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

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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.

I write from the perspective of a training rural generalist (Australian College of Rural and Remote Medicine) with a specialist focus in Obstetrics and Gynaecology. I am also an Aboriginal woman, I have ancestral connections to the Nukunu people in South Australia and was born and raised on Dharawal country in New South Wales. I am also chair of Violence Prevention Australia, we aim to improve access to resources focusing on primary prevention of all forms of violence and believe the largest impact is made when we prevent the first act of violence in any setting (domestic, interpersonal or self-harm).

From my varied perspective I believe the importance of universal access to abortion care has many repercussions. Not only is it a basic health care right in a first world country but I believe the outcomes of complete autonomy over one's reproductive ability results in better health and safety for all involved.

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,

TGA approval for new contraceptive methods needs to occur and be streamlined, this would include access to the new self -injectable progesterone or combined contraceptive patches. Offering a broader range of long acting reversible contraceptives thus improving access.

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

There should be national wide standardisation of sexual health education including availability of and access to contraceptives. Removing the need for referral for LARC procedures would also improve availability and access.

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

Increase the PBS rebates for clinicians providing LARCs to sufficiently cover the costs of the procedure involved. This would ensure that anyone in our population can access appropriate and effective contraception without paying a gap.

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

There should be nation-wide public funding of all costs associated with abortion care at all stages, through all methods (as is the case in the Northern Territory). All hospitals with obstetric and gynaecology centres can and should offer abortion care, the skills and facilities already exist and are no different to those involved in management of miscarriages or termination of pregnancy for medical reasons. Surgical termination must be accessible financially and geographically for all people in Australia, it is a choice for many but also is a necessity for those in whom medical abortion is contraindicated.

Ensure non-GP specialists have abortion care training and skills to streamline care and reduce barriers for patients. Where I work in a tertiary women's hospital in WA, we frequently see women for threatened miscarriages in our emergency department, they may request an abortion. We are unable to provide that service and have to advise them to attend their GP to obtain a referral to Marie Stopes, then apply back to our hospital for funding (having to meet specific criteria). This process is onerous, lengthy and costly for the patient.

Medicare should be extended to cover all costs involved in accessing abortion care, inclusive of associated travel and accommodation costs for the patient as well as a support person. This is especially important as a means of providing culturally appropriate care. There should also be targeted and sustainable funding for migrant and refugee women's health programs, including abortion care and contraception. To better facilitate this migrant and refugee health information needs to be included in regional health planning. More investment needs to be made into providing a bilingual and bicultural health workforce. This would provide a culturally safe and accessible space for migrants and Indigenous Australian. Cultural safety promotes self-determination which would increase reproductive people's ability to seek contraception and abortion care. Access to contraception is paramount in preventative health.

Your postcode and income shouldn't dictate pregnancy options available to you. If a person cannot afford the costs incurred for travel to receive abortion care how are they expected to raise a child without constant financial stress and/or psychological stress.

Harmonise abortion laws across Australia to make accessing care less stressful and confusing, this would allow clinicians who move frequently to confidently recommend and provide abortion care without concern or delay.

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;

Amendments should be made to the risk management plan and regulatory reforms for medical abortion medication, over regulation is a barrier to access.

There needs to be a broader prescriber base for mifepristone training and prescription, to include nurse practitioners, rural/regional midwives and nurses. This would help to improve access. In many regional and remote areas nursing staff often offer the continuity of care ideal for abortion care. Provide post graduate education pathways to upskill the current workforce.

Another barrier to access in rural/remote areas is the need for individual pharmacists to be registered, access would be improved if this was removed or granted to a pharmacy (not individual pharmacists), meaning a pharmacist could simply place an order through their local wholesaler, like any other medication.

Also, the limitation of gestation needs to be addressed. Currently the gestation of 63 days reduces the number of appropriate abortions that could occur, other countries safely allow prescription up to 70 days.

A royal commission into the health and wellbeing of the health workforce also needs to occur, given the recent and persistent stressors seen within the health sector. Providing equitable reproductive healthcare relies on a stable, committed and resilient workforce.

Abortion care must also be a mandatory part of every medical schools curriculum nationwide. All doctors need to have an understanding of abortion care whether they want to become providers or not.

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

As mentioned above: More investment needs to be made into providing a bilingual and bicultural health workforce. This would provide a culturally safe and accessible space for migrants and Indigenous Australians. Cultural safety promotes self-determination which would increase reproductive people's ability to seek contraception and abortion care.

From my point of view as an Aboriginal doctor I believe the best way forward to a culturally appropriate service delivery of abortion and contraceptive care is a collaborative approach with community. Engagement from early on to create awareness of contraceptive options, sexual health and well being practices. Also funding to covers costs associated with seeking abortion care e.g the cost of appointments, the medication or the surgery, the travel involved as well as accommodation. Indigenous women in rural or remote areas are more likely to have medical conditions excluding them from having medical abortions. Also the reduced access to appropriate medical care in rural and remote areas results in later diagnoses of pregnancy and thus later gestation abortions. The costs of an attending support person must also be covered. These women need to be supported through their decision and subsequent journey in a culturally appropriate and sensitive manner.

e. sexual and reproductive health literacy;

Improve sexual education within schools. A national curriculum of standardisation of education for children in schools which is accessible and inclusive. Normalise reproductive health and sexual wellbeing to reduce stigma associated with menstruation, contraception, abortion and sexually transmitted infections. Inclusive within this would be a focus on consent, these changes would also reduce the incidence of sexual assault, rape and partner violence.

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

There needs to be a national inquiry into reproductive violence for people with disabilities starting with the removal or babies and children from parents with disabilities and forced sterilisation.

There needs to be a national strategy, in consultation with people with disability, to improve access to comprehensive and disability inclusive sexual and reproductive health and information.

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

Improving safety within the clinical setting for LGBTIQ+ people, transgender and non-binary people and people with variations of sex characteristics by increasing awareness and education of staff including the utilisation of inclusive language.

Medical procedures resulting in limitations of fertility for people with variations of sexual characteristics at young ages need to be strictly regulated to ensure appropriate management for the best interests of the patient.

h. availability of reproductive health leave for employees; and

Introduce Reproductive Health Leave, this would cover leave required to access procedures for contraception, abortion and miscarriage as well as cover leave for menstrual conditions and fertility treatments. Menstruating people and people who can fall pregnant do not have sicknesses requiring “sick leave” they should have access to other forms of leave to cover their basic health needs. This reproductive health leave should be legislated in the National Employment Standards as universal, protected entitlement.

Research should be commissioned into the impact of reproductive health on people in the workforce. Public consultation should occur to establish community interest and support.

i. any other related matter.

No comment.

Recommendations

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

- Establishment of a national taskforce on abortion access to address abortion equity across all States and Territories.
- Medicare funding of all costs associated with abortion care including the costs of a support person and the costs of care for migrant persons irrespective of visa status.
- Invest in a bilingual and bicultural health force promoting cultural safety.
- Harmonise abortion laws across Australia.
- A Royal Commission into the health and wellbeing of the Australian health workforce.