the women's
the royal women's hospital

13 December 2022

Committee Secretary
Senate Standing Committees on Community Affairs

Via: committee website
Copy: community.affairs.sen@aph.gov.au

Subject: Universal access to reproductive healthcare

Dear Committee Secretary,

Please find attached The Royal Women's Hospital submission to the Senate Standing Committee on Community Affairs' Inquiry into Universal access to reproductive healthcare.

We understand that this submission is a public document and may be published on the committee's website and quoted in the committee's report to Parliament.

Yours sincerely,

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Submission from The Royal Women's Hospital, Melbourne
Universal access to reproductive healthcare

1. Introduction

The Royal Women's Hospital believes that all women and girls deserve access to the best possible health and healthcare across the lifespan, no matter what their socio-economic, geographic or educational status; their physical, mental or intellectual ability; their sexual orientation, gender identity or presentation; their cultural background, spoken language, practices or beliefs.

While many women in our country enjoy good health and are able to access exceptional healthcare, there are a number of factors that fundamentally affect women's health and the provision of health care, and these impact thousands of women every day. Factors include inherent biases in care decisions, educational systems, services, medical research, geography, and legal and governance structures – to name a few.

A good example of this is the difficulties many women and pregnant people face in exercising their sexual and reproductive rights and autonomy, despite the fact that the services being sought are legal and supported by the majority of the community.

The Women's is committed to promoting the sexual and reproductive health of all women and pregnant people and securing their sexual and reproductive rights. In this paper, we provide an outline of some of the key issues the Women's wishes to put before the Committee for its consideration.

2. About the Women's

Established over 165 years ago, the Women's is Australia's first and largest stand-alone hospital dedicated to improving and advocating for the health and wellbeing of women and newborns. The Women's cares for women through all stages of life, with services ranging from maternity, gynaecology, sexual and reproductive health, including abortion care, women's cancer services, women's mental health, and specialist care of newborns. The hospital also offers a range of state-wide specialist health care services for pregnant women who use alcohol and other drugs, women with disability, women experiencing homelessness, and women who have experienced genital mutilation.

As a tertiary-level hospital and one of Australia's major teaching hospitals, the Women's work goes beyond acute care playing a unique role in Victoria's, and indeed Australia's, healthcare system, advancing research and practice, and providing state-wide training, leadership and advocacy. Key advocacy areas include family violence, abortion and contraception, public fertility, and the social determinants of health and their impact on health equity.

The Women's is the largest provider of public abortion services in Victoria and, through its Clinical Champion Program funded by the Victorian Department of Health, plays a key role in building workforce capability and capacity across the Victorian healthcare system. The aim is to improve access to abortion and long-acting reversible contraception (LARC) services that are safe, evidence-

based and timely through mentoring, training and supporting local clinical champions within public hospital settings. This Victorian program also aims to support the establishment and expansion of surgical abortion services in more public hospitals. Current Victorian public hospitals involved in the program include those operated by Grampians Health, Monash Health, Bendigo Health and Barwon Health.

Further, the Women's partners with a number of other organisations including Women's Health Victoria and the Centre for Excellence in Rural Sexual Health at the University of Melbourne Medical School to progress improvement in abortion care and access through research, advocacy and other activities.

3. Abortion and contraception – addressing the gaps

By their mid-30s, one in six Australian women report having at least one abortion. Recent research has identified that women with less control over their reproductive health – whether through family violence, drug use or ineffective contraception – are more likely to terminate a pregnancy[1].
Access to safe, effective and appropriate contraception and abortion is basic healthcare, fundamental to women's self-determination and key to addressing gender inequity. However, in Australia, we are yet to widely recognise and accept this, and we are well behind many similar countries.

3.1 Contraception

In Australia, access to comprehensive contraception advice and services is highly variable. For example, there are many barriers preventing primary care provision of long-acting reversible contraception[2] (LARC), which is largely viewed as the most effective reversible method of preventing unintended and adolescent pregnancy. Compounding this issue, very few public hospitals offering women's healthcare provide contraception advice and services. While primary care providers play a vital role in the provision of LARC, the number of providers trained to deliver these forms of contraception in Australia is low, particularly in rural and remote areas. This is due to a range factors including a workforce skill deficit, misinformation, inadequate incentives, difficulty accessing peer and expert support, and unclear referral pathways. This leads to inequities of access for many women and girls to what is a safe and effective contraception method.

In Australia, the Pharmaceutical Benefits Scheme (PBS) subsidy is not available for some LARC, making access even more restricted. However in the UK, the IUD, the IUS, the contraceptive injection and the hormonal implant are all available free on the NHS and widely accessible through a GP, sexual health clinic, practice nurse or young person's clinic.

3.2 Early medical abortion

Early medical abortion (using the medications mifepristone and misoprostol) is a well-established alternative to surgical abortion for early pregnancy. These routinely used medications are widely recognised as safe and effective, including by the World Health Organization. Early medical abortion is non-invasive, which should be the first option considered. It is ideally provided in a primary care

[1] Taft AJ, Powell RL, Watson LF, Lucke JC, Mazza D, McNamee K. Factors associated with induced abortion over time: secondary data analysis of five waves of the Australian Longitudinal Study on Women's Health. Australian and New Zealand Journal of Public Health. 2019;0(0). At: https://www.ncbi.nlm.nih.gov/pubmed/30727034
[2] LARC includes intrauterine devices and contraceptive implants

setting (GP or community health) with the support of a local hospital gynaecology unit. In many other countries, it is considered to be a standard option and easy to access.

Yet in Australia, there are many barriers to accessing early medical abortion medication. Marketed as **'**MS-2 Step**'**, early medical abortion medication is distributed by a single provider in Australia and highly restrictive regulations are imposed by the Therapeutic Goods Administration (TGA). For example, in Australia, only a doctor can prescribe MS-2 Step. Yet cohort studies in the UK, Canada and Europe demonstrate that removal of prescribing restrictions improves access, shows no additional adverse outcomes, and significantly lowers gestational age at time of abortion, thus reducing risks for the woman and decreasing the need for post procedure clinical management. In addition, prescribing doctors must seek special permission (an 'authority script') from the PBS each time mifepristone is prescribed. This is because in Australia, mifepristone has been classed as a "highly specialised drug" by the TGA and therefore has additional restrictions. This is not the case in the US, Canada and the UK where mifepristone is treated like any other drug and can be dispensed at abortion and contraception clinics or at any pharmacy.

3.3 Surgical abortion

With various conditions, surgical abortion is legal in all Australian states and territories, providing it is done by a registered medical professional.

Yet many publicly funded hospitals in Australia that provide maternity and women's health services do not provide abortion services at all. Others provide very limited services or have complicated care and referral pathways that cause significant delays and create additional risk, trauma, cost and complexity as gestational growth advances. This is particularly acute for women and girls who live in rural, regional and remote areas where access to any hospital is challenging, let alone a hospital that provides abortion care.

One of the reasons for this is that public hospitals are not mandated through state government directives or funding agreements to provide contraception and surgical abortion care. Each state health authority releases clinical capability framework directives[3] that govern the level of service a public hospital must provide (with hospitals ranked from Level 1, being basic care, through to 6, being high risk or complex care). Yet these directives (and individual funding agreements) do not include any mention of women's health or gynaecological care, let alone the mandated provision of abortion or contraceptive services.

3.4 Workforce capacity and capability

A deficit of abortion and contraception services in the public health sector presents additional barriers related to workforce development. Too few opportunities exist to train and refresh sexual and reproductive healthcare professionals when there are so few currently delivering these services. Where training does exist, it is concentrated in metropolitan regions and in tertiary services. This has led to a very fragmented workforce and a dearth of trained health professionals with the ability to train others.

[3] For example, see the service description tables on pages 10, 15, 19,22, 24, 27 of Capability frameworks for Victorian maternity and newborn services

Comprehensive abortion and contraception education is required at undergraduate and postgraduate levels to equip medical, nurse practitioner, nursing and midwifery health professionals with the essential skills and knowledge needed to provide best practice LARC and abortion care. A national strategy is required to ensure educational institutions and professional colleges develop evidence-based curricula and clinical practice guidelines. And an emphasis should be placed on lifelong learning and continuing professional development opportunities.

4. Other sexual and reproductive health issues – addressing the gaps

4.1 Endometriosis

In Australia, it is reported that 6.3 per cent of women aged 40-44 have clinically confirmed endometriosis. This debilitating and painful condition can have serious impacts on a woman's fertility, ability to work, mental health, physical mobility and sexual function. Access to early diagnosis and treatment is critical as at present, there is no cure.

Early diagnosis can help to address some of the symptoms of endometriosis however, the average worldwide diagnostic delay has been reported as seven years from when symptoms start, compared to eight years in both the UK and Australia[4]. This makes early treatment inaccessible for many women. According to a study co-authored by Professor Martha Hickey from the Royal Women's Hospital in Melbourne and the University of Melbourne Department of Obstetrics and Gynaecology: "Clinical diagnosis is difficult, partly because the symptoms are often non-specific and may be attributed to other conditions. For example, endometriosis may mimic or cause irritable bowel syndrome. Symptoms may also be misdiagnosed as functional or psychosomatic or dismissed or normalised (for example, as painful periods)." In addition, women consistently report difficulties in convincing doctors about the severity of their symptoms.

Medicare does not cover the full cost of laparoscopic surgery, an essential diagnostic tool. Some private health insurance companies do cover the remaining out of pocket fee however for many women without private insurance who are seeking a diagnosis over several years, the cost of appointments, diagnostic procedures and pain management treatments has a significant impact.

4.2 Healthy Aging – Menopause

Menopause is often a hidden and stigmatised process, but it is a part of normal aging. Many women experience varying degrees of menopause symptoms, including hot flushes, headaches, brain fog, loss of memory, body aches and pains and insomnia. Other women, including those who have early menopause as a result of cancer treatment, can experience significant symptoms. However, as a result of the stigma surrounding this, many women suffer in silence.

The World Health Organization states, "Health-care providers may not be trained to recognize perimenopausal and post-menopausal symptoms and counsel patients on treatment options and staying healthy after the menopausal transition. Menopause currently receives limited attention in the training curricula for many health-care workers".[5]

[4] Ye L, Whitaker L H R, Mawson R L, Hickey M. Endometriosis Easily Missed? BMJ 2022; 379 :e068950 doi:10.1136/bmj-2021-068950
[5] https://www.who.int/news-room/fact-sheets/detail/menopause

The British Menopause Society has developed a vision for menopause care that includes three key factors[6].

1. The patient experience – ensuring that women have access to a wide range of types of information and can see a suitably trained healthcare professional to discuss their experience of menopause and the options available to them.

2. A well-educated workforce – making sure that they are 'vision-ready' with the optimum skill mix to cater for a wide population demand.

3. Integrated care – establishing clear referral pathways between services so that care can be integrated around the needs of the individual, not disjointed by institutional or professional silos.

4.3 Women with disability

In Australia, it is estimated that 9.5 per cent of women of childbearing age have a disability. Yet women with disability are particularly disadvantaged when it comes to exercising their reproductive rights. Our health system makes it extremely challenging for women with disability to access appropriate sexual and reproductive healthcare and advice, as well as relevant maternity care and support, parenting advice, and fertility and gynaecological services.

Many hospital and primary care providers lack basic training to support the sexual and reproductive health of women with disability and have a poor understanding about their health rights and needs. Some needs, such as specialised pre and postnatal care and parenting support are simply ignored by our health and disability system. For example, during pregnancy and after birth, many women with disability are required to self-fund disability-specific support services, equipment and parenting aids simply because this type of support is not covered by the NDIS.

The Royal Women's Hospital's 'Women with Individual Needs Clinic' (WIN) in Melbourne offers support to women with spina bifida and paraplegia, multiple sclerosis, cerebral palsy and limb absence, as well as intellectual or learning disabilities, acquired injuries and disabilities, sensory impairments and neurological disabilities. The clinic offers specialist midwifery antenatal and postnatal appointments and social work support, with out of hours support if needed. New mothers can also access an extended postnatal ward stay, with the option of a support person, such as a parent, partner or other person, staying on the ward with the woman for the duration. Unfortunately for many women, this type of care is simply not accessible because this clinic is the only disability-informed maternity care clinic in Australia.

A barrier to understanding the challenges for women with disability and system improvement is the lack of early identification. There is currently no national standardised way of asking about disability status. National standardised identification and recording of disability status is fundamental to providing appropriate funding, services and support for this at-risk group of women.

[6] https://thebms.org.uk/wp-content/uploads/2021/08/BMS-Vision-MAY2021-01C.pdf

5. Recommendations

5.1 Abortion and contraception

5.1.1 Improve timely access to early medical abortion medication by reviewing TGA requirements that present barriers including:

- Allowing nurse practitioners, midwives and clinical nurse consultants to prescribe medical abortion medication and support women through the process;
- Expanding the gestational age criteria to 10 weeks instead of 9 weeks (as it is currently);
- Removing the requirement that healthcare professionals receive specialised training to prescribe medical abortion medication and removing the need that they seek an 'authority script' from the PBS; and
- Providing medical abortion medication to women pre-pregnancy for "in case" usage.

5.1.2 Mandate that all public hospitals that operate at Level 2 or above service capability have provision of abortion and contraception services tied to their funding and all states include women's health or gynaecological care in their clinical capability framework directives for public hospitals.

5.1.3 Improve workforce capacity by:

- Reviewing Medicare Benefits Schedule item numbers relating to sexual and reproductive healthcare to reflect the skill, expertise and time required by health professionals to a) provide medical abortion medication and contraception options; and b) provide complex abortion care and support;
- Introducing national funding, enabling people to have an individual sexual and reproductive health care plan, equivalent to the existing incentives for mental health or chronic care plans. This recognises the time and skill required for assessment and care planning and acts as a financial driver in primary care settings;
- Mandating that educational institutions and professional colleges develop and implement evidence-based sexual and reproductive health curricula and clinical practice guidelines;
- Funding advanced training models in sexual and reproductive healthcare appropriate to obstetricians and gynaecologists, GPs, nurse practitioners, nurses and midwives.

5.1.4 Reduce the cost of essential sexual and reproductive healthcare by providing PBS subsidies for all long acting reversable contraceptives and increasing the variety of oral contraceptives available on the scheme.

5.1.5 Improve access to referral information by collaborating with Victoria to implement the successful 1800myoptions model across Australia, thus ensuring women have evidence-based centralised information, and know where to access affordable abortion, contraception and sexual health services in their state or territory.

5.1.6 Establish a national approach to the collection, monitoring and analysis of abortion data in all states and territories across public and private providers to inform funding, service and system reform. This will inform the provision and funding of services and serve as benchmark against which we can monitor progress.

5.1.7 Extend MBS to include abortion and contraception for non-Medicare eligible women and girls and negotiate with private health insurance providers to improve coverage for international students and those on working visas to ensure access to sexual and reproductive healthcare throughout their time in Australia.

5.2 Other sexual and reproductive health issues

5.2.1 Implement all recommendations in the *National Women's Health Strategy 2020-2030* related to endometriosis and other chronic women's health conditions.

5.2.2 Adopt the three key focus areas from the British Menopause Society vision (or similar) for menopause care to improve health outcomes for women experiencing menopause and address some of the factors related to gender inequity.

5.2.3 Improve access to disability-informed maternity care in public hospitals across Australia by looking at lesson's learned at the Women's WIN Clinic model and implementing this model in other health services.

5.2.4 Enable women with disability to access funding through the NDIS for vital disability-specific support services, equipment and parenting aids.