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RANZCOG SUBMISSION TO THE SENATE INQUIRY INTO UNIVERSAL ACCESS TO REPRODUCTIVE HEALTHCARE

Response to the Inquiry by the Senate Standing Committees on Community Affairs

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

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RANZCOG Submission to The Senate Inquiry into Universal Access to Reproductive Healthcare

About RANZCOG

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG; the College) strives for excellence and equity in women's health across Australia and New Zealand. The College trains and accredits doctors in the speciality of obstetrics and gynaecology, and GP obstetricians, so that they can provide the highest standard of healthcare. As the peak body in education, training and advocacy in obstetrics and gynaecology, we support all women and the clinicians who treat them.

Introduction

RANZCOG recognises that sexual and reproductive health is an essential component of healthcare and welcomes the opportunity to provide comments on the *Senate inquiry into universal access to reproductive healthcare*. We provide a specialist perspective on the inquiry terms of reference and identify some of the key barriers to universal sexual and reproductive health (SRH) access. We highlight the role of College members in sexual and reproductive healthcare, discuss regulatory and cost barriers to service access, and identify the significant impact a lack of public hospital pathways to abortion and contraception care has not only on equitable access to SRH care, but also on workforce development and training. The College has established a Sexual and Reproductive Health Special Interest Group to ensure that issues of contraception, abortion and sexual health are addressed in training and guidelines. This group has led the development and implementation of a two-year training pathway in abortion and contraception with the aim of providing specialist leadership in these areas. Training opportunities, however, remain limited by the current regulatory and hospital service environment that in many states and territories provides limited public health service pathways to accessible sexual and reproductive health care.

Summary of RANZCOG recommendations

RANZCOG recommends the following:

1. Contraception options supported by the Pharmaceutical Benefits Scheme (PBS) be expanded and public hospital clinics providing long-acting reversible contraception (LARC), including postpartum be developed to increase both access and training.
2. RANZCOG regards abortion as essential healthcare, and all public hospitals should provide a first trimester surgical abortion pathway to enhance equitable access and workforce training.
3. Therapeutic Goods Administration changes are made so that the medications for medical abortion are available like other prescribed medication.
4. The establishment across all jurisdictions of a publicly funded and accessible directory of abortion and contraception providers to help patients and providers find appropriate care, similar to the "1800 My Options" in Victoria.
5. A dedicated federal funding stream to establish service pathways through public hospitals, and consumer information as has occurred with endometriosis and pelvic mesh care.

Cost and accessibility of contraceptives

PBS coverage and Therapeutic Goods Administration (TGA) approval processes for contraceptives

PBS coverage

PBS covers only the basic oral contraceptives available. The formulations that may be more helpful for androgen symptoms such as acne or hirsutism are not subsidised by the PBS, limiting choice, and increasing inequity. In addition, the progestogen only pills which inhibit ovulation are not subsidised. PBS should also subsidise the vaginal ring, to increase affordable contraceptive method mix. With more choice, there will be higher acceptability, satisfaction, and continuation rates. In particular, increased community acceptance contraceptive vaginal ring may be useful in future when multi-purpose vaginal rings (pregnancy/ human immunodeficiency virus / sexually transmitted infection (STI) prevention) become available.

TGA approval process for contraceptives

Streamlining TGA approval processes for new contraceptive methods and label changes to ensure Australian consumers have access to the latest methods in line with access in similar countries including the United Kingdom (UK) and United States of America (USA). The TGA approval process for contraceptives is expensive and therefore limits the types of contraceptives available to women in Australia. The license for the use of the Mirena intrauterine system has been extended in the United States to eight years based on results from a Phase 3 extension trial evaluating the efficacy and safety of Mirena. This is currently requiring a full submission which will delay this change by 12 months, increasing the cost to health services and women. [1]

Awareness and availability of long-acting reversible contraceptive and male contraceptive options

There is low awareness of LARC methods in the community. Australia has one of the lowest rates compared to similar wealthy countries with only 11% of women using LARC methods (implants 7% intrauterine device (IUDs) 4%).[2] This compares to 46% using LARC in the United Kingdom (UK). Of note, LARC methods are highly cost effective and increased availability and uptake has the potential to result in enormous cost savings. Publicly funded campaigns to increase knowledge and access are needed to counter social media misinformation.

Options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions

Contraceptive services can be prohibitive to people who are not eligible for Medicare, especially when requiring procedures in the office or under anaesthesia. Contraceptive services should be free for all clients regardless of visa status. Free access to contraception should be considered for high-risk groups. Increased LARC uptake in the UK has been supported by incentives to GPs.[3] The current Medicare Benefits Schedule (MBS) rebates for contraceptive procedures by GPs (for example, LARC insertions) do not provide sufficient remuneration to be financially viable for a GP practice or community service to offer bulk billed provision. This results in GP and community clinics needing to

charge a gap, which can be prohibitive to those without the financial resources. Further not all people who fall into this category have healthcare or concession cards. MBS rebates for contraceptive procedures should be increased to reflect the real-world costs of these services. The consultations and procedures need to be funded separately and rebate options to include effective analgesia need to be considered (such as topical anaesthetic to increased outpatient IUD insertion acceptability and uptake).

Public hospital services for contraception are important to ensure equity of access across Australia and hospitals should have clinics and theatre lists dedicated to the provision of contraception choices. Increasing access to free outpatient contraceptive procedures, especially in rural and remote areas is key to reducing disparities that currently exist with rural women being 1.4 times more likely to have an unintended pregnancy[4] . Such services need to include IUD insertions, ultrasound-guided IUD removal, office hysteroscopy for complex IUD removals, and ultrasound-guided impalpable implant removal. Access to these procedures could avoid long wait-times related to hospital and theatre capacity. Procedures done without sedation or general anaesthesia are also generally safer. This will also increase training for specialists and GPs in outpatient contraceptive procedures.

For contraceptive procedures requiring a general anaesthetic or sedation, consideration should be given to upgrading the urgency of these procedures in public hospitals. These are often labelled as Category 3 procedures with 'acceptable' wait times of 12 months. Access in the private sector is not always possible for those in rural or remote areas, and those with limited financial resources. Access to LARC removal is also important for LARC uptake, as limited access to removal contributes to LARC hesitancy. This is especially important among marginalised populations with mistrust of the health system, due to historical and contemporary practice of state-sponsored coercive contraceptive use.

Immediate postpartum provision of contraception should be part of bundle of care in maternity services, including public hospitals. Funding of LARC in hospitals appears to be a barrier. Training in post-placental IUD in public hospitals should be made a priority action, along with strategy to train and maintain skills of post placental IUD providers in smaller rural and regional birth volume centres. Antenatal contraceptive counselling should be included in antenatal care schedule to allow time for informed decision-making in postnatal contraceptive choice. This has been implemented in other settings, with contraceptive counselling undertaken by midwives around 22 weeks. A very significant move would be to incorporate antenatal contraception counselling in the Australian Department of Health National Pregnancy Care Clinical Practice Guideline[5].

RECOMMENDATION 1:
Contraception options supported by the PBS be expanded and public hospital clinics providing LARC, including postpartum initiation be developed to increase both access and training.

Cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas.

RANZCOG regards abortion as an essential component of health care. Despite this, there currently exists enormous variation in access to abortion care across the country. Surgical and inpatient medical abortion on request are not readily available in public hospitals in a number of states including

Queensland, New South Wales, and Western Australia. In New South Wales, for example, there are only a few low cost or publicly accessible surgical abortion clinics in the state. In the first year, following decriminalisation, New South Wales Health reported that only 0.7% of abortions had been conducted in a public hospital. Surgical abortion usually comes with out-of-pocket direct cost (e.g. cost of procedure) that can be significant, except in certain jurisdictions where provision in public hospitals occurs. Choice of surgical or inpatient medical abortion is usually limited by indication for abortion – usually surgical if abortion is on request, which is not available in most public hospitals; and inpatient medical abortion if performed in the context of a fetal anomaly or medical condition of the pregnant person, which is often offered routinely in a maternity service (e.g. abortion for pre-viable, premature rupture of membranes). Increasing access to inpatient medical abortion increases choice for people seeking abortions on how they would like to receive care. Inpatient medical abortion may be preferred by persons who are afraid of procedural anaesthesia, who require additional support or those who may prefer intact remains of the pregnancy for their bereavement needs.

In urban areas of the majority of states and territories private community providers are the main providers of abortion care, but due to the high costs of running safe, quality independent community based surgical services, including accreditation costs, several clinics have closed over the past two to three years. [6]People living in rural and remote areas do not have ready access to surgical abortion, despite being more likely to have an unintended pregnancy.

The Cost of early medical abortion provision is prohibitive for GPs or community clinics to provide a bulk-billed service, due to the MBS rebate being based on the length of an appointment. The generic consultation MBS item number does not account for the high administrative load associated with early medical abortion provision. There is the option of introducing a specific MBS item for early medication abortion provision with a higher rebate, but there is associated risk to client privacy, especially for a young person who is covered under their parents Medicare, or a private health insurance paid by their parents (as the case of some international students). Use of low sensitivity urine pregnancy test (LSUPT) can reduce the administrative load associated with serum beta Human chorionic gonadotropin (HCG) follow-up of early medication abortion. However, the LSUPT is not adequately covered by the current MBS item number for urine pregnancy test. There is the option of introducing a specific item number for the LSUPT but may risk privacy (as per early medical abortion MBS item point above).

Abortion is time-sensitive healthcare, and delays related to the direct and indirect costs of abortion can lead to eventual continuation of an unwanted pregnancy.[7],[8] Indirect costs include the loss of income, childcare, and travel and accommodation to access services not locally available. Literature demonstrates the impact of this, especially for people living in rural and remote area. [9]Delays can lead to more expensive procedures due to the increased medical complexity of abortion provision with increasing gestation, including the need for admission and inpatient medical abortion when the client reaches the upper gestational limit of medical or surgical abortion provided in a particular area.[10] For example, people who are not able to access an abortion after 20 weeks in Western Australia due to the state's current abortion legislation need to travel interstate to receive an abortion, or continue the pregnancy if they are unable to afford the large associated costs. This is particularly inequitable as 2nd trimester requests for abortion are associated with socioeconomic marginalisation.

Table 1:Out of pocket costs for abortion care in Australia where public hospital pathways are not available

Weeks pregnant	Out of pocket cost A$
<12	400-680
12-14	600-800
14-16	1000-1300
16-20	2000-3000

The Cost of abortion for people not eligible for Medicare is even higher. Abortion should be available at no-cost to everyone, regardless of visa status. Indirect costs of abortion should also be publicly subsidised/funded if services are not provided locally, given their important contribution to timely access. This is especially important for people living in rural or remote areas, and people needing abortions after the first trimester, as they often need to travel due to the lack of appropriate services in their area. An example is the Patient Assistance Travel Scheme in the Northern Territory that subsidises/covers the cost of travel and accommodation for a person seeking abortion and an escort for psychosocial support if they are needing to travel for abortion services not available locally. Other patient assistance travel schemes are not so extensive and may not cover all costs.

Abortion laws should be harmonised across jurisdictions to eliminate inequity that is perpetuated by disparate abortion laws. There is anecdotal evidence of domestic cross-border travel for abortion healthcare based on the personal experiences of abortion providers in Australia. Cross-border travel for abortions is expensive and not accessible to many. Until harmonisation of abortion laws occurs and the need for cross-border travel for abortion remains, public funds should cover interstate travel for abortion as essential healthcare.

RECOMMENDATION 2

RANZCOG regards abortion as essential health care, and all public hospitals should provide a first trimester surgical abortion pathway to enhance equitable access and workforce training.

RECOMMENDATION 3

Therapeutic Goods Administration changes are made so that medical abortion pills are available like other prescribed medication.

Workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals.

Abortion healthcare should be a mandatory component of medical, nursing and midwifery university curriculum. Abortion is not widely covered in healthcare worker education in universities (medical, nursing, midwifery), despite the high prevalence of lifetime abortion occurrence in Australia. Student doctors, nurses and midwives who are not exposed to the socio-political, public health and clinical aspects of abortion may be less aware of the inequity in abortion care and may be less likely to be

actively involved in providing, assisting, or supporting abortion healthcare as health workers after graduation. Abortion curriculum should cover, at a minimum, the clinical aspects of abortion (including methods of abortion and safety of methods with particular focus on common misconceptions of abortion risks on mental health and future pregnancy outcome; and the relative safety of abortion vs forced continuation of pregnancy, birthing at term, and parenting/fostering/adopting/kinship care), public health aspects (including prevalence of abortion in Australia and globally, the prevalence of abortion in different populations, the burden of unmet need for abortion – including impacts of unsafe abortion), the socio-political context of abortion (including legal landscape of abortion in Australia and globally, the inequitable health financing of abortion in Australia with limited public provision of abortion on request, abortion stigma and its impacts on pregnant people and conscientious providers of abortion, and responsibilities of conscientious objectors to people seeking and providing abortions). Abortion teaching should include reflective approaches to encourage students to apply bioethical principles to discussions around abortion healthcare (for example, using Values Clarification and Attitudinal Transformation workshops – see IPAS)[11].

Public hospitals are the primary training facilities for health practitioners working in clinical practice but there is a lack of training in abortion care in most states and territories due to the limited public hospital provision. Training in abortion care should begin in medical school and be a core element of Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG) and Fellowship of the Royal Australian College of General Practitioners (FRACGP) training. Pathways for abortion services for all indications should be provided in obstetrics and gynaecology departments in all public hospitals in Australia. This will not only improve equitable access, but it will also increase the number of health workers trained and willing to provide and support abortion care (including obstetrician gynaecologists, GPs, anaesthetists, nurses, midwives, social workers and Aboriginal Health Workers and Practitioners). Such services should be led by a multidisciplinary team (doctors, nurses, midwives, social workers, Aboriginal Health Practitioners) who can provide mentorship to early career health workers across disciplines in abortion healthcare.

Currently trainees in obstetrics and gynaecology are unlikely to be exposed to medical and surgical abortion procedures during their six-year program. This has led to a workforce that relies on procedural general practitioners operating in community clinics and a shrinking workforce. While it is important to train other health professionals, the complex patients will always be referred to the care of obstetricians and gynaecologists and so it is vital to ensure they receive this training. Furthermore later procedures are mostly undertaken in hospital settings, but the training of specialists has also been curtailed by a lack of public hospital services. Currently, abortion healthcare services in public hospitals are often limited to specific indications, such as abortion requests in the setting of fetal conditions or medical conditions affecting the pregnant person's health. This limited provision of abortion in public hospitals is harmful for health worker training in abortion as it may create or perpetuate the impression among health workers that abortions are only performed in the context of specific indications such as fetal and/or medical conditions and may also skew the perception of the true need for abortion in the community. As previously highlighted, this limited exposure to routine abortion care in public hospitals limits opportunities for experiential learning in the counselling and technical skills, including the performance of 2nd trimester surgical abortions, feticide procedures and the management of medical abortions at home and in-facility settings.

A hub-and-spoke model of abortion training could be undertaken to support abortion training for health workers in primary care, community care and regional hospitals, supported by a referral abortion service located within a tertiary hospital. This model may be especially useful in training rural and remote health workforce. Currently, most abortions are provided in community settings (GP clinics, Aboriginal Medical Services, Family Planning organisations and other not-for-profit and for-profit organisations) by primary care and community care practitioners. These are performed as medical abortions at home or surgical abortions in day procedure units. Clients with complex medical or psychosocial needs, or those requesting inpatient medical abortions are often undertaken in a local hospital (when available). In some jurisdictions, a tertiary hospital provides a referral service for abortion requests that are outside the scope of practice of community or local hospital providers. These institutional relationships based on referral needs could be strengthened and expanded to provide training opportunities to health workers in different tiers of abortion care.

RANZCOG has recently launched a two-year program that aims to provide a framework on which to build expert training in the knowledge, clinical skills and professional attitudes required to provide comprehensive high level medical sexual and reproductive health services. This program, to be undertaken by the trainee in their final two years of the Fellowship, will produce a cadre of specialists focussed on contraception and abortion who will be capable of leading public hospital services and of training other clinicians. The current challenge for this program is that there are limited number of public hospitals across the country with comprehensive abortion and contraception services that can provide the opportunity for this training pathway. This pathway will also open up opportunities for training of GPs in the procedural skills required to provide surgical abortion in the community setting where most are currently undertaken. As it now stands, their training is not standardised and there is no oversight of practice. RANZCOG thus plans to develop a formal training pathway for GPs that will credential them for surgical procedures.

With regards medical abortion, relatively few general practitioners (around 10%) are credentialled to provide medical abortion. Medical abortion can be easily managed by any medical practitioner, including in rural practice, who routinely cares for women presenting with spontaneous miscarriage. No extra procedural skills are required, provided the practitioner can refer those women needing surgical evacuation of incomplete abortion to an appropriate hospital. However, there are currently multiple barriers facing GPs. The requirement to be a MS-2Step provider involves several hours of online training and the need to obtain an authority for each prescription is onerous. Pharmacists also have to be registered to be able to supply the medication. RANZCOG recommends that TGA changes are made so that medical abortion pills are available like other prescribed medication. Another key impediment to medical abortion provision cited by GPs is their concern over a lack of support from public hospitals should complications occur. This would be resolved with the establishment of public hospital pathways to abortion care.

Best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery

Best practice in sexual and reproductive health care involves the creation of a health care setting that is respectful, engages in safe and sensitive communication to facilitate trust, addresses issues of safety and quality, is reflective and advocates for patients and staff. Specialised sexual and reproductive health clinics establish services according to the principles of quality care, but many people interact

with non-specialised services (GPs, hospital clinics, radiology departments) that can exacerbate stigma and marginalisation. Aboriginal and Torres Strait Islander peoples should expect a culturally safe environment, and all practitioners should be trained in cultural competency.

A trauma-informed care paradigm of service delivery is a whole-of-organisation approach where every aspect of a service - including its policies, governance structures, and service delivery - is designed with the aim of preventing re-traumatisation and promoting recovery of clients with a history of trauma. A trauma-informed approach requires a foundational knowledge of trauma that includes understanding of the prevalence of trauma in the community, the different types of trauma (e.g., post-traumatic stress disorder, complex trauma, inter-generational trauma), the neurophysiology of trauma and its[12] behavioural and cognitive symptoms – often manifesting as behaviours seen as "problematic" or "difficult" by service providers. Clients experiencing complex and inter-generational trauma – forms of trauma that are rooted in interpersonal and structural/institutional violence — are at risk of re-traumatisation during their interpersonal interactions with staff at a service, and their interactions with the policies and procedures of that service, if the client experiences these interactions as unsafe. A trauma-informed service will design policies and procedures and deliver service that aims to avoid re-traumatisation of clients with this trauma-informed lens.

Trauma-informed approaches in sexual and reproductive healthcare are crucial for several reasons. Firstly, the interpersonal client-provider interactions in sexual and reproductive healthcare are physically and emotionally intimate, and may be interpreted as unsafe by trauma survivors, especially survivors of sexual assault. Secondly, clients seeking sexual and reproductive healthcare such as contraception and abortion may be at higher risk of experiencing interpersonal (e.g., domestic, family and sexual violence) and structural violence (e.g., misogyny, racism, homo- or transphobia), and subsequent trauma. Thirdly, sexual, and reproductive healthcare has been, and continues to be, the site of structural violence against women and people with uteruses, LGBTQIA+ people, Aboriginal and Torres Strait Islander people, people with disabilities, and other marginalised people. Examples of historical and contemporary policies and practices that are structurally violent include the over-regulation of SRH services such as abortion and gender-affirming therapies, coercive use of contraception, sterilisation and abortion, and the inadequate public funding of essential SRH services.

Table 2:Incorporate the trauma-informed principles of 'safety', 'trustworthiness', 'choice', 'collaboration', and 'empowerment'[13]:

Safety	Abortion services that are located away from maternity or antenatal services may provide emotional safety to a person seeking abortion, who may find the sight or sound of other pregnant people, people birthing or newborns psychologically distressing. Person seeking abortion should be given the choice of provider of preferred gender, where possible. Arbitrary gestational limits for abortions for any indication creates an unsafe environment for clients who may need time and support to resolve any ambivalence in decision-making before deciding on pregnancy outcome.
Trustworthiness	Abortion service should have consistent staffing to provide consistent access to services. Dependence on a single provider providing a particular method of abortion (e.g., 2nd trimester surgical abortion) puts trustworthiness of service at risk if certain services become unavailable when the sole provider is on leave or unavailable.

Choice	Abortion services should provide a full range of abortion and post-abortion contraceptive methods to maximise a client's choice in abortion care, or timely referral to other providers with such capacity. This includes the choice of inpatient medical abortion on request.
Collaboration	Abortion services should have systems in place to include meaningful engagement of consumers of abortion services in service improvement and design as experts with lived experience. At every interaction, abortion providers should affirm clients seeking abortion in their decision-making as the expert in their own lives, while abortion providers provide technical expertise in abortion procedures.
Empowerment	Abortion services should offer non-directive pregnancy options counselling for clients seeking abortion experiencing ambivalence, with the aim to empower clients to develop cognitive skills to clarify their values, evaluate available options against their values, and make pregnancy decisions based on their firmly held values. Abortion services should offer post-abortion counselling for those with psychological distress from their abortion decision with the aim to encourage the client to view the decision that affirms their firmly held value can promote bodily autonomy and recovery from trauma.

Sexual and reproductive health literacy

Around one in five young people find it difficult to understand health information. There is little research to identify what sexual health information young people are using and why[14]. Many people access non-credible sources on social media platforms such as TikTok[15]. Increasingly it is important to provide visual aids such as simple illustrations, images, informational graphics, and videos. Such resources are lacking in Australia particularly on a national level and should be housed on credible government endorsed digital platforms. RANZCOG recommends that a national publicly funded and accessible directory of abortion and contraception providers across the country is established to help patients and their healthcare practitioners find appropriate care, similar to the "1800 My Options" in Victoria.

RECOMMENDATION 4

The establishment across all jurisdictions of a publicly funded and accessible directory of abortion and contraception providers to help patients and providers find appropriate care, similar to the "1800 My Options" in Victoria

Experiences of people with a disability accessing sexual and reproductive healthcare

There are barriers to sexual and reproductive health access for people with a disability including lack of support for choice, lack of accessible information, social myths about disability and sexuality. People with disability are more likely to experience sexual assault at all ages and are under screened for cervical and breast cancer. Social support and sexuality education are key factors in enabling agency[16]

Experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare

Access for transgender and non-binary people to sexual and reproductive health services can be challenging. Inclusive clinical care that addresses the relationship between sex assigned at birth, gender identity and social determinants of health is crucial to achieving health equity for this group of people. Dedicated sexual and reproductive services where staff are trained in gender diversity and liaise closely with expert clinicians may be more acceptable to transgender and non-binary people.

Availability of reproductive health leave for employees

There is currently no specific reproductive health leave for employees. Ultimately, RANZCOG would support discussions around reproductive health leave being legislated in the National Employment Standards as a universal, protected entitlement.

Any other related matter

The above recommendations for optimal universal sexual and reproductive healthcare will require leadership and support from the federal government. This requires a co-ordinated response ideally with the establishment of a unit in the Australian Department of Health that is responsible for the monitoring of sexual and reproductive health service delivery, uptake and consumer access.

RECOMMENDATION 5

A dedicated federal funding stream to establish service pathways through public hospitals, and consumer information as has occurred with endometriosis and pelvic mesh care.

The College acknowledges, with thanks, the work undertaken by the RANZCOG Sexual Reproductive Health Special Interest Group for this submission.

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