Submission to the Senate inquiry into universal access to reproductive healthcare

15 December 2022

About Women's Health Matters

Women's Health Matters (WHM) is an independent, non-partisan think tank that works to improve the health and wellbeing of all women in the ACT and surrounding region. We seek to improve access to health information and enhance knowledge and understanding about the causes of health and illness among anyone who identifies as a woman.

We advocate on behalf of all ACT women, especially those experiencing disadvantage and vulnerability. We want women to feel in control of and understand the determinants of their own health and wellbeing. We do this through health promotion and by providing evidence-based social research, policy development and advocacy services to governments, the corporate sector, policy makers, service providers and peak bodies.

Our submission

WHM supports and welcomes the Senate Inquiry into Universal Access to Reproductive Healthcare. We view the inquiry as a timely opportunity to consider barriers to the implementation of the *National Women's Health Strategy 2022-2030*. Maternal, sexual and reproductive health is a priority area of the Strategy, with one of the three key priority areas of action being to increase access to sexual and reproductive health information, diagnosis, treatment and services. We note that equitable access to pregnancy termination services is a key measure of success, and this is a focus of our submission.

We also note that universal access requires consideration of all women and people with uteruses[1] living in Australia, including First Nations people and all non-Indigenous people who have settled here through colonisation and migration, and irrespective of visa category or Medicare access.

Our submission is informed by the voices of women and people with uteruses who have accessed or tried to access an abortion in the ACT, which we collected via a community survey for our submission to the recent *Inquiry into abortion and reproductive choice in the ACT (2022)*. This survey collected 102 responses. We have also drawn from our 2018 survey research: *Improving choices and options – The views of ACT women about their sexual and reproductive health needs*. This survey collected 510 responses from ACT women. Both of these documents are included as appendices to our submission.

Reproductive justice

WHM supports and calls for reproductive justice, which acknowledges that reproductive rights include the formal and substantive right not to have a child, through abortion and/or contraception, as well as the right to have a child, and the right to parent children without fear of violence or discrimination.[i]

We acknowledge the deliberate and active reproductive violence that occurs against people in the ACT as in Australia more generally, particularly Aboriginal and Torres Strait Islander people, people with disabilities, people living in poverty, and people being subjected to reproductive coercion, among others. This includes practices such as forced sterilisation and the forced removal of children. Responses to reproductive injustice that are led by and for Aboriginal and/ or Torres Strait Islander communities should be supported and resourced.

[1] In this submission we use the term women and people with uteruses. Where sources have used different language or categories, we have reflected the terminology used for accuracy.

Recommendations:

Support abortion access and equity

1. Establish a National Taskforce on abortion access to address abortion equity across all States and Territories, including navigation, health information and support
2. Extend Medicare to include all migrants irrespective of visa category
3. Support availability of abortion for all indications in all public hospitals
4. Support amendments to the Risk Management Plan regulatory reform for medical abortion medication that will improve access and equity
5. Fund a national telephone service and website to provide health information, navigation and referral pathways, and support for pregnancy options, including abortion, and contraception

Enable workforce development

6. Enable nurse-led early medical abortion care, including by expanding nurse practitioner scope of practice
7. Establish a Royal Commission into the health and wellbeing of the Australian health workforce
8. Include sexual and reproductive health education in undergraduate degrees and postgraduate training programs including medicine, midwifery, nursing, general practice and obstetrics and gynaecology on a mandatory basis
9. Provide post-graduate education pathways to upskill the current nursing workforce which are accredited by reproductive health peak bodies
10. Improve LGBTIQ+ inclusion in all levels of health care education
11. Provide ongoing investment to support and develop a bilingual, bicultural health workforce that is professionally recognised and appropriately remunerated

Support contraception access and equity

12. Increase Medicare Benefits Schedule (MBS) rebates for LARC provision
13. Extend the Pharmaceutical Benefits Scheme (PBS) to allow more comprehensive choice of effective contraceptive options
14. Streamline Therapeutic Goods Association (TGA) approval processes for contraceptives to facilitate greater choice

End reproductive violence and coercion

15. Establish a national inquiry into reproductive violence, including for Aboriginal and/or Torres Strait Islander people and people with disabilities
16. Support and resource responses to reproductive injustice that are led by and for Aboriginal and/or Torres Strait Islander communities
17. Fund research into the prevalence, nature and prevention of reproductive coercion

Investigate reproductive health leave

18. Commission research into the impact of reproductive health on the engagement of people with uteruses in the labour force, and to evaluate existing reproductive health leave policies
19. Conduct public consultation to establish community interest and support for reproductive health leave, with a view to considering its inclusion in the National Employment Standards.

Cost and accessibility of abortion care in the ACT

Medical abortion

Medical abortion up to 9 weeks gestation is available in the ACT through a small handful of prescribing GPs[ii]. In addition, medical abortion is available from some public and specialist clinics and medical abortion by telehealth is available from the MSI Australia private clinic. There is no clear information available about where to access a prescribing GP either for clinicians or the public. Only four GPs are listed on HealthPathways.

Accessing a medical abortion requires tests and ultrasound to confirm the gestation of a pregnancy and whether it is intra-uterine. Recent evidence given at the *Inquiry into abortion and reproductive choice* in the ACT indicates that access to ultrasound is also an increasing challenge in this pathway.

From a pharmaceutical perspective, there are 157 trained dispensers (pharmacists) across the Territory, although the availability of medical abortion medication is dependent on a pharmacy being willing to stock and dispense the medication, as well as current stock levels. Similarly to GP services, there is currently no clear information publicly-available information about where medical abortion medication is stocked and dispensed in the ACT.

Pregnant people accessing medical abortion through a primary care pathway are subject to variable costs. The entire pathway is estimated to cost up to $200 for Medicare card holders and around $1,000 for non-Medicare card holders. People on temporary visas, including international students who are subject to a one year waiting period on pregnancy-related health care under the Overseas Student Health Cover (OSHC) arrangements,[iii] are particularly disadvantaged with regard to cost.

Surgical abortion

A surgical abortion pathway in the ACT is provided solely through the private MSI Australia clinic. Costs for a surgical abortion start at $650.00 and range up to $1,980.00 depending on a person's gestation and whether they hold a Medicare or Health Care Card.

MSI cannot offer surgical abortion post-16 weeks gestation or for patients with comorbidities or who are at an increased risk. Therefore, in spite of the ACT legal framework in which abortion is legal at any gestation, people who do not fit the criteria for access at MSI Australia must travel to a clinic interstate at significant cost. These women and pregnant people are more likely to experience additional layers of complexity, for example domestic and family violence.

Pregnant people who are required to travel interstate are eligible for the Interstate Patient Travel Assistance Scheme (IPTAS) to cover expenses. IPTAS is only available to people with a Medicare card, and does not cover taxi fares, meals, public transport, parking fees, medical procedures, or costs for a support person, all of which may be needed to access interstate abortion services.

Surgical abortion is only provided in the public system in extremely restricted circumstances. The Fetal Medicine Unit at Centenary Hospital for Women and Children provides abortion, including post-16 weeks gestation, in the case of fetal anomaly or severe maternal morbidity. Abortions beyond 20 weeks gestation require approval by a Termination Review Committee, with some conditions exempt. "Social" circumstances or mental illness are outside of the scope of the Fetal Medicine Unit service.

Accessibility

Through our 2022 survey, women and people with uteruses reported to WHM about delays in referrals and getting appointments as key challenges, highlighting the many points at which even subtle forms

of stigma or conscientious objection by practitioners can impede access to the kind of abortion care that is desired and needed. The likelihood and impacts of stigma are greater at the intersections of multiple forms of marginalisation. Aboriginal and/or Torres Strait Islander people may already be subject to racism, dismissive behaviour or assumptions about the care they may need. During consultation, we heard examples of women being pressured to have tubal ligation.

Trans men, nonbinary people and people with intersex variations may be exposed to gender-based discrimination, including assumptions, negative body language or comments about their need for or choice of contraceptive access or abortion care. People with disability are also subjected to ableism, and often lack access to appropriate sexual and reproductive health care in part due to lack of understanding by health professionals.[iv] People from migrant and refugee backgrounds are subject to discrimination where there is a lack of trained interpreters and bilingual, bicultural health workers.

Through our 2022 survey, we heard that a small number of respondents had tried but not been able to have an abortion in the ACT/region. The majority had attempted in the last 10 years. Our survey found that objection/refusal by practitioners is the leading reason reported for being unable to access an abortion, with 42% nominating 'health providers refused or chose not to help me' as a main reason for being unable to access an abortion.

When we asked people who had an abortion what worked well with the support they received, the most widely cited factor was kind, compassionate, non-judgemental and competent care by medical professionals. This kind of support is not currently available to all people seeking an abortion, and many still experience stigma and encounter systems that are ill-equipped to meet their needs.

The cost of primary care appointments is frequently raised in WHM's research as a barrier for women accessing health care,[v] with the ACT having one of the lowest bulk billing rates in the country. This is reflected in our survey on abortion, with 41% of people who were able to access abortion reporting that 'Medication, tests, procedure and/or appointments were too expensive', while significant numbers had trouble taking time off work or study (14%). Other indirect costs include child care, and travel costs to and from appointments or interstate.

Responses to our survey highlight how unaffordability of abortion care is compounded by life circumstances:

> *The cost and being a victim of DV made it almost impossible for me to access because I was already in debt from my ex and it was hard to find the money, let alone have the procedure*

We heard that while at a household level, women and people with uteruses may be financially secure, stigma or coercion from partners or family members may prevent them being able to draw on these resources. In the case of migrant and refugee women and people, stigma in their religious and ethnic communities may mean they are unable to draw on local resources and networks to afford care.

Availability of appointments, in a primary care system under significant strain, is also a critical barrier. Significant numbers of those who were successful in accessing abortion reported trouble finding appointments (18%). WHM supports a move toward nurse-led models of care to address the barriers created by cost and service availability in primary care.

When we asked people who had an abortion what worked well with the support they received, the most widely cited factor was kind, compassionate, non-judgemental and competent care by medical professionals. However, this kind of support is not currently available to all people seeking an abortion,

particularly with the impacts of COVID-19 on already strained workforces, and many still experience stigma and encounter systems that are ill-equipped to meet their needs.

Health information and support

There is limited independent and publicly available information for people seeking abortion in the ACT. Health information is available from the websites of ACT Health, WHM and Sexual Health and Family Planning ACT (SHFPACT). These pages list options for surgical abortion in the ACT region, but there is no publicly available list of GP providers online. There is no ACT-specific information online about pregnancy options, including adoption and kinship care.

SHFPACT provides navigation in an unfunded capacity and maintains a private list of GP prescribers of medical abortion medication. This information is provided to pregnant people contacting SHFPACT for service options. SHFPACT and MSI Australia provide free, confidential, non-judgmental, and non-directive unplanned pregnancy counselling for people experiencing an unplanned pregnancy. Some GPs may also provide this service.

We have repeatedly heard that accessing abortion requires a high degree of health and computer literacy as information is not readily available. Our 2018 survey indicated there may be a lack of understanding about where to go to access services such as termination of pregnancy and the difference between a medical and surgical termination of pregnancy among ACT women.

These findings were backed up by our 2022 survey, in which nearly 30% (n=26) of women and people with uteruses who had had an abortion said they would have preferred another type of abortion instead of the one they had. Many respondents who would have preferred another type of abortion indicated that information and support to navigate options was sorely lacking, compounded by delays in accessing appointments. This points to a need for better health information and navigation, and an opportunity to build from the successful models of 1800MyOptions in Victoria, Children by Choice in Queensland and Pregnancy Choices Tasmania.

Cost and accessibility of contraception in the ACT

In our 2018 survey, 78 (18.16%) of 413 respondents reported at least one barrier to accessing contraception in the ACT, with some reporting multiple. The main barriers were: affordability (n=26, 33.77%); time (n=18, 23.38%); confusing information about contraception (n=9, 11.69%); and limited services available (n=5, 6.49%). A significant issue was the low number of bulk-billing GPs.

It is concerning that the cost and timely availability of primary care services is a barrier to accessing contraception, particularly given that, as noted by respondents, contraceptives often support other aspects of reproductive health (such as conditions such as painful periods). There is a need to reduce the cost of and increase availability of accessing contraceptives to support reproductive choice.

In our 2018 survey when asked if they found it easy to find reliable and relevant information about their sexual and reproductive health, 73.33% of respondents who answered the question answered ‘Yes’, and 26.67% selected ‘No’. It is worth noting that as the sample was self-selecting, it is likely to be biased toward people with an interest in sexual and reproductive health. Despite this, women reported that they had difficulty finding the information they needed that was age appropriate, relevant to their chronic conditions, menopause and/or LGBTIQ+ friendly. Many respondents also commented that they have experienced poor contraceptive counselling from doctors:

It can be difficult to find correct, up to date and accurate information regarding contraceptives. Particularly when seeing male GPs who will just happily prescribe the pill in one of its forms without actually examining what might be best for the particular situation.

With this in mind, long-acting reversible contraceptive (LARC) use among the women surveyed remained relatively low at 24.15% of the total sample. WHM is currently conducting a general survey of women's health in the ACT, which will close in 2023. Early unpublished findings from this dataset likewise suggest LARC users make up about 24% of the sample.

Early findings from this dataset also indicate most people (around 63%) were either very satisfied or extremely satisfied with their current form of contraception. Around 10% were dissatisfied or very dissatisfied. For those who were dissatisfied, we asked what is preventing them from changing their current form of contraception. Around 25% cited cost, around 23% said they were not sure what options there are, around 23% said their doctor had advised other options were not suitable to them, around 17% said that they didn't have time, and around 17% cited preferences or dynamics in their relationships. Almost 50% nominated other reasons through free text answers, in which many raised concerns about pain and side effects of various forms of contraception.

There are early indications from our 2022 survey that people using the combined pill are more likely than average to be *dissatisfied* with their contraception, while people using a LARC may be somewhat more likely to be *satisfied* with their contraception. Collectively, these findings suggest a need for health promotion and information about contraceptive options.

Reproductive coercion

In the course of our research, we heard multiple stories of reproductive coercion in the ACT from community organisations and services providers. According to MSI Australia, reproductive coercion is "behaviour that interferes with the autonomy of a person to make decision about their reproductive health", and can include sabotage of another person's contraception, pressuring another person into pregnancy, controlling the outcomes of a woman or person with a uterus's pregnancy. For example, forced continuation of a pregnancy or forced abortion, or forcing a person into sterilisation

Reproductive coercion can be structural, arising from social, political or environmental factors which create an enabling environment for the control of reproductive choice and health, or interpersonal, intentional, controlling behaviours from another person (for example, resulting from domestic and family or sexual violence). There is very little data on reproductive coercion in Australia, which precludes the development of practice guidelines for health practitioners to respond effectively.[vi]

Availability of reproductive health leave

Paid reproductive health leave recognises the value of reproduction for society, and that reproductive bodies involve changes which are not illnesses and so are not suited to sick leave. Reproductive health leave may support workforce capacity, with evidence indicating people with endometriosis and menopausal symptoms may drop out of inflexible workforces, and that reproductive health leave may support retention in feminised sectors such as aged care, nursing and teaching.[vii]

While it has a long international history in the form of menstruation leave, availability of reproductive health leave in Australia is currently limited, and is being driven by a handful of organisations and

unions. These include the Victorian Women's Trust,[viii] Health and Community Services Union,[ix] Modibodi,[x] Victorian Greens,[xi] and ourselves at Women's Health Matters.[xii]

Existing policies differ in terms of the number of days in the entitlement, ranging from 5 days to 24 per calendar year. Their scope also differs: Victorian Women's Trust and Modibodi have a more limited focus on menstruation and menopause and for Modibodi, miscarriage. HACSU, WHM and the Victorian Greens have a much wider reproductive health scope to their claim, policy and platform. WHM supports a wider reproductive health scope and the explicit inclusion of abortion and fertility treatment, both to destigmatise abortion and because lack of paid leave adds to the high cost of abortion care.

A strength of the Victorian Women's Trust and Modibodi policies is their inclusion of flexible work arrangements, which also appear in the HACSU claim and our WHM policy. The combination of leave and flexibility have an explicit aim of revolutionising gender relations in the workplace by allowing women and people with uteruses to be more embodied at work. WHM supports combining a broad scope of reproductive health with these flexible arrangements. There is a need to build the evidence on reproductive health leave, and drive support within the Australian community.

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[i] See SisterSong, who coined the term reproductive justice: https://www.sistersong.net/reproductive-justice, accessed 4 August 2022, https://msi-australia.medium.com/in-response-to-overturning-roe-v-wade-we-need-reproductive-justice-now-ec7f09f120ce, accessed 4 August 2022.

[ii] It is estimated by Deep End GPs Canberra that this number is around 13. According to MS Health, as many as 54 prescribers may have undergone the required training to prescribe.

[iii] Carolyn Poljski, Regina Quiazon, and Chau Tran, "Ensuring Rights: Improving Access to Sexual and Reproductive Health Services for Female International Students in Australia," *Journal of International Students* 4, no. 2 (April 1, 2014): 150–63, https://doi.org/10.32674/jis.v4i2.475.

[iv] See Women's Health Matters (2022*), 'I have to ask to be included…' The views of ACT women with disabilities about their health and health needs, access to services, supports and information, and barriers to maintaining health*, https://www.womenshealthmatters.org.au/wp-content/uploads/2022/02/Womens-Health-Matters-Women-with-disability-health-and-wellbeing-report-February-2022.pdf

[v] See for example, https://www.womenshealthmatters.org.au/wp-content/uploads/2020/10/ACT-Womens-Health-Matters.pdf, accessed 8 August 2022.

[vi] https://www.mariestopes.org.au/wp-content/uploads/Hidden-Forces-Second-Edition-.pdf, accessed 10 August 2022, Nicola Sheeran et al., "Reproductive Coercion and Abuse among Pregnancy Counselling Clients in Australia: Trends and Directions," *Reproductive Health* 19, no. 1 (July 30, 2022): 170, https://doi.org/10.1186/s12978-022-01479-7.

[vii] Mark E. Schoep et al., "Productivity Loss Due to Menstruation-Related Symptoms: A Nationwide Cross-Sectional Survey among 32 748 Women," *BMJ Open* 9, no. 6 (June 1, 2019): e026186, https://doi.org/10.1136/bmjopen-2018-026186.; Petra Verdonk, Elena Bendien, and Yolande Appelman, "Menopause and Work: A Narrative Literature Review about Menopause, Work and Health," *Work* 72, no. 2 (January 1, 2022): 483–96, https://doi.org/10.3233/WOR-205214.

[viii] https://www.vwt.org.au/menstrual-policy-2/, accessed 2 December 2022.

[ix] https://hacsu.asn.au/Why-HACSU-is-fighting-for-Reproductive-Health-and-Wellbeing-Leave~25689, accessed 2 December 2022.

[x] https://www.modibodi.com/blogs/womens-underwear-online/modibodi-launches-menstrual-menopause-miscarriage-leave, accessed 2 December 2022.

[xi] https://greens.org.au/vic/news/workers-would-get-reproductive-leave-under-plan-address-gender-inequality, accessed 2 December 2022.

[xii] https://www.womenshealthmatters.org.au/womens-health-wellbeing/womens-health-matters-reproductive-leave-policy/, accessed 2 December 2022.