Submission to the Senate Standing Committees on Community Affairs, inquiry on universal access to reproductive healthcare

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Executive summary

As a provider of unplanned pregnancy counselling and termination referrals, it is clear that access is neither equitable, nor accessible. Whilst abortions are legal within NSW, it remains a postcode lottery as to whether one can access timely, local and affordable care. Abortions within the Northern Rivers Region of NSW are provided by private providers and NGO's, meaning that women, non-binary people and trans men must pay $600 and travel two and a half hours for a surgical termination. This is not possible for many people, particularly with the devastating impact of the 2022 major floods, low socioeconomic background of the Richmond catchment, and rising cost of living.

Abortions should not be a privatised issue. This is a health issue, and basic human right. All public Tertiary hospitals should be providing free abortions, to all who need them.

Recommendations

Universal access to reproductive healthcare is essential. I support this important Inquiry, with the following recommendations:

- Implement publicly funded surgical and medical termination of pregnancy clinics at all tertiary hospitals, or at specialised publicly funded abortion clinics, and include non-Medicare holders in free access to terminations within these spaces.
- Increase access to public vasectomy's, tubal ligation, and IUD insertions under general anaesthetic by gynaecologists (current waitlist is over 1 year within Northern NSW).
- Increase funding to NGO sexual health clinics who are already providing bulk billed contraception and abortion services, so that they can meet the need of communities.

Background

On 28 September 2022, the Senate referred an inquiry into the universal access to reproductive healthcare to the Senate Community Affairs References Committee for inquiry and report by 31 March 2023.

There is a current consultation listed on the Senate Standing Committees on Community Affairs website, which is open until 11.59 pm AEDT on 15 December 2022. I appreciate the opportunity to provide a submission. This submission is written in response to the Committee Terms of Reference.

I consent to this submission being published on the inquiry website and shared publicly online.

Terms of Reference response

This section is framed in direct response to the Committee Terms of Reference.

Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to:

a. cost and accessibility of contraceptives, including:

i. Pharmaceutical Benefit Scheme (PBS) coverage and Therapeutic Goods Administration (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;

Currently, not all contraceptives are included on the PBS. For example, the contraceptive vaginal ring and progesterone only pills are not covered by the PBS. This drastically reduces contraceptive options for low-income people. The vaginal ring would be a great alternative for women who use the oral contraceptive pill but forget to take it, however without PBS coverage, few can afford it. Another under-utilised, long-acting contraceptive option is vasectomy. One of the contributing obstacles for increasing uptake in vasectomies is the extended wait times in rural areas for the public vasectomy list.

- Increase PBS coverage of contraceptives, for example include the vaginal ring and progesterone only pills.
- Increase provision of vasectomies. Current wait times for public vasectomies in Northern NSW is 365 days.

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

Currently in Northern NSW, people requiring a surgical termination must travel 2 and a half hours to a private clinic either in Coffs Harbour or Brisbane city. The costs range between $500 to $700 for a surgical termination under 10 weeks gestation. Due to the general anaesthetic, people must have someone drive them home from the clinic. The cost and distance of travel is a huge barrier and distressing for those unable to have a local medical termination. Medical terminations are accessible within the Northern River's including provision by private providers, and a bulk billed option provided by Choices Sexual and Reproductive Health Clinic in Lismore. Significant barriers to access include; local GP's lack of knowledge of referral pathways, lack of funding to Choices clinic hindering ability to meet community need.

- Implement public surgical and medical termination clinics within public hospitals state-wide, or publicly funded specialised termination clinics within communities, with support from public hospitals obstetrician/gynaecology teams.

- Increase Medicare rebates for abortion services, to incentivise primary health physicians to train in this service provision, and to reduce private costs for people seeking surgical or medical abortions.

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;

Registered Nurses and Midwives make up the largest portion of healthcare staff. Utilising this workforce is imperative to providing safe, affordable, and accessible sexual and reproductive healthcare. Midwife and/or Nurse Practitioner led medical abortions would significantly improve access to long acting reversible contraceptives (LARC) and abortions, particularly for rural and remote areas, as these are typically long held positions within communities.

Nurses are a hugely underutilised human resource within our private health care system. With no Medicare rebates available for nurses to do cervical screening tests, contraceptive counselling, STI screening, LARC insertion and removals etc, private practices have no incentive to increase their offerings in this area, which would decrease the costs and wait times for people trying to access these services.

- Increase training of nursing staff to facilitate improved provision of LARC in rural regions. For this to be feasible, Medicare item numbers must be introduced to support private practices to utilise these skills.
- Reduce the training requirements for MS2STEP for medical practitioners and allow nurse practitioners to prescribe medical abortions to increase abortion access within rural and remote areas.

The implementation of public abortion services within tertiary hospitals would increase education and awareness of abortions as a de-stigmatised, essential part of health care. Furthermore, in order to ensure sustainability in future service provision, termination of pregnancy training should be mandated as curriculum in Medical Degrees and included in Obstetrics and Gynaecology internship rotations. Advanced TOP service provision training should be provided and prioritised in Obstetrics and Gynaecology specialist training programs.

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

Sexual and Reproductive Health NGO’s tend to provide highly specialised and sensitive care to marginalised groups already. Borrowing from their specialist knowledge and protocols when implementing new government health services and/or increasing funding for NGO’s so that they are able to increase their offerings (including expanding further into rural areas) would support the provision of culturally safe and trauma informed practice.

Currently, any medical termination patient’s with complications such as retained products of conception or incomplete abortion are referred to the local LHD’s Early Pregnancy Assessment Service (EPAS) for treatment. Anecdotally, many patient’s referred to EPAS for further care report dissatisfaction in their experience, and report a significant lack of trauma informed care.

e. sexual and reproductive health literacy;

Increase funding for dedicated education programs within high schools with emphasis on not only anatomy and reproduction, but safety in relationships, consent and pleasure.

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

No comment.

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

The transgender and gender diverse community are currently in crisis in rural NSW with no dedicated gender affirming clinic to prescribe hormones. The closest gender affirming specialist (sexual health physician) is in the Goldcoast, and his books are closed to new patients. There are a few private GP's who are continuing hormone management of established patients, but few who can initiate. This is further complicated by patient's wishing to initiate masculinising hormone therapy requiring a specialist to provide an authority number for them to begin accessing testosterone.

Choice's clinic does provide continued management of patients who are established on hormones, however our availabilities are exhausted, due to a lack of funding (only providing 2 clinic days a week) and the huge need within the community.

The Transgender and gender diverse community is a high-priority population with the highest suicide rates of any population group in Australia. There is evidence that mental health outcomes improve significantly when individuals can access gender-affirming hormones. This population is in desperate need of improved access to gender affirmative healthcare locally, within the Northern River's.

- A dedicated clinic, or expansion of an existing service (Choices clinic) is desperately needed to be able to meet the needs of the transgender and gender diverse community of the Northern River's, the rainbow region of NSW.

h. availability of reproductive health leave for employees; and

No comment.

i. any other related matter.

Women are only fertile for a very small window during their cycle, and given the inability to predict ovulation accurately, it is extremely difficult to manage this in a way that is not disruptive to women's quality of life, due to the side effects linked with all hormonal contraceptive's. Men, however, are fertile every day of the year. Currently, all responsibility is placed on women to manage their contraceptive needs. It is an outdated, patriarchal health care system that given this knowledge, continues to put all of the pressure on women to control their fertility in order to avoid an unplanned pregnancy. Innovative research is required to broaden the possibilities for male centred contraceptive options, and increased education is needed within high schools and the broader community, to increase uptake in condom usage and awareness and accessibility of emergency contraception pills for when barrier methods fail.

Within the above paragraph, I am referring to women and men for ease of communication, however I am referring to women as those assigned female at birth, and men as those assigned male at birth, given the reproductive capacities of both.

- Increase funding for research into long acting, reversible male contraceptive options.
- Increase education and uptake in barrier methods through high schools, and wider community advertisement and education.