Inquiry into universal access to reproductive healthcare

Melbourne Hearing – 28 April 2023

Questions on Notice from Senator Larissa Waters

Answers due COB 5 May 2023

The Royal Women's Hospital

1. Your submission recommends "providing medical abortion medication to women pre-pregnancy for "in case" usage". Can you talk a bit more about what that would involve and how it should be administered?

Providing medical abortion medication to women before pregnancy for 'in case' usage would require a major change to TGA regulations that govern the prescription of these medications. However, this model is important as it supports women in exercising their reproductive rights and offers flexibility for women in specific situations. This may include women who live in very remote areas, women experiencing reproductive coercion, family violence, and those unable to access or use contraception for other reasons. We propose that after counselling, and consideration of the individual woman's situation and risk/benefit profile, the prescriber would issue a script for a specific number of prophylactic doses. Specific instructions on when and how to use the medication would then be supplied to the woman, as well as follow up advice and support, either face to face or via telehealth.

2. You've noted that lack of service provision leads to many professionals not having the skills needed to deliver reproductive healthcare. As a training hospital, what do you recommend should be part of the curriculum and ongoing professional development programs? How can skills be maintained and updated?

We believe it is crucial to develop, maintain and extend opportunities to upskill clinicians in all components of medical and surgical abortion care, and contraception provision. This should include GPs, nurses, nurse practitioners, midwives and pharmacists. To increase the number of health professionals proficient in delivering reproductive healthcare, the Women's is currently:

- Working extensively with medical training body RANZCOG to embed training in contraceptive counselling and insertion/removal of LARC into the national curriculum for trainee obstetricians/gynaecologists at undergraduate and postgraduate levels.
- Delivering individualised skills-based training and mentoring to established Victorian-based health professionals in the practical use of LARC, including Implanon and intra-uterine devices.
- Providing training for obstetrics and gynaecology specialists and advanced GPs who wish to upskill in abortion care in medical abortion and later gestational surgical abortion.
- Providing training and mentoring in point of care ultrasound for reproductive healthcare practitioners.
- Developing opportunities for clinicians to access specialist and collegiate networks for ongoing peer-based skills development.

- Developing a pilot project to expand nurse practitioner and midwife training to include the full range of reproductive healthcare.

- Advocating for incentives that encourage healthcare professionals to maintain and improve their reproductive healthcare skills via formal training throughout their careers and to provide a full range of reproductive healthcare services within their communities.

- Advocating for changes to TGA regulations to allow nurse practitioners, midwives and clinical nurse consultants to prescribe medical abortion medication and support women through the process.

3. You've talked briefly about the Women's proposal for a training program and facility. Can you provide more information about what that involves, any funding that's needed to establish / maintain a sexual and reproductive health training hospital, and whether the model could be rolled out to more locations?

We believe a national training, research and advocacy centre in contraception and abortion would help to address the systemic and workforce barriers currently limiting women's access to sexual and reproductive healthcare. The Women's proposal builds on our current work in rural and regional Victoria and is in its very early stages, however we envisage that it will:

- Include both in-hospital training for post graduate specialisation, as well as decentralised training and mentoring in primary care to increase the numbers of practitioners and centres equipped to provide sexual and reproductive health services.

- Involve people with lived experience to inform and develop best practice models of care, including groups such as young women, adolescents, First Nations, LGBTIQA+, culturally and linguistically diverse, migrant and refugee populations.

- Work with all professional colleges to develop national curricula for trainees and ongoing training for all relevant health professionals in contraception and abortion care.

- Look at national quality of care standards and work with representative bodies and government to enable and extend the role of social workers, pharmacists, nurses and midwives in reproductive healthcare service provision.

- Develop practice frameworks and standards for nurse practitioner, nursing, and midwifery led models of care.

- Undertake and commission research into new and understudied areas of abortion care, service provision and need, including women's preferences, method effectiveness and barriers to care.

- Develop a digital resource hub as a repository of best practice and evidence-based resources to guide practice.

- Advocate for the development of a national abortion data collection framework to collect data and monitor trends in all states and territories.

- Strengthen advocacy efforts to ensure metro and regional public hospitals provide abortion and contraception services enabling people to access care closer to home.

In terms of funding needed to establish / maintain sexual and reproductive health training within a hospital, this would depend on the scale and scope of the program.

4. We've heard lots of stories from women about how painful IUD insertion was. Is that due to a lack of training, or is it an inherently painful process? Is more research required to address that (including if stories about pain is deterring people accessing LARCs)?

There may be some discomfort with IUD insertion but if properly inserted, discomfort and mild pain should resolve itself soon after insertion. Research suggests that predictors of pain associated with IUDs include not having given birth, pre-existing painful periods, and anxiety, stress and fear. There is also increasing evidence that suggests familiar surroundings (eg. your usual GP rather than a large hospital) and being with a trusted and well-coordinated team of practitioners leads to lower pain scores and higher satisfaction scores.

It is important that any health professional who is inserting an IUD is properly trained and confident in its use. This is why we are recommending initial and then ongoing training and mentoring for health practitioners. This should include practical skills as well as ongoing peer support and training in patient communication and care. The Women's is actively engaged in researching models of care and methods of pain relief in hospital outpatient and primary care same-day services.

5. Medicare does not cover the full cost of laparoscopic surgery, which you've noted is essential for diagnosing endometriosis. What is the current out of pocket expense for that procedure (for those without health insurance coverage)? What would need to change for MBS to cover the full cost?

We should have clarified in our original submission that the costs of laparoscopic surgery is prohibitive for women who access the service in private hospitals but do not have private insurance or who cannot afford out-of-pocket costs or who cannot access the surgery through a public hospital.

As a public hospital, the delivery of services and procedures for admitted patients is funded by the state government through the National Health Reform Agreement. While we know anecdotally that some women struggle to access laparoscopic surgery, which is essential for diagnosing endometriosis, we do not have expertise in terms of the specific cost barriers and solutions for the private health sector. However, we do note that the Commonwealth Government's Medical Costs Finder website states "For patients with private health insurance who had a laparoscopy in a private setting across all of Australia, 66% had an out-of-pocket cost". The website goes on to state that those patients typically paid $500 out-of-pocket, non-inclusive of other fees, such as private hospital accommodation, theatre, or medical devices, private insurance excess or co-payment.

6. Can you tell the Committee a bit more about the 'Women with Individual Needs Clinic'?
    a. Was there an identified service gap that the clinic was designed to address?
    b. Are women referred to the clinic, and is there a waiting list?
    c. Would you like to see similar clinics in other major hospitals?

The Women with Individual Needs (WIN) project was originally funded by the Victorian Department of Human Services as part of a package aimed at promoting and supporting cultural shifts from traditional hospital practices to more flexible, women centred practices for a range of maternity services.

The WIN Clinic was established as a pilot at the Women's in 2002 following research conducted by the hospital into the needs of women with disability. This research found women were fearful about navigating the healthcare system and anxious about being able to comprehend information. They wanted an appropriate level of support in labour and the postnatal period, and required disability-aware information about caring for their babies. Health professionals said they were concerned about their own lack of skills, knowledge and practical experience, the number of women with disability not accessing ante-natal care, and the risks some women faced in terms of social isolation, low income, a lack of family support and unstable housing. The research also identified a complex intersection between family support services and child protection services, challenges with disability identification, inadequate and drastic interventions, and poor coordination across agencies.

Other research indicates that women with disability have poorer perinatal outcomes, including higher risk of preterm babies, and caesarean section. Their infants are more likely to be low birth weight and more likely to be admitted to a neonatal special care or intensive care unit. Women with disability also have poorer experiences, often relating to lack of knowledge of care providers and reduced autonomy and are often overrepresented in the court system.

Today, the Women's WIN Clinic cares for approximately 60 women per year. Around 9 per cent identify as being from an Aboriginal and/or Torres Strait Islander background and 25 per cent of women are born overseas.

The WIN Clinic is the only hospital-based service of its kind in Australia and supports pregnant women with acquired brain injuries, intellectual or learning disabilities, physical disabilities or sensory impairments. The clinic has a dedicated midwife, who provides continuity of antenatal and postnatal care, pregnancy related information and postnatal outreach for up to six weeks after the baby's birth. The midwife also provides care coordination within the hospital liaising with medical and allied health colleagues, assisting with care and service integration, and providing support at appointments, specialist childbirth education and liaison with community-based midwifery services. The WIN clinic offers new mothers 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 of her stay. Some women choose to have their NDIS support worker for emotional support. A social worker assesses a woman's psychosocial needs, provides information about service options, advocacy, practical assistance, emotional and other supports and referral to community services. The social worker also provides support to families and partners, assistance with accessing material and/or housing aid (if needed) and developing a post-natal care plan with the woman.

Disability identification is a major issue. There is currently no consistent or recommended method of asking about disability status within health services nationally. It is not included in the list of mandatory reporting items within the Perinatal National Minimum Data Set, despite it having a potential impact on health outcomes for both mothers and babies. This makes it impossible to understand the prevalence of women accessing maternity services with a disability locally and nationally. Addressing this is important as accurate data will help to inform public policy, allow for population-level surveillance, improve clinical care planning and provision, and inform research into the link between disability status and other maternal and perinatal outcomes. Failure to correctly and consistently identify, document and refer patients with a disability may lead to adverse clinical outcomes, poor patient experience, and potential funding shortfalls for health services.

The Women's, in partnership with La Trobe University, recently completed research that will improve our understanding about how women prefer to be asked about disability status. It will also provide us with greater insight into the existing identification processes in maternity services nation-wide. In addition, the Women's is currently implementing and evaluating a new question and response function in our patient management system on disability.

Generally, hospital maternity units are established and funded for women who are well or experiencing little complexity and require a short admission. With the capacity to care for approximately 60 women per year, there is no doubt the Women's WIN Clinic model is a very modest service and is not able to meet demand. The services provided though this 'wrap around' model are not fully covered from within the current hospital funding model thus limiting our capacity. We believe that the program could be expanded with additional funding. This would enable us to:

- Formally evaluate the impact of the Women's WIN Clinic on clinical outcomes and experiences enabling us to identify barriers and opportunities, share our insights and potentially expand this model to other hospitals across Australia.

- Ensure the sustainability and expand the existing WIN Clinic at the Women's to provide maternity care support to more women with disability as well as expand the clinic to support women needing in-hospital gynaecological care.

7. In March, the government announced $6.4M for training medical professionals and frontline workers to recognise and respond to sexual violence. What do you know about that training, how and where it will be delivered, and who will deliver the training? Are there existing programs delivering those skills to healthcare workers? Should the program include training on recognition of reproductive coercion?

We understand that the Government's $6.4M funding package to expand a pilot program to train frontline workers went to Monash University. The new funding is part of the National Plan to End Violence Against Women and Children 2022–2032. We are not involved with this program.

However, since 2014 the Women's has led the Strengthening Hospital Responses to Family Violence (SHRFV) initiative, to support the Victorian government's family violence reform agenda. Since then, the SHRFV initiative has built a robust system to support Victorian hospitals in their response to family violence, in accordance with the recommendations of the Victorian Royal Commission into Family Violence (2015). The initial investment in the SHRFV initiative by the Victorian government totalled $38.4m over four years. In the years since it was established, the SHRFV program has created a coordinated, state-wide structure that uses a whole of hospital approach that engages hospital leadership, supports systems growth and builds health service capacity to identify and respond to family violence in both patient and health workforce cohorts across Victoria.

The issue of reproductive coercion is embedded in the SHRFV program. It is particularly important in the maternity care setting as it most commonly presents as the use of violence or coercion to force a woman to become pregnant against her will, terminate a wanted pregnancy, or continue with an unwanted pregnancy. Currently there is limited research to inform best practice specific to reproductive coercion. Despite this, the same principles of safely recognising and responding to family violence apply. The SHRFV program recommends routine antenatal screening for family violence and advises healthcare professionals that acknowledging that reproductive coercion and abuse exists and validating a woman's experience will help to build therapeutic relationships where a woman feels safe and supported. Understanding reproductive abuse allows healthcare professionals to better address a woman's need for contraception and promotes reproductive autonomy.

8. When the Women's Health Advisory Council was established earlier this year, the Assistant Minister noted that it would help to tackle medical misogyny. What are some of the key areas that you would like to see the Council look at?

The Women's is focused on addressing gender inequality and bias within a health context, particularly in terms of systemic bias in relation to service access, treatment approaches, health costs and medical research, all of which lead to unequal health outcomes, especially for women.

There are also a number of stigmatised areas of women's health where barriers and service gaps continue to exist. This is particularly true for areas such as choice and ability to exercise reproductive rights and safe and timely access to contraception and abortion services. We are particularly concerned about the structural barriers, gender bias and discriminatory practices built into the health system including the lack of funding and national coordination of specialist women's health services, especially abortion and contraception care. Connected to this are other barriers such as gender-blind MBS funding and unnecessary restrictions on mainstream women's health care (eg. TGA restrictions on some early abortion and contraception drugs and devices). We are advocating for improved resources and access to contraception, abortion services, public fertility services and improved treatment and outcomes for people with endometriosis, menstrual issues, persistent pelvic pain and menopause.

The Women's aims to provide healthcare that addresses and removes structural barriers and discriminatory practices that impact health outcomes for women, especially those experiencing disadvantage. We recognise some groups of women are healthier than others, not because of personal choice, but because of social, economic and environmental circumstances over the course of their lives. We believe greater attention needs to be paid to the social determinants of health and ways to redress disadvantage and discrimination that affects women's ability to access high quality, inclusive and culturally safe public healthcare. We need to focus on improving health outcomes for Aboriginal and Torres Strait Islander women, women and girls with lived experience of disability, those who are vulnerable, and victim/survivors of violence. We are also advocating for additional health system investment from all levels of government into gender sensitive, accessible and inclusive mental health services specifically for women.

We are calling for greater representation of women in leadership and STEM and to systematically consider gender when designing governance structures, developing policies, commissioning research and designing programs and services. We believe there needs to be awareness and understanding of sex and gender inequalities in medical and health research and greater adoption of and investment in gender-specific approaches to research funding, translation, recruitment and promotion.

We advocate for an intersectional approach to gender, which takes into account a number of factors that affect gender equality. There are some specific gendered issues that dramatically impact outcomes for people according to their sex and gender and family violence is one of the most critical ones. The disproportionate incidence and effects of family violence on women and their children is one of the most compelling examples of gender inequality we have in Australia.

We hope the council will look at these issues to determine the best recommendations for addressing them at a system wide level.

Melbourne Hearing – 28 April 2023

Questions asked during hearing by Senator Marielle Smith

Senator MARIELLE SMITH: Could I ask you to come back to me on something. If you're able to have a think about what the key factors for success have been in enabling you to expand that program [continuity-of-care maternity model], it would be really useful as we think about where it's happening or not happening in other parts of the healthcare system. I'm really interested in what the spaces are where we could kind of press against to influence and see it expanded.

The Women's continuity-of-care maternity model, or Caseload, as it is known, has been operating for several years at the Women's. It involves a known-midwife (and back-up midwives) assigned to an individual woman throughout the ante-natal, labour, birth and postnatal periods. The woman is able to build a relationship with the same midwife during her care journey and access other specialists at hospital if needed.

The Women's offers several streams of Caseload midwifery care: the Baggarrook program for Aboriginal and Torres Strait Islander mothers, babies and families; the Cosmos program for women with a low-risk of complications, and a new program, the Magnolia Trial, for women experiencing socio-economic disadvantage and other hardships, this latest program is very new.

According to a research paper by Professor Caroline Homer AO (an expert in this area) "Research suggests women who received midwife-led continuity of care were more likely to have a midwife they knew with them during labour and birth, more likely to have a spontaneous vaginal birth and less likely to have epidural analgesia, episiotomies or instrumental births. Women were less likely to experience a pre-term birth, and their babies were at a lower risk of dying (including all deaths before and after 24 weeks' gestation and neonatal deaths). Women rated midwife-led continuity of care models highly in terms of satisfaction and there was a trend towards a cost-saving effect for the midwife-led models, although there was inconsistency in reporting of both these outcomes. The review concluded that "most women should be offered midwife-led continuity models of care."[1]

In terms of our experience here at the Women's, the midwifery-led continuity of care model has been successful due to:

- the commitment of our leadership and workforce to this model;
- the successful and measurable outcomes for women (we regularly conduct research into this model in partnership with La Trobe University);
- the culture at our hospital, which is very respectful of midwifery-led expertise; and
- the positive experiences for both midwives and women participating in the program.

[1] Models of maternity care: evidence for midwifery continuity of care, Caroline SE Homer https://www.mja.com.au/system/files/issues/205_08/10.5694mja16.00844.pdf

However, there are a number of factors to consider for those seeking to implement this model. These include organisational readiness and ensuring a sustainable funding model (in addition to activity-based funding, which only covers standard maternity care in a hospital). Of particular importance is a commitment to investing in and supporting Caseload teams to avoid negative impacts on staff due to workload, burn-out and demand issues on what is often a very small and specialist team. There are many research papers and references that cover these issues in great detail. We particularly recommend the work of Professor Homer, including her book, *Midwifery Continuity of Care*, which includes chapters on design and implementation, cost effectiveness, and evaluation, and also the work of Professor Della Forster, Professor of Midwifery and Maternity Services Research with the Judith Lumley Centre, La Trobe University and the Royal Women's Hospital.

The Women's is currently working with the Victorian Government and other partners to develop the Women's at Arden in Melbourne, a new, low-risk hospital offering a full range of inpatient and outpatient maternity, women's health and neonatal services. The Women's facility at Arden will include low complexity, high-quality midwifery-led maternity care in a welcoming, de-medicalised environment that minimises unnecessary intervention. Meanwhile, the Women's at Parkville would then be able to focus on tertiary hospital care with greater capacity to offer emergency care, complex obstetric care, neonatal intensive care, and specialist gynaecology and oncology care for women from across the state. The Women's at Arden is expected to be completed by 2032.