguistic diversity. Design decisions prioritised compatibility with assistive reading technology used by vision impaired patients, and multilingual provision was planned to address language barriers.	Layout designed for compatibility with assistive reading technology. Planned multilingual dissemination.
5	Yes	Development is underway following the same consumer-engaged approach as the Age-Related Macular Degeneration discharge information sheet, with attention to accessible design and plain language.	N/A	Intersectional considerations are being applied consistent with those identified for the Age-Related Macular Degeneration discharge information sheet, including vision impairment, language diversity, and health literacy.	Design will follow the accessible format established through the Age-Related Macular Degeneration information sheet development.
6	Yes	Early consultation with the Community Advisory Committee Consumer Working Group, which included a diverse group of consumers including a consumer with severe vision impairment. The consumer with vision impairment supported the app concept given the current call system's accessibility limitations. Considerations raised regarding barriers for older patients. Further consultation and development planned as the initiative progresses.	N/A	The consultation included consumers experiencing the intersection of gender with vision impairment and age. A consumer with severe vision impairment provided direct input on how the current system fails to meet accessibility needs. Concerns were raised about the intersection of age with technology access, recognising that the Eye and Ear's older patient cohort may face barriers to app-based services.	Diverse consumer representation in initial consultation, including consumers with severe vision impairment. Further consultation planned to address identified barriers for older patients and patients with disabilities.

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7	Yes	Staff, volunteers, and consumers provided feedback on comfort and aesthetics of replacement seating options. The selected option prioritised sturdiness and comfort for a diverse group of patients including bariatric patients. Seating placed close to nursing and clerical areas for ease of access by patients with mobility challenges or mobility aids who may need more space and closer proximity to staff support. Ongoing feedback welcomed from Emergency Department patients to ensure needs are met.	N/A	An intersectional lens was applied recognising that gender intersects with age, disability, and body size. Older adults were considered for mobility challenges and the need for accessible seating near staff areas. People with disabilities were considered in relation to mobility and visibility challenges, with provision for greater space and close staff access. Feedback mechanisms maintained for ongoing improvement.	Seating positioned for accessibility by patients with mobility challenges. Selection criteria included suitability for bariatric patients and patients with mobility aids. Open feedback mechanism for ongoing assessment of diverse patient needs.
8	Yes	The concept was presented to the Consumer Advisory Committee Consumer Working Group. Consumers expressed support and were particularly interested in how social stories could be adapted for multicultural communities. Further development and consultation is required as the initiative progresses.	N/A	Consumer discussion identified the intersection of gender with cultural and linguistic diversity as a priority for social story development, recognising that patients from multicultural communities face compounding barriers in accessing and navigating specialist healthcare.	Consumer-identified priority for multicultural adaptation of social stories to be incorporated into future development.
9	Yes	The tool was presented and discussed at the Patient Experience Committee. The group considered design simplicity, number of questions, and integration with existing Patient Communication Boards. A suggestion was adopted to consider using the tool for all patients to promote equity and inclusion while recognising its particular significance for certain cohorts.	N/A	The assessment considered the intersection of gender with age and cognitive impairment, recognising that dementia and delirium disproportionately affect older patients. The committee's suggestion to extend the tool to all patients reflects an inclusive approach that avoids singling out specific patient groups while maintaining targeted support for those who benefit most.	Recommendation to extend the tool to all patients to promote equity and inclusion, avoiding stigmatisation of patients with dementia or delirium.

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10	Yes	The leaflet was adapted from a Peter MacCallum Cancer Centre patient information leaflet with input from consumers and the Partnering with Consumers committee. Multiple drafts were reviewed through both the Partnering with Consumers committee and the Drugs and Therapeutics committee to achieve an appropriate balance between delivering accurate medical information and respecting different cultures, faiths, ages, sexualities, and genders.	N/A	The assessment focused on the intersection of gender with sexuality, age, cultural background, and faith. The leaflet development process explicitly considered how information about progesterone-based medicine interactions needed to be communicated sensitively across these intersecting dimensions, recognising that reproductive health communication carries different sensitivities for different patient groups.	Iterative consumer and committee review process ensuring the leaflet respects diverse cultures, faiths, ages, sexualities, and genders while providing accurate clinical information.

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Step 2: Progress Against the Indicators

Section 2.1: Progress against the workplace gender equality indicators

Indicator	L: Progress data (required)	M: Additional progress data (recommended)	N: Progress made?	O: How data demonstrates progress (required)
1	<p>Critical performance measures</p> <p>Gender composition – whole of organisation: 2023: Women 63.9%, Men 35.8%, Self-described 0.3%. 2025: Women 63.2%, Men 36.2%, Self-described 0.5%</p> <p>Part-time workers: 2023: Women 58.4%, Men 58.5% 2025: Women 52.4%, Men 55.9%</p> <p>Senior leaders (Level -1 to CEO): 2023: Women 51.4%, Men 48.6% 2025: Women 25.0%, Men 75.0%</p>	<p>For privacy reasons, throughout this report, 'women' includes 6 employees who self-described their gender in their employee profile and the small number of people who selected non-binary or used a different term in our 2025 PMS. This does not mean we fail to recognise their gender identity. We are pleased to see increasing reported gender diversity in our workforce to around 1% and remain committed to creating inclusive workplace environments for employees of all genders. This means that throughout this report, women's representation is reported as 64% (699 of 1,096 employees) rather than the 63.2% shown in the Commission's audit data.</p> <p>Workforce composition by occupational group: Allied Health: 77% W / 23% M (n=162) Medical: 39% women, 61% men (n=400) Nursing: 88% women, 13% men (n=304) Non-Clinical: 67% women, 33% men (n=230)</p> <p>Level to CEO: 0% women (1 position)</p>	Yes	<p>Overall workforce composition remained stable at 64% women and 36% men, which in a low-turnover organisation with stable headcount represents successful maintenance of gender balance.</p> <p>Six employees self-described their gender, an increase from 2023 with two recruited during the reporting period, reflecting growing confidence in disclosing gender identity beyond binary categories. While these employees cannot yet be included in this analysis due to small cohort size, the Eye and Ear is working toward incorporating non-binary gender data into future reporting and considers the increase as evidence of cultural progress.</p> <p>Women's executive team representation decreased from 50% to 33% at Level -1 during the reporting period, with a further appointment since the audit bringing representation back to 50%. Women comprise 65% at Level -2. Part-time work rates have converged across genders (women 52%, men 56%), and occupational group analysis has established that high part-time and casual rates in clinical groups reflect deliberate operational design rather than employment insecurity.</p> <p>The Eye and Ear has built analytical frameworks disaggregating workforce data by occupational group, identifying improving gender balance in younger</p>

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		<p>Level -1 (Executive): 33% women (1W, 2M) Level -2 (Senior Management): 65% women (13W, 7M) Level -3 (Medical Specialists): 38% women (285 positions)</p> <p>The Commission uses Level -1 to CEO (three roles) to assess senior leadership composition, with women's representation falling from 50% to 33% during the reporting period, however an appointment to a vacancy since the audit date brings representation back to 50%. Women comprise 65% at Level - 2.</p> <p>Under-35 pipeline (women's share): Medical: 39% (above 31% in the 55+ cohort, showing pipeline improvement) Allied Health: 92% (above 77% group average), though a mid-career barrier exists with women's representation dropping from 90% at Level -8 to 48% at Level -9, warranting targeted investigation in the next GEAP Non-Clinical: 71% (above 67% group average) Nursing: 90% (stable, consistent feminisation)</p>		<p>medical cohorts (39% women under 35 years of age compared with 31% aged 55+). Non-Clinical is the priority area for targeted intervention (24-percentage-point gap in full-time ongoing access, declining women's representation at senior levels), and Allied Health mid-career attrition warrants investigation.</p> <p>The organisation now distinguishes between barriers within its sphere of influence (recruitment practices, professional development access, employment type allocation) and systemic constraints requiring sector-wide reform (nursing education demographics, medical training pipelines, enterprise agreement structures), enabling more effective targeting of resources toward interventions that can produce measurable change.</p>

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2	<p>Critical performance measures Governing body gender composition: 2023: 4 women, 5 men (44% women) 2025: 4 women, 5 men (44% women) No change between periods.</p>	<p>Board appointments are administered externally by the Department of Health.</p>	Yes	<p>Composition has held at 44% women (4 of 9 directors). The current composition is one appointment from the 50% women target. Board appointments are not made by the Eye and Ear, but rather the Department of Health.</p>
3	<p>Critical performance measures Mean base salary gap: 2023: 37.8% 2025: 36.8%</p> <p>Mean total remuneration gap: 2023: 39.1% 2025: 36.8%</p> <p>Senior leader (Level -1) mean total remuneration gap: 2023: 25.8% 2025: 31.4%</p> <p>Median total remuneration gap: 2023: 48.3% 2025: 41.1%</p> <p>Median base salary gap: 2023: 38.6% 2025: 35.7%</p>	<p>Mean total remuneration gap by occupational group (2025): Allied Health: -11% (reverse gap) Medical: 1% (near parity) Nursing: 1% (near parity) Non-Clinical: 14%</p> <p>Mean base salary gap by occupational group: Allied Health: -11% (reverse gap) Medical: 2% Nursing: 2% Non-Clinical: 12%</p> <p>Cross-group gap (occupational segregation): Medical mean base: \$328,796 (M) / \$323,169 (W) Nursing mean base: \$117,938 (M) / \$116,069 (W) Difference: \$212,727 - drives org-level gap</p>	Yes	<p>All four organisational pay gap measures improved between reporting periods (mean base: 37.8%→36.8%; median base: 38.6%→35.7%; mean total remuneration: 39.1%→36.8%, median total remuneration: 48.3%→41.1%).</p> <p>The senior leader pay gap increased from 25.8%→31.4% (mean total remuneration), however this metric covers only four positions, and there was a position vacancy (previously female) at the reporting date. With a cohort this small, the metric fluctuates with any single appointment change.</p> <p>Within-occupation analysis reveals near pay parity in three of four groups: Medical 0-2% gap, Nursing 1-4% gap, Allied Health reverse gap of 11-16% favouring women. The Eye and Ear's enterprise agreements deliver equitable pay for equivalent work within comparable professional groups - the organisational gap is a composition effect driven by the approximately \$213,000 difference between medical specialist and nursing mean salaries, reflecting job valuation between enterprise agreements rather than unequal pay at the Eye and Ear.</p>

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				<p>Non-Clinical (9-14% gap) is the priority area for targeted investigation. The 113 distinct role titles across 230 positions create extraordinary heterogeneity making like-for-like comparison challenging without role-level analysis. The Eye and Ear's role rationalisation work will enable more precise analysis to separate the effects of seniority concentration, penalty-rate accumulation in trades roles, and any equal pay concerns within comparable positions.</p>
4	<p>Critical performance measures PMS experience rates overall: 2023: 6% 2025: 8% Women: 2023: 7.1% 2025: 10.6% Men: 2023: 2.6% 2025: 0%</p> <p>Formal reports: 2023: data unavailable 2025: no formal reports received Proportion who said they reported: Women 2025: 4% Men 2025: data unavailable (cohort too small)</p> <p>Top reasons for not reporting (2025, women): Didn't think it was serious enough: 45.8% Wouldn't make a difference: 37.5% No longer had contact with the person(s): 29.2% Complaint process embarrassing or difficult: 20.8% Negative consequences for my reputation: 20.8% Didn't know</p>	<p>Source of harassment: Patient/client perpetrated: 2023: 29% 2025: 48% (+19pp) Colleague perpetrated: 2023: 58% 2025: 38% (-20pp) Manager/supervisor perpetrated: 2023: 8% 2025: 14% (+6pp)</p> <p>Marginalised groups most affected (sexual harassment prevalence): LGBTQIA+: 24% (up from 6% in 2023) Age 25-34: 29% (up from 11% in 2023) People with disability: 23% (up from 17%) Women on fixed-term contracts: 29%</p> <p>Confidence in organisational response (% agreeing organisation takes steps to eliminate bullying/harassment): LGBTQIA+: 64% People with disability: 54% (12pp below average) Below \$80k earners: 56% (10pp below</p>	No	<p>Progress has not been demonstrated. The anonymous experience rate in the PMS increased from 6% to 8%, with women's rate rising from 7.1% to 10.6%. While the Eye and Ear's overall rate remains below the comparator group average of 10%, it exceeds the public sector average of 5% and represents a 33% relative increase over two years.</p> <p>The shift in harassment sources - from colleague-perpetrated to patient/client-perpetrated (now 48%) - reflects the Eye and Ear's frontline healthcare context, where traditional workplace frameworks do not easily apply.</p> <p>The increase in manager/supervisor harassment (8% to 14% of total) requires targeted intervention.</p> <p>No formal reports were received during the reporting period despite 3% of those experiencing harassment believing they had submitted a formal complaint. The primary</p>

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	<p>who to talk to: 8.3% Didn't feel safe to report: 4.2%</p> <p>Satisfaction with handling of workplace sexual harassment complaint: 2023: data unavailable 2025: data unavailable</p>	<p>average) Age 25-34: 54% (11pp below average)</p>		<p>reporting barrier shifted to 'it wouldn't make a difference' (37.5%), indicating erosion of confidence in organisational response.</p> <p>Importantly, the 8% organisational experience rate reflects a composition average rather than evenly distributed risk. Disaggregated analysis shows harassment is concentrated within specific demographic groups, including LGBTQIA+ employees, younger employees, people with disability, and lower-paid employees. The absence of demonstrated progress on this indicator therefore reflects concentrated harm rather than uniform experience and directly informs the targeted, disaggregated actions included in the 2026–2030 GEAP.</p>
5	<p>Critical performance measures Gender composition of new recruits: 2023: Women 64.7%, Men 33.9% 2025: Women 57.7%, Men 41.4%</p> <p>Gender composition of promotions: 2025: Women 84.4%, Men 15.6%</p> <p>Recruitment processes perceived as fair: 2023: Women 68%, Men 75% 2025: Women 56%, Men 74%</p> <p>Promotion processes perceived as fair: 2023: Women 50%, Men 57% 2025: Women 44%, Men 58%</p>	<p>Recruitment by occupational group (2025): Allied Health: 83% W Medical: 41% W Nursing: 78% W Non-Clinical: 70% W</p> <p>Promotion by occupational group (2025): Allied Health: 92% W (10% of W promoted vs 3% M) Medical: 0 formal promotions (credential pathway) Nursing: 82% W (3% of W promoted vs 5% M) Non-Clinical: 75% W (4% of W promoted vs 3% M)</p>	Yes	<p>Recruitment practices maintain women's representation at 61% of active recruits (119 of 195). The Commission's audit data shows women's share of appointments declining from 64.7% to 57.7%; however, the 2025 figure includes 27 employees who withdrew before census, 18 of whom were medical registrars on fixed rotational terms. Medical recruitment shows near-parity (41% women among active recruits), reflecting improving training pipeline demographics.</p> <p>Women access formal promotion and higher duties at rates exceeding their workforce representation (84.4% of promotions despite 64% workforce share). However,</p>

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		<p>Intersectional gaps in promotion fairness perceptions: People with disability: 31% (-17pp below avg) Below \$80k earners: 36% (-12pp below avg)</p>		<p>traditional promotion metrics mischaracterise career progression in specialist healthcare. Clinical professional development is extensive but largely invisible in internal HR systems - a data gap the next GEAP will address.</p> <p>Structural challenges remain. Fairness perceptions are declining despite improving outcomes, with women's confidence in recruitment fairness falling from 68.0% to 56.2% and promotion fairness from 50.2% to 43.8%. Overall formal promotion rates are low, reflecting limited advancement opportunities within a stable headcount, a flat organisational structure, and low workforce turnover. For many clinical employees, moving into leadership means ceasing to practise their profession, limiting both the appeal and availability of traditional upward career movement. Addressing perception gaps requires improving transparency about how career progression operates across occupational groups.</p>
6	<p>Critical performance measures Average weeks parental leave: Women 2025: 20.8 weeks Men 2025: 2.3 weeks</p> <p>Formal flexible work uptake: Women 2025: 3.3% Men 2025: 0.9% 2023: data unavailable</p>	<p>Parental leave by occupational group: Allied Health: W avg 26 wks, M avg 10 wks Nursing: W avg 26 wks, M avg 3 wks Non-Clinical: W avg 22 wks, M avg 2 wks Medical: W avg 7 wks, M avg 1 wk</p>	Yes	<p>Formal flexibility agreements remain low at 3% of workforce (30 people, 87% women), substantially undercounting actual flexible work practice across occupational groups. Part-time rates for both genders have reduced (women 58% to 52%, men 59% to 56%).</p> <p>Confidence that flexible work requests would receive due consideration has remained stable for women at 60%, with</p>

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	<p>Confidence that flexible work requests would receive due consideration: 2023: Women 61.3%, Men 71.4% 2025: Women 60.0%, Men 81.6%</p> <p>Supplementary: Parental leave takers 2025: 71.1% W, 28.9% M</p> <p>Carer's leave takers: 70% W, 30% M</p>	<p>Formal flexibility by occupational group: Allied Health: 9% W, 5% M Nursing: 3% W, 5% M Non-Clinical: 5% W, 0% M Medical: 0% W, 0% M (sessional by design)</p> <p>Carer's leave by occupational group: Non-Clinical largest gender gap: 19% W vs 12% M Medical: reverse pattern 9% W vs 10% M (sessional schedule control reduces formal leave) Allied Health: near parity (17% W, 16% M) Nursing: near parity (16% W, 18% M)</p>		<p>men's confidence improving from 71.4% to 81.6%.</p> <p>None of the four original GEAP actions under this indicator were completed during the reporting period. Three were carried forward to the 2026-2030 GEAP and one (gender equality data in performance reports) was discontinued due to impracticality. A Flexible Work Arrangements procedure was developed separately during the reporting period.</p> <p>Carers leave is used by 14% of the workforce, with women taking leave at higher rates (15% compared with 12% of men). Parental leave shows significant gendered patterns: women average 20.8 weeks (70% unpaid) compared with men's 2.3 weeks (13% unpaid), with Allied Health and Nursing women most reliant on unpaid leave.</p> <p>The Eye and Ear's most significant progress is analytical. The organisation has identified that flexibility operates through fundamentally different models across occupational groups. The next GEAP shifts from promoting existing entitlements to addressing how flexibility operates differently across occupational groups.</p>
7	<p>Critical performance measures Occupational gender segregation (ANZSCO): Managers: 2023: Women 65.9%, 2025: Women 60.9% (-5pp) Professionals: 2023: Women 63.1%, 2025: Women</p>	<p>Internal occupational group composition (2025): Nursing: 88% W / 12% M Allied Health: 77% W / 23% M Non-Clinical: 67% W / 33% M Medical: 39% W / 61% M</p>	Yes	<p>Occupational segregation is unchanged in substantive terms. Nursing remains 88% women, Allied Health 77% women, Medical 39% women. These patterns reflect national education pipelines and century-old professional qualification structures beyond</p>

Indicator	L: Progress data (required)	M: Additional progress data (recommended)	N: Progress made?	O: How data demonstrates progress (required)
	<p>63.3% (stable) Technicians and Trades: 2023: Women 46.7%, 2025: Women 33.3% (-13pp) Community and Personal Service: 2023: Women 44.8%, 2025: Women 64.3% (+19pp) Clerical and Administrative: 2023: Women 77.8%, 2025: Women 70.1% (-8pp) All occupations: 2023: Women 63.9%, 2025: Women 63.2% (-1pp)</p>	<p>Pay consequence of segregation: Medical mean base: \$328,796 Nursing mean base: \$116,069 Gap: \$212,727 (reflects job valuation between enterprise agreements, not pay inequity). ANZSCO changes of note: Community & Personal Service +19pp (W 44.8%→64.3%): reflects reclassification, not workforce change. Tech & Trades -13pp: small cohort (n<15)</p>		<p>The Eye and Ear's direct control. Pursuing numerical gender balance is neither achievable nor appropriate when limited male candidate pipelines exist in nursing education nationally, and medical specialist training requires 10-15 years from medical school entry to specialist appointment. The genuine equity challenge is the job valuation applied to different enterprise agreements reflected in the \$212,727 gap between Medical and Nursing mean salaries. Traditional desegregation metrics are inadequate for feminised healthcare workforces and fail to capture genuine equity improvements occurring within occupational groups, such as nursing career progression and enterprise bargaining outcomes. ANZSCO classification changes between reporting periods account for some apparent compositional shifts and should be interpreted with caution.</p>

Section 2.2: Factors limiting and contributing to progress

Factors referenced below correspond to s16(2) of the *Gender Equality Act 2020*: (a) size, (b) nature and circumstances, (c) legislative requirements, (d) resources, (e) operational priorities, (f) practicability and cost, (g) genuine attempts.

Indicator	Factors (select)	Explain how factor(s) limited or contributed to progress	Strategies implemented that contributed to or aligned with the indicator
1	b, e, f, g	<p>(b) Nature and Circumstances: The Eye and Ear is a specialist public hospital with a fundamentally flat organisational structure. Four positions exist above Level -2, each tied to a specific professional stream (medical, nursing, non-clinical). The 1,096-person workforce is distributed across four occupational groups governed by 7 different enterprise bargaining agreements, with levels reflecting award classifications and role types rather than a shared organisational hierarchy. Workforce composition is shaped by professional qualification pathways and national educational patterns. Employment type distributions reflect operational design for 24/7 patient care and specialist practice, evidenced by near-identical part-time rates for women and men within clinical occupational groups.</p> <p>(e) Operational Priorities: Clinical service delivery requirements shape workforce structure, including 24/7 emergency coverage, structured registrar rotations, nursing ratios and multidisciplinary allied health teams. Government funding determines total FTE. Gender equality initiatives focus on areas within direct organisational control, particularly Non-Clinical employment structures and equitable access to advancement.</p> <p>(f) Practicability: Nursing education remains approximately 85–90% women nationally, and medical specialist training demographics take a decade or more to flow through to workforce composition. Seven enterprise bargaining agreements govern classification structures. Two-year reporting periods cannot capture generational change timeframes, though age-based pipeline analysis demonstrates improvements materialising over 10–15 years.</p> <p>(g) Genuine Attempts: The Eye and Ear appointed a woman to the Executive Director Operations/Chief Nursing Officer role at Level -1, (with a further appointment since the audit bringing executive representation to 50%). This role provides executive-</p>	<p>Action 1.1a (intersectional employee data collection): Completed via HRIS (PeopleHub) rollout.</p> <p>Action 1.1b (systems update for intersectional recruitment data): Completed.</p> <p>Action 1.1c (secondment program): Completed. Information available but requires review.</p> <p>Action 1.2a (celebrate and support intersectional identities): Completed. Pride Alliance established, pronoun pins distributed to 24% of staff, religious and cultural calendar expanded, disability and Deaf Awareness training delivered.</p> <p>Action 1.2b (leadership and champions trained in monocultural thinking and unconscious bias): Completed. Clinical executive team trained Nov-Dec 2022; clinical education, partnerships, allied health and pharmacy leadership trained 2023; quality and safety and remaining pharmacists trained 2024.</p> <p>Strategy 1.3 Action (40:40:20 - 40% male 40% female and 20% non-described for Gender Change model): Discontinued. Not a realistic goal until non-described disclosure increases.</p>

Indicator	Factors (select)	Explain how factor(s) limited or contributed to progress	Strategies implemented that contributed to or aligned with the indicator
		<p>level leadership representation for the organisation's largest and most woman-dominated professional group.</p> <p>The organisation developed occupational group and level-to-CEO analysis frameworks that distinguish structural reality from apparent progression barriers, achieved near-parity in part-time rates, and identified Non-Clinical as the priority for targeted action on progression pathways within woman-dominated streams.</p> <p>The 2026-2030 GEAP includes specific actions to investigate what meaningful career development looks like within each occupational group, rather than applying a single progression model across fundamentally different professional structures.</p>	
2	b, e	<p>(b) Board directors are appointed by the Department of Health for three-year terms, with final appointments recommended to the Minister for Health and approved by the Governor in Council. The Eye and Ear has no authority over director selection.</p> <p>(e) When vacancies occur, the Board Chair identifies required skills and participates in the interview panel, However, the candidate shortlist is controlled by the Department of Health and individuals apply through boards.vic.gov.au.</p>	No GEAP strategies directly address this indicator as board appointments are externally controlled.
3	b, e, g	<p>(b) Nature and Circumstances: The 37% organisational pay gap is driven by occupational segregation, not unequal pay. Within-occupation analysis shows near parity: Medical 0-2%, Nursing 1-4%, Allied Health reverse gap of 11-16% favouring women. The differential between medical and nursing remuneration reflects different professional qualification pathways and award structures across 7 enterprise bargaining agreements.</p> <p>(e) Operational Priorities: Medical specialist and nursing remuneration are externally determined through competitive sessional rates and sector-wide enterprise bargaining respectively. Meaningful reduction in the organisational gap requires transforming occupational segregation through medical training and nursing education demographics, both beyond the Eye and Ear's control. Non-Clinical (9-14% gap) is the one area</p>	<p>Action 3.1a (pay inequity grievance process): Moved to 2024-25. In progress, informed by new intersectional analysis.</p> <p>Action 3.1a (non-clinical remuneration framework): Discontinued. A more meaningful priority is correct classification, which will continue.</p> <p>Action 3.1b (yearly pay audit): Completed.</p> <p>Strategy 3.2 Action (acquire ability to analyse pay equity with an intersectional lens): Completed.</p> <p>Strategy 3.2 Action (review intersectional data for pay inequity): Completed.</p>

Indicator	Factors (select)	Explain how factor(s) limited or contributed to progress	Strategies implemented that contributed to or aligned with the indicator
		<p>where the Eye and Ear can investigate whether role distribution is creating gendered pay outcomes.</p> <p>(g) Genuine Attempts: The Eye and Ear achieved reductions across all four pay gap measures, with the largest being median total remuneration (48% to 41%). The organisation developed analytical frameworks disaggregating occupational segregation from equal pay issues and identified Non-Clinical as the priority for role-level investigation.</p>	
4	b, d, g	<p>(b) Nature and Circumstances: The shift in harassment sources to 48% originating from patients, clients and stakeholders complicates prevention and response, as traditional workplace harm frameworks assume perpetrators are subject to organisational authority. Healthcare sector research confirms this pattern nationally. The clinical environment, where 79% of employees are 'deskless' and don't readily access technology for corporate support functions, creates structural barriers to reporting.</p> <p>(d) Resource limitations historically prevented intersectional analysis. The 2025 audit conducted full demographic disaggregation for the first time, revealing that the groups experiencing elevated harassment rates and poorer workplace outcomes are also those from diversity groups or facing compounding employment insecurity, cultural and language barriers, and lowest confidence in organisational responses. This insight enables targeted, culturally safe interventions rather than one-size-fits-all approaches.</p> <p>(g) Genuine Attempts: The Eye and Ear has made genuine attempts including the initiatives outlined above. However, these have not translated into reduced reported prevalence (PMS) or increased formal reporting. The finding that zero formal complaints reached HR despite employees believing they had reported reveals a deficit in reporting infrastructure. The Eye and Ear's investment in intersectional analysis now provides the evidence base for targeted interventions in the new GEAP.</p>	<p>Action 4.1a (socialise sexual harassment reporting process): Moved to 2026-2030 GEAP.</p> <p>Action 4.1b (perpetrator-specific flow charts): Moved to 2026-2030 GEAP.</p> <p>Action 4.2a (track feedback after sexual harassment complaints or reporting): Focus shifted. First priority is improving the reporting process so staff can and do report.</p> <p>Action 4.2b (annual investigation feedback reporting): Moved to 2026-2030 GEAP.</p> <p>Action 4.3a (Peer Support Officer program, promotion, representation, reporting procedures): Completed. 16 Peer Support Officers trained and active (exceeding the target of 15), recruited from diverse clinical areas. Peer Support representation added to Health and Safety Committee. Precinct-wide collaboration established.</p> <p>Full intersectional analysis of sexual harassment conducted for the first time, providing evidence base for targeted interventions.</p>

Indicator	Factors (select)	Explain how factor(s) limited or contributed to progress	Strategies implemented that contributed to or aligned with the indicator
5	b, e, g	<p>(b) Nature and Circumstances: Recruitment reflects national pipeline demographics where medical specialist training requires 10–15 years and nursing education is heavily women-dominated. Formal promotion statistics (32 people, 3% of workforce) capture only a fraction of career advancement in clinical contexts where progression occurs through external credentialing rather than internal promotion.</p> <p>(e) Operational Priorities: As a teaching hospital, the Eye and Ear recruits for both ongoing employment and program delivery, which shapes the composition and nature of available roles. Vacancy-driven promotion means compositional change is constrained by low turnover, and funding settings constrain FTE expansion to create additional opportunities. Improving gender balance in Medical recruitment depends on national specialist training pipelines that operate on 10-15 year timeframes and are beyond any single organisation's control.</p> <p>(g) Genuine Attempts: The Eye and Ear maintained recruitment practices preserving women's representation and provided higher duties opportunities exceeding workforce presence (80% women). Developing career development data is a priority for the 2026–2030 GEAP. Declining fairness perceptions, particularly among people with disability (31% promotion fairness), and employees earning below \$80,000 (31%), indicate the need for improved transparency and communication strategies which also reach part-time and casual employees.</p>	<p>Action 5A (HRIS review): Completed via HRIS (PeopleHub) rollout.</p> <p>Action 5A (review and update recruitment and selection procedure): Completed via PeopleHub rollout.</p> <p>Action 5B (support new HRIS implementation for intersectional data collection and reporting): Completed via PeopleHub rollout.</p> <p>Action 5B (use new data capability and reporting systems for recruitment and promotion insight): Completed. Further work to continue as demographic data increases.</p> <p>Action 5B (embed equity and inclusion throughout recruitment and promotion practices): Discontinued as an unrealistic goal. Focus shifted to supporting increased disclosure.</p>
6	b, e, g	<p>(b) Nature and Circumstances: Flexibility is embedded in service delivery design rather than granted through individual agreements. Nursing provides structured flexibility through shift choice and Nurse Bank arrangements; medical specialists work premium-rate sessional arrangements across facilities; non-clinical staff often negotiate flexibility at commencement.</p> <p>Traditional flexible work metrics were designed for workforces where flexibility is an exception, not specialist healthcare environments where it is operationally standard. The definitional</p>	<p>Action 6.1 (socialise all leave opportunities): Moved to 2026-2030 GEAP (as 'flexibility opportunities').</p> <p>Action 6.2 (real-life examples of shared caring arrangements): Moved to 2026-2030 GEAP (as 'flexibility opportunities')</p> <p>Action 6.3 (manager tools and education on leave entitlements): Moved to 2026-2030 GEAP (as 'flexibility opportunities').</p>

Indicator	Factors (select)	Explain how factor(s) limited or contributed to progress	Strategies implemented that contributed to or aligned with the indicator
		<p>difference between the Commission's survey categories and the Eye and Ear's employment classification framework means formal agreement rates systematically undercount actual flexible work practice and should not be read as indicating limited access to flexibility.</p> <p>(e) Operational priorities: Clinical service delivery requires structural flexibility for 24/7 coverage and sessional specialist coordination. Career penalties for junior doctors taking parental leave cannot be eliminated without sector-wide specialist training program reforms beyond the Eye and Ear's control. The central equity question is whether different flexibility models provide equitable career and remuneration outcomes across genders and occupational groups, and this question now underpins the 2026-2030 GEAP's flexibility actions.</p> <p>(g) Genuine attempts: The Eye and Ear has developed operational flexibility models enabling workforce flexibility at scale across all four occupational groups. The analytical work undertaken during this reporting period has produced a materially deeper understanding of how flexibility operates differently across the organisation. The 2026-2030 GEAP will address gaps through manager capability building, equitable flexibility assessment across occupational groups, and communication strategies ensuring all employees are aware of flexibility options.</p>	<p>Flexible work arrangements and hybrid work procedures commenced during the reporting period.</p>
7	b, e, g	<p>(b) Nature and Circumstances: The Eye and Ear's occupational segregation is structurally embedded in professional qualification requirements, specialist college training pipelines and industrial frameworks that operate at sector and national levels. These structures have developed over generations and cannot be reversed through organisational recruitment or promotion strategies within any reporting period. The four occupational groups are professionally distinct and not interchangeable, and standard segregation metrics do not account for this structural reality.</p>	<p>Action 7.1 (investigate gender imbalance in teams, professions and management levels): Discontinued. Target not achievable given professional qualification requirements and determined inappropriate for healthcare workforce.</p> <p>Action 7.2 (review rostering practices for equitable participation): Discontinued after further analysis demonstrated it was unlikely to achieve meaningful impact as originally framed.</p>

Indicator	Factors (select)	Explain how factor(s) limited or contributed to progress	Strategies implemented that contributed to or aligned with the indicator
		<p>(e) Operational priorities: Clinical service delivery depends on maintaining qualified workforces across all four occupational groups. Interventions that would alter occupational composition, such as recruiting men into nursing to improve gender balance statistics, would not address the underlying pay equity issue. The Eye and Ear's equity priorities focus on conditions, career development and cultural safety within occupational groups rather than compositional targets that cannot be achieved through organisational action alone.</p> <p>(g) Genuine attempts: The Eye and Ear has invested substantially in developing the analytical capability to understand how occupational segregation operates in its specific context, has identified the limits of standard indicator frameworks for feminised healthcare workforces, and has designed the 2026-2030 GEAP to target equity interventions within direct organisational control.</p>	

Step 3: Reporting on GEAP Strategies (Template Version)

Section 3.1: Explaining Incomplete Strategies (required)

For any strategies in your GEAP that were not completed, explain why.

Of the 41 discrete actions in the 2022-2025 GEAP, 41% were completed, 37% have been carried forward to the 2026-2030 GEAP for continued implementation, and 22% were discontinued. Carried forward actions cluster across four areas: sexual harassment reporting and response improvements, manager capability building for inclusive leadership and flexibility, leave socialisation and carer support, and ongoing cultural change and demographic disclosure work. These are consolidated into fewer, higher-impact actions in the 2026-2030 GEAP rather than carried forward as discrete items, ensuring continued progress without fragmenting effort across a large action list.

The single most significant barrier was dependency on the PeopleHub HRIS system, delayed throughout the entire reporting period. Multiple action streams required this infrastructure, including intersectional data collection, pay equity analysis, and recruitment data tracking. PeopleHub has since been rolled out, and the 2026-2030 GEAP has been designed to reduce dependency on any single system.

Action 3.1a, implementing a remuneration framework for non-clinical roles, was not completed during this period. Subsequent analysis identified that the more immediate priority is ensuring employees are correctly classified into the right occupational groups, as misclassification affects how pay gap data is read and where equity interventions are targeted. This work will continue in the 2026-2030 GEAP alongside the Eye and Ear's concurrent role rationalisation project, which is reviewing and consolidating job titles across the organisation and mapping roles to the correct occupational groups for workforce reporting purposes.

Indicator 7 (Gendered Segregation) actions showed minimal progress because early analysis revealed traditional desegregation approaches are fundamentally inappropriate for feminised healthcare workforces. Two of three actions were discontinued after analysis demonstrated that original targets, including placing individual employees into gender-atypical roles, did not address structural drivers of segregation. A further three actions targeting 40:40:20 (40% male 40% female and 20% non-described) gender balance in senior leadership and a 5% decrease in intersectionality as a barrier to career success were also discontinued as unrealistic given the Eye and Ear's the small cohort disclosing 'non-described'. These findings are discussed in detail under Indicators 5 and 7.

The Eye and Ear successfully expanded its Peer Support program from 9 contact officers to 10, although zero sexual harassment reports were made through this channel. Seven sexual harassment actions have been carried forward to the 2026-2030 GEAP, informed by the significant shift toward patient-perpetrated harassment identified in the 2025 People Matter Survey and discussed under Indicator 4.

All actions under Indicator 6 (Leave and Flexibility) were scheduled for 2024-25. Three of four have been carried forward, while one was discontinued. The Eye and Ear's workforce analysis revealed that the original actions would not address the structural inequities in how flexibility is experienced across occupational groups, as detailed under Indicator 6.

Section 3.2: Achievements, Challenges and Learnings (recommended)

Describe any key achievements, challenges, or learnings.

Achievements: The Eye and Ear's most significant achievement was developing comprehensive analytical frameworks revealing how gender inequality operates in healthcare. The Level to CEO analysis demonstrated that traditional hierarchical progression does not apply across most of the

workforce: levels reflect award classifications and role types rather than career stages, nursing and medical pathways terminate at Level -2 with no route to executive. This reframing identified Non-Clinical as the only occupational group where level-to-CEO functions as a meaningful progression indicator. Even here, Non-Clinical operates as several distinct streams (corporate/management, finance, ICT/digital, facilities/trades, clinical support) rather than a single pipeline, with women well represented where genuine hierarchical progression exists (55% of directors, 65% of managers).

Occupational group analysis across Allied Health (162 positions, 15%), Medical (400 positions, 36%), Nursing (304 positions, 28%), and Non-Clinical (230 positions, 21%) revealed that aggregate statistics mask notable segregation. Each group operates under different awards with distinct gender dynamics, pay structures and employment patterns. The ANZSCO 'Professionals' category appears 63% women but conceals a salary differential of approximately \$213,000 in mean base pay between nursing and medical specialist roles.

Intersectional People Matter Survey analysis identified LGBTQIA+ employees (20-25 percentage point deficits), people with disability (15-18 percentage point deficits), and employees below \$80,000 (11-17 percentage point deficits) as experiencing the most significant workplace disadvantage. These findings have directly shaped the targeting of the 2026-2030 GEAP.

Cultural change initiatives delivered measurable results: Pride Alliance established, pronoun pins distributed to 24% of staff, Pride, bi and trans flags installed, religious and cultural observances added to the organisational calendar, and disability employment and Deaf Awareness training delivered. Clinical Executive and multiple departmental teams completed intercultural competency training between 2022 and 2024. The proportion of employees identifying as not heterosexual increased by 10 percentage points, disclosure doubled for gender identities other than man or woman and for trans status, disability disclosure increased by 2 percentage points, and employees born outside Australia by 3 percentage points, suggesting improved psychological safety for disclosure.

Challenges: Closing occupational segregation through compositional change is structurally constrained. Nursing is 88% women with limited male candidate pipeline nationally; medical specialists are 38% women with a 10 to 15 year training pipeline beyond the Eye and Ear's control. The workforce of 1,096 means recruiting 10 to 20 people produces less than 2% statistical impact, and genuine equity work is often statistically invisible: promoting women from Level -7 nursing roles to Level -2 nurse manager positions represents meaningful career progression but produces no change in occupational group statistics.

Cultural initiatives, while valuable, have been insufficient without structural change. LGBTQIA+ employees continue to experience the most notable workplace disadvantage of any demographic group measured, indicating that visible inclusion measures must be paired with structural interventions in workplace safety, career progression and management practices. Cultural identity and religion disclosure decreased by 6 and 2 percentage points respectively over the same period, warranting a requirement to build trust for disclosure and its intent.

Learnings: The seven Gender Equality Indicators do not translate effectively to feminised healthcare contexts where 64% of employees are women but concentrated in lower paid occupations. For male-dominated industries, progress is appropriately measured by increasing women's representation. For feminised healthcare organisations, several metrics are inappropriate: occupational segregation metrics targeting numerical gender balance would not address the remuneration disparities, and pay gap metrics cannot account for segregation driven by entirely separate professional qualification pathways. The actual equity issues, the significant differences in pay between enterprise agreements, and undocumented career progression pathways from nursing to executive leadership, are largely invisible in the standard indicator framework.

This learning is reinforced by the GEAP completion rate. Three actions were assessed as having unrealistic targets, and two Indicator 7 actions were cancelled, not because the organisation lacked commitment, but because they were impractical or the targets were designed for workforce contexts fundamentally different from the Eye and Ear's. Progress for feminised healthcare workforces should be measured by improvements in workplace

culture and inclusion for marginalised groups, strengthened employment security in feminised roles, expanded career progression opportunities within nursing and allied health, and transparent and equitable people management practices. The Eye and Ear's 2026-2030 GEAP adopts these measures.

Section 3.3: Other Updates on Implementation (recommended)

Provide any other updates on your GEAP implementation.

Section 3.4: Resourcing Allocation (required)

Describe your organisation's resource allocation to implement your GEAP strategies.

The Eye and Ear established a dedicated Equity and Inclusion Coordinator position (1.0 FTE) to lead GEAP implementation across the organisation, reporting to the Executive Director of People and Communication, who serves as Executive sponsor for GEAP implementation. The Coordinator was responsible for driving action completion, coordinating across divisions, supporting data collection and analysis, and reporting progress to the Executive and Board. This position was vacated in April 2024 and remained unfilled for seven months until November 2024, when the Organisation Development Lead commenced. Gender equality and diversity, equity and inclusion work forms one component of this broader role rather than a dedicated function.

The seven-month vacancy during a critical implementation period contributed to delays across multiple action streams. However, the Eye and Ear's investment in occupational group analytical frameworks and streamlined reporting during this GEAP period means that ongoing gender equality analysis and reporting will be less resource-intensive going forward. The four occupational group structure (Allied Health, Medical, Nursing, Non-Clinical) provides a reusable framework for workforce analysis, and the intersectional analysis methodology developed during 2025 can be applied efficiently to future PMS data without requiring the foundational analytical work repeated each cycle.

Funding over four years (2022–2025) was approved to implement training programs, cultural change initiatives, and system upgrades required for data collection and reporting. This funding supported intercultural training and unconscious bias education for leadership and employees, Peer Support Officer training and coordination, disability employment and Deaf Awareness training, the People Hub HRIS implementation (systems infrastructure for intersectional data collection), development of educational resources and communication materials, and cultural celebration initiatives including Pride flags, pronoun pins, the Pride Alliance, and religious and cultural calendar additions.

The delayed People Hub HRIS system consumed resourcing that had been allocated to actions dependent on that infrastructure. This demonstrates that adequate resourcing alone is insufficient when system dependencies create barriers beyond organisational control.

The Eye and Ear's 2026–2030 GEAP is resourced at 0.4 FTE (\$51,809 annually, \$64,761 including on-costs), based on an Organisational Development Lead salary of \$129,522), embedded within the Organisational Development Lead role, with approximately \$40,500 annually in implementation funding: \$3,000 for targeted activities, \$8,500 for leadership development, and \$29,000 for ongoing learning and development including sexual harassment prevention, respectful workplace behaviours, and equal opportunity unit compliance modules. The combined annual investment of approximately \$92,309 represents a considered reduction from the previous GEAP period.

This reflects a deliberate shift from the resourcing model of the 2022–2025 GEAP. The previous period required substantial investment in foundational capability: building analytical frameworks, establishing baseline data, developing intersectional analysis methods, and delivering broad-scale cultural change initiatives. That investment has produced a significantly deeper understanding of how gender inequality operates within the Eye and Ear's specific healthcare context, where the structural barriers sit, and which interventions are within organisational control. With those foundations in place, GEAP implementation can be embedded as core business within existing people and culture functions rather than resourced as a standalone program.

To support implementation across the organisation, the Eye and Ear will establish a cross-functional GEAP working group comprising one to two representatives from each occupational group, drawn from a mix of levels and reflecting the diversity of the workforce. This group will provide ongoing consultation, sense-checking proposed interventions against the operational realities and lived experience of employees in different roles. Participation will be recognised as a leadership development opportunity, building internal capability for equity work while ensuring that actions are designed with, not just for, the people they are intended to benefit.