Australian Nursing and Midwifery Federation submission

Senate Community Affairs References Committee: Inquiry into universal access to reproductive healthcare

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Introduction

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 322,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

Thank you for the opportunity to make a submission to the *Inquiry into universal access to reproductive healthcare* (the Inquiry). Nurses and midwives provide care across all reproductive healthcare services and, as female dominated professions, often have direct experience of the enablers and barriers to universal access to sexual and reproductive health services for women. Achieving priorities under the National Women's Health Strategy is imperative for the health of all people living in Australia, the health of Australian communities, short- and long-term equity for women, and for helping professions to continue to provide care.

The health system must enable women to exercise their choice and control in decision-making about their bodies' without discrimination or disadvantage. With policy reform, the full scope of nurses and midwives can be utilised across the breadth of reproductive and sexual healthcare services to contribute to this goal.

Our response will focus on the Terms of Reference of particular relevance to ANMF members.

Response to Terms Of Reference

Terms of Reference a, b and c

a. cost and accessibility of contraceptives, including:

i. PBS coverage and TGA approval processes for contraceptives,

ii. awareness and availability of long-acting reversible contraceptive and male contraceptive options, and

iii. options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;

Due to more advanced developments in reversible forms of female contraception compared to male contraception, women take greater responsibility for the cost and use of contraceptives, and carry a greater health burden of contraceptive side effects and failure.

To create equity for women and enable them to exercise their choice and control in decision-making about their bodies in relation to contraceptives there must be:

- increased counselling for women provided by health practitioners around the short and long term use of contraceptives on women's health at the time of prescribing and in monitoring the ongoing use of contraceptives;
- no financial disadvantage for women selecting a contraceptive that may be better suited to their circumstances and preferences; women are limited in their choice of contraceptive use due to PBS coverage (for example, the copper intrauterine device is not PBS listed, nor are some newer oral contraceptives); the cost of medicines is compounded by out-of-pocket GP consultation fees, particularly when seeking access to long-acting reversible contraception (LARC) methods;
- increased promotion and utilisation of male contraceptives; some men are unable to access vasectomies due to cost; cost and responsibility for contraception is often then the burden of the woman;
- timely, equitable access to contraceptives, including those requiring specialist consultation, regardless of the woman's social, economic, cultural or geographic circumstances;
- access to pharmacists, particularly outside of metropolitan regions, and the pharmacists' stock must also be considered (for example, stock should include not only levonorgestrel but also ulipristal acetate); and
- avenues for women experiencing family violence to access contraception without additional risk to herself from the perpetrator.

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

The cost and accessibility of reproductive healthcare must take into consideration the social, economic, geographical, spiritual and emotional determinants of health. Women's access to reproductive healthcare of their choice will be influenced by:

- where they live and the services available locally including the available health care providers' values;
- their capacity to pay for the service including additional costs they may incur in attending for the service (for example, lost wages, childcare, and travel costs); and
- the extent, and values and attitudes of their social supports.

These factors limit a woman's choice of health care provider or service, and can delay, disqualify or prohibit them from obtaining the care of their choice with significant short and long term consequences. Health care cost for termination increases because of limited services, and decreased access due to location, delaying time to intervention/termination. It is recommended there be cost analysis comparing medical termination of pregnancy (MToP), surgical termination of pregnancy (SToP), and dilation and evacuation (D&E) that considers not only the cost to the healthcare system but the cost to the economy and community through emotional/personal costs to the people affected, and workplace productivity losses.

Women report that even if they have timely access to MToP its cost can be prohibitive when including fees for medical consults, ultrasound, pathology and medicines. It is recommended the Inquiry review all fees associated with MToP, SToP, and D&E, as cost is a barrier to access.

Access to MToP in rural areas can be reduced due to availability of prescribers and MS-2 Step certified pharmacists. In addition to this, access to SToP in regional/rural areas can be limited as it is either not offered, or offered infrequently (for example, surgery performed once a week or less frequently). Private organisations rarely provide these services outside of metropolitan areas thereby requiring lengthy travel for women if the local public service cannot accommodate them.

The health of rural and remote people in Australia is poorer than those residing in metropolitan areas. People living in these areas experience higher rates of chronic disease, injury and early mortality. The more isolated a community, the less access to health care and specialist services but

the greater the disease risk.[1] It then follows that the cost and accessibility of reproductive health care to rural and remote populations needs to be addressed as a priority.

The health status of Aboriginal and Torres Strait Islander peoples is considerably poorer than any other group in Australia. Poor access to local and trusted health care services limits pregnancy and early postnatal care for many Aboriginal and Torres Strait Islander peoples with increased adverse maternity outcomes compared to other people living in Australia.

The Inquiry should also consider the unique barriers to reproductive and sexual health care that exist for older people, people living with a disability, culturally and linguistically diverse people, people experiencing homelessness, people experiencing family violence, sexual assault victims, and incarcerated people. The impact of these barriers, to not only accessing care, but on receiving care that respects and aligns with the woman's choice and decision making about her body must also inform the Inquiry. Integration of sexual and reproductive health care with other health care through holistic care models and seeking peoples' lived experience to inform reform is essential to overcome some of these barriers, improve access and create equity for these people.

c. *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;*

Nurses and midwives are the largest health workforce, with the greatest reach, enabling care to be delivered across all areas of health, education and the workplace, in all geographic locations throughout Australia. They are a highly educated, capable and regulated workforce that has long been at the forefront of health care delivery and advancing solutions by implementing practice changes across a range of health services. Nurses and midwives have the expertise to provide holistic, person-centred care that addresses the person's physical, psychological, social and spiritual needs in the context of their lived experience. It is imperative the contribution of nurses and midwives to sexual and reproductive health is recognised and their full scope of practice realised to improve the health of women living in Australia. Building on the existing nursing and midwifery workforce, nurse and midwife-led models of care offer a viable solution, to the largely medical model, to increase access to reproductive health care services for women living in metropolitan, regional, rural and remote areas.

[1] Muirhead, S. and Birks, M. 2019 Roles of Rural and Remote Registered Nurses in Australia: An Integrative Review." *Australian Journal of advanced nursing, 37*(1): 21-33.

Strategies in Response to Terms Of Reference A, B, and C

To promote equitable access to reproductive healthcare and address the barriers identified in terms of reference a, b and c, the ANMF recommend greater utilisation of the skills and expertise of nurses and midwives.

This involves reproductive and sexual health care being viewed as a component of overall health and wellbeing and managed within a holistic care framework. Women's health care becomes fragmented when provided by practitioners who need to refer women to other services for reproductive and sexual health care. Holistic care recognises reproductive and sexual health care as an element of whole of life care for women. Increasing access to holistic women's health practitioners to improve continuity of care and provision of reproductive and sexual health care alongside management of other health care needs decreases fragmentation of services and the associated risks.

Nurses and midwives must lead access to sexual and reproductive health care through opportunistic and targeted health initiatives building on the holistic underpinning of nursing and midwifery practice. In order for this to occur, Governments need to invest in the nursing and midwifery workforce and health care system reform by removing barriers to access to the MBS and PBS for nurses in primary health care, nurse practitioners and midwives. This includes, but is not limited to:

- removing gate keeping that exists for people to access additional Medicare-funded services only via medical practitioner referral. Nurses and midwives play a central role in providing initial and accessible health care, particularly to people living in rural and remote parts of Australia. To strengthen access to sexual and reproductive health care, actions must be taken to overturn existing referral processes and allow nurses and midwives to refer to specialised clinics and/or allied health practitioners directly without a medical practitioner intermediary;
- removing mandated requirements for collaborative arrangements that, in the process of meeting this requirement, can force people seeking care from nurse practitioners and participating midwives to consult with additional health care practitioners with whom they wouldn't normally choose to consult, further delaying care;
- expanding Medicare funded telehealth services to include all health practitioners providing women's health care recognising the multidisciplinary input required to manage women's reproductive and sexual health;

- allowing nurses and midwives to order diagnostic investigations, which includes radiology and pathology;
- supporting nurses and midwives working in reproductive and sexual health to perform procedures, which may include hysteroscopy, cone biopsies, insertion and removal of IUDs, hormone replacement and contraceptive implants;
- funding public nurse-led and midwife-led services where sexual and reproductive health care can be provided as a component of holistic care, including, but not limited to, contraception counselling and monitoring, LARC prescription and insertion, early pregnancy care and advice, termination counselling, MToP prescription and administration, routine asymptomatic testing for STIs, uncomplicated cervical screening and referral, and assisted access to specialist services as required;
- providing block funding for nurses in primary care to provide holistic care that encompasses sexual and reproductive health care;
- ensuring there are adequate resources, for example the right number of nurses and/or midwives to provide sexual and reproductive health care or enough time allocated to provide services within a holistic framework;
- providing funding for nurses and midwives to undertake additional advanced practice education in women's health and sexual health, particularly available to those in rural and remote areas where upskilling existing nurses and midwives will have the greatest impact on improving short term access;
- improving access to publicly funded specialist maternity services, including midwife-led models of care, prior to second trimester for all pregnant women, to provide pregnancy counselling and support in early pregnancy;
- re-establishing rural maternity units;
- establishing a national pregnancy choices telephone support line staffed by nurses and midwives dedicated to reproductive health counselling and facilitating women's access to reproductive healthcare services taking into consideration their individual needs and location;
- providing additional funding beyond the cost of the service being accessed alone to facilitate access where travel, childcare or loss of wages will be incurred by the woman to receive the sexual and reproductive health care of their choice and that meets their needs; and
- continuing national and state government support for health services designed and led by Aboriginal and Torres Strait Islander peoples, such as the Waminda Birthing on Country program.

Access to reproductive and sexual health care in rural and remote areas cannot be improved without considering the broader health workforce issues. In addition to the measures above, to address access to health care for people living in, and bolster the health workforce in, rural, regional and remote areas of Australia, the ANMF recommends:

- strategies to address professional isolation be implemented. Professional isolation is a significant concern for the health workforce in rural and remote areas. Sometimes nurses live and work alone in a community for 5 - 7 weeks and are the only health practitioner. This isolation is compounded by technological connectivity issues, and a lack of educational offerings and issues regarding personal safety;
- increasing support for structured clinical placement opportunities in rural and remote health care facilities, for nursing and midwifery students, to promote and showcase the benefits of being a part of the rural and remote health workforce and country living;
- improving support for newly graduated nurses and midwives in rural and remote health facilities to aid retention; as well as assisting rural and remote nurse and midwife managers in their role as preceptors for beginning registered practitioners;
- offering financial support for rural and remote nurses and midwives to participate in ongoing professional development including clinical (reflective) supervision and in-person attendance at conferences; and
- additional leave entitlements and scheduled stand down time for nurses and midwives working in isolated practice to prevent burnout and promote workforce retention.

d. best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery;

There is no one best practice approach to sexual and reproductive healthcare. Where sexual and reproductive healthcare is viewed as a component of the person's overall health needs through a holistic lens, it enables the person's unique values, preferences, and background to inform the care provided. The ANMF suggests removing barriers that prevent nurses and midwives from providing holistic person-centred care in a timely manner thereby supporting the health care system to meet the needs of those receiving care.

The ANMF also recommends governments continue to build on and expand programs to create a diverse lived experience workforce equipped to inform and shape culturally sensitive care that meets the needs of all people living in Australia.

e. sexual and reproductive health literacy;

There are many programs targeted at improving sexual and reproductive health literacy in Australia. These programs can only go so far whilst stigma and silence exists around many aspects of sexual and reproductive health across the lifespan. It is essential sexual and reproductive health needs are normalised and there are opportunities for people to explore the options available to them without social stigma and rebuke.

Sexual and reproductive health literacy programs within schools can vary greatly. Initiatives such as Respectful Relationships and Safe Schools are a good start for improving family violence and LGBTQI+ safety within schools, but they are not dedicated to sexual or reproductive health. As such, schools are left having to bring in outside assistance or teach it themselves. Rural schools are likely to face greater difficulty in accessing sexual health nurses or health promotion officers due to geographic distance from providers.

The ANMF recommends utilising modern forms of communication, such as podcasts, Apps and other social media, to bring sexual and reproductive health into everyday conversation and reach diverse groups who may not engage with established health promotion campaigns and techniques. It is imperative sexual and reproductive health information continues to challenge long held negative attitudes about this significant health care area to break down barriers to access and to raise awareness of sexual and reproductive health issues within the community in general to reduce stigma and discrimination.

f. experiences of people with a disability accessing sexual and reproductive healthcare;

People living with a disability have the right to complete integration and inclusion within the community, family, school and workplace. Assistance should be provided for this to take place. People living with a disability should be assisted to access, understand and make decisions about their health, including their reproductive and sexual health. Designing health care services in collaboration with key stakeholders with lived experience of a disability is essential to ensuring equitable access and removing barriers.

Whilst sex work is now largely decriminalised across Australia, there can still be stigma associated with providing and accessing this service. In order to promote the safety and sexual health of the sex worker workforce, it is critical that sexual health services be provided in a way which is culturally safe, non-judgmental and accessible.

It is also recognised that people living with a disability and/or mental illness can already feel marginalised and face stigma and discrimination. Stigma can be exacerbated in circumstances where they access the service of sex workers. It is important to remove any potential barrier this often-marginalised cohort of the community may face in accessing these services to support their sexual health.

g. experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;

Gender diverse people, particularly those who are transgender, non-binary, and people with variations of sex characteristics, are more likely than other groups living in Australia to delay or avoid seeking health care.[2] While the reasons for this are complex, 25.2% of sex and gender diverse Victorians reported experiencing unfair or discriminatory treatment by nurses, doctors and other staff in health care settings in 2020.[3] In addition, many intersex people have pain and scarring from non-consensual childhood genital surgery and forced hormone use in order to fit the gender *binary*, often without explanation or consultation, and now have feelings of resentment and distrust about health practitioners.[4]

These experiences highlight the importance of delivering person-centred health care across all settings. It is imperative that stakeholders with lived experience of gender and sex diversity are consulted on future models of care or programs to support their sexual and reproductive health.

h. availability of reproductive health leave for employees; and

Women are more likely than men to access personal leave to perform caring responsibilities as was demonstrated by the COVID-19 pandemic.[5] Women are also disproportionately affected by leave required for sexual and reproductive health care. When taking into account women's use of personal leave for sexual and reproductive health and caring responsibilities, women are left with less time than their male counterparts for other personal leave for non-reproductive and sexual health conditions, and following grief and loss, resulting in inequity.

[2] Australian Institute of Health and Welfare (2018) Australia's health: in brief. https://www.aihw.gov.au/getmedia/fe037cf1-0cd0-4663-a8c0-67cd09b1f30c/aihw-aus-222.pdf.aspx?inline=true

[3] Victorian Agency for Health Information op. cit. p. 52

[4] Royal Australian College of General Practitioners (2016) SG16 - Sex, sexuality, gender diversity and health contextual unit https://www.racgp.org.au/education/education-providers/curriculum/contextual-units/populations/sg16-sex,-sexuality,-gender-diversity-and-health#ref-num-1 (accessed 2/22021)

[5] Rauhaus, B.M. & Johnson, A.F. (2021). Social inequities highlighted by the prolonged pandemic: Expanding sick leave. *Journal of Public and Nonprofit Affairs, 7*(1): 154-163. https://doi.org/10.20899/jpna.7.1.154-163

From the onset of puberty to post menopause girls and women deal with sexual and reproductive health conditions that can make it difficult to participate fully in daily activities. Despite these health conditions women continue to participate in education, the workforce and other social and community roles when unwell as there is a soldier-on mentality, lack of understanding, limited-to-no flexibility and taboo associated with these often sensitive and private health conditions. This can also be due to a lack of available personal leave.

Formal reproductive leave policies would allow workers to take a number of leave days to cover discomfort or treatments associated with menstruation, menopause, endometriosis, tubal ligation, hysterectomy, pregnancy or IVF, without being penalised by having to deplete their personal leave. Such leave has the potential to improve workplace equality, enhance employee job satisfaction, improve conditions for female employees and achieve greater social and gender equity.

i. any other related matter.

Too often, new programs or initiatives are provided with short term funding only to address a health care need as a pilot or trial. By the time the program has been established and is being widely utilised, the funding period ceases resulting in an end to the program regardless of its success. This results in the people receiving care experiencing a stop-start, fragmented health care service, unclear referral pathways, and uncertainty for the workforce regarding ongoing employment. These factors create barriers to people receiving the care they require, impacts workforce retention and costs the health care system.

Governments need to commit to funding long term, sustainable programs and initiatives that can be developed and evaluated to provide ongoing services to people living in Australia and to retain a highly skilled workforce. It is imperative that any reform to the health care system to address equity for women and improve access to reproductive and sexual health care is designed to continue beyond a political cycle.

Conclusion

Thank you for the opportunity to respond to the *Inquiry into universal access to reproductive healthcare*. Nurses and midwives play a pivotal role in improving access to, and the experience of, sexual and reproductive health care for women living in Australia. Action taken to reduce inequities in access to health care must consider where the full capacity and capability of nurses and midwives can be utilised as detailed in our submission.