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Dear Senator Rice

I would like to thank you, and Senators Askew, Payman, Smith, Tyrrell and Waters, for asking such important questions at the hearing I attended in Melbourne on Friday 28 April; questions that demonstrate engagement and familiarity with core issues inhibiting universal access to abortion today. I want to also thank the Australian Greens for its commitment to the issue and implore other political parties to adopt its unequivocal pro-choice stance.

I would like to take the opportunity to provide some additional clarifying information about the questions I was asked at the hearing.

In further response to Sen. Waters question about WHO's Abortion Care Guideline (2022), I would like to highlight the following recommendations:

- WHO recommends **against the use of ultrasound scanning** as a prerequisite for providing abortion services and indicates that ultrasound should be ordered upon clinical indication on a case-by-case basis (p. xxvi)
- WHO recommends that '**Women may self-manage** parts or all the abortion process' and that 'Restrictions on prescribing and dispensing authority for abortion medicines may need to be modified or other mechanisms put in place for self-management within the regulatory framework of the health system' (p.98)
- **The following health workers** should be able to manage EMA to 10 weeks (70 days): community health workers, pharmacy workers, pharmacists, traditional and complementary medicine professionals, auxiliary nurses/ANMS, nurses, midwives, associate/advanced associate clinicians, and the pregnant person (pp.69-70)
- General medical practitioners and specialist medical practitioners should be able to manage EMA to **12 weeks' gestation** (pp.69-70)

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- WHO recommends against anti-D immunoglobin administration for medical and surgical abortions before 12 weeks; thus determination of RH status should not be a prerequisite for early medical abortion (p.45)

Regarding Sen. Payman's question about whether private clinics would be necessary if public hospitals were to integrate abortion care into pregnancy care. In my answer to this question, I was thinking only of surgical abortion provision and did not sufficiently emphasise the importance of increased primary care provision. Australian uptake of EMA is low (24 %) compared to England and Wales (73 %), Scotland (88%) and Sweden (93%).[1] All patients should be given a choice of method where appropriate but it's likely that, when primary care provision is supported by enabling regulation and adequate Medicare rebates, surgical services will become less common (NT leads the way in the provision of EMA in Australia, and it's estimated about 73 % of abortions in the territory are medical abortions).

In further response to Sen. Tyrrell's question about best practice examples in Australia and overseas. There are inadequacies in abortion law and provision throughout Australia and, indeed, through the rest of the world. As you know, most abortions in Victoria, New South Wales, Queensland and Western Australia are in private GP offices or abortion clinics with significant out-of-pocket costs for patients.

Nevertheless, there are important lessons to be learnt both from Australia and overseas when thinking through how governments can facilitate universal abortion access. Optimal systems of provision is a topic of my current research. The following information is based on literature reviews and my ongoing interviews with providers and advocates through Australia.

The ACT

The ACT has the most progressive abortion legislation in Australia and has recently moved to provide abortion at no cost through a clinic operated by MSI Australia. Affordability is key to abortion access, but contracting out health

[1] According Keogh et al. (2021), there were approximately 67546 surgical and 20741 medical abortions in 2017-18.

care to private operators concentrates service provision in metro areas and retains abortion exceptionalism within healthcare delivery.

South Australia

The Pregnancy Advisory Centre in Adelaide offers all abortion care (medical and surgical) fully under Medicare. The service was established in 1992 after a departmental commitment enabled workforce development for a multidisciplinary team in the public health system. The PAC has extended clinical practice, published clinical research, and led the way for approval of the general use of medical abortion by authorised prescribers before MS Health was able to commercially distribute medical abortion drugs. The PAC has been the only public clinic in Australia where surgical abortions have been routinely provided to 23 weeks.

The PAC is located in an Adelaide suburb but surgical services were moved to the Queen Elizabeth Hospital four years ago. This is less than optimal because there is no dedicated space for abortion provision, and patients move between four different areas. The move resulted in a reduction in surgical capacity. There are calls for an integrated PAC to be included within the new Women's and Children's Hospital, which would make it a world-class service. The PAC performs most (63 %) abortions in SA and often experiences long waiting lists (at busy times this can be 2 weeks for an initial consultation followed by a further three weeks for surgical procedures). Rural and regional access remains a problem, which is worsened because the decentralised provision of EMA in primary care was prevented by law until decriminalising legislation came into effect in 2022.

Tasmania

Enabled by a state government commitment to the issue, Tasmania has made some great inroads into ensuring abortion access over the last 2 years. Family Planning Tasmania offers an EMA service in its clinics, with the use of a bedside ultrasound that streamlines the abortion procedure. Total out-of-pocket costs (including medication) are $192 (for health care card holders) or $220 for Medicare Card holders. 50 per cent of all abortions in Tasmania are EMA abortions performed by FPT (this provides more detail to my answer to Sen.

Tyrrell's question re the ratio of surgical/medical abortions in Tasmania). The Women's Health Fund and Youth Health Fund can cover these out-of-pocket expenses to people in need. In addition, Women's Health Tasmania have recently launched Pregnancy Choices Tasmania (modelled on 1800 MyOptions in Vic) to help people find a local sexual and reproductive health service.

All surgical abortions are offered under Medicare to patients at three hospitals. Waiting lists for surgical services are about 2-3 weeks. Importantly, there is no provision for surgical abortion beyond 14 weeks at the public hospitals in Tasmania (patients can have a medical induction, however). A panel is convened to make decisions about abortion after 22 weeks of pregnancy at the Royal Hobart Hospital. This panel system is an institutional rather than legal requirement and lacks transparency. We do not know who is on the panel (whether it is comprised solely of doctors, for example), the grounds upon which they make decisions, and advocates have reported that the reasons why the panel refuses some abortion decisions are not always communicated effectively to patients.

Northern Territory

NT offers EMA and surgical abortions fully under Medicare, with high uptake of EMA (73%). In my evidence I was uncertain as to whether the Family Planning Welfare Association of Northern Territory offers telemedical EMA. Having looked at their website it appears that they do not, transparently at least (although there is a number to call if you are wanting an abortion, which is an important service). The law continues to be relatively restrictive in the NT (technically doctors retain decisional control of abortion regardless of gestation). As with many health care services, abortion access is more difficult in remote locations. Telemedical EMA could bridge this gap, but would remain restricted because of requirements (usually set by individuals and institutions) that people stay within 2-3 hours of an emergency service following an EMA. In its guidelines released in 2022, WHO did not discuss, and made no recommendation regarding, proximity requirements to emergency care facilities. This may be a further example of the over-regulation of abortion because EMA induces a miscarriage, which can happen anywhere.

I refer to the submissions made to the inquiry from Dr Ahmad Syahir Mohd Soffi and FPWANT, which point to waiting lists of up to 6 weeks for surgical

services at the Royal Darwin Hospital, the need for regulatory change to support non-medical provision of EMA, and greater support for people (including international students and people seeking asylum) who are not eligible for Medicare or PATS.

Canada

Internationally, Canada has no specific abortion law and regulates abortion like all other health care. This is optimal legislation. As with Australia, Canada's large geographical size, and concentration of abortion services in metro areas, causes difficulties in access for people in rural and remote areas.

Mifepristone/Misoprostol has only been commercially available since 2017. It is now available through a normal prescription (from a doctor or nurse practitioner) and local pharmacy. Health Canada removed the ultrasound requirement in 2019 in response to delays in access, and many midwives are only ordering ultrasounds when they are deemed appropriate (e.g. the patient is uncertain of the date of their last menstrual period, potential ectopic pregnancy) (see Carson et al. 2023).

Provincial governments provide public funding for EMA and surgical abortions, and telemedical services expanded (except in Quebec) in response to the COVID-19 Pandemic (Ennis et al. 2021). Many barriers remain: physicians are not prescribing EMA, and instead refer abortion seekers to clinics in large urban areas; and some provinces place conditions on receiving state funding for abortion (e.g. restricting where patients can receive state-funded care to particular clinics and hospitals). Lack of emergency support and access to ultrasounds have also been noted in the literature (e.g. Renner 2022).

Sweden

In Sweden all obstetrician-gynaecologists and midwives are trained to perform abortions, and this is understood to be part of their core work. Abortion care is publicly-funded and local health authorities must provide abortion within a week from the first patient contact. Most abortions (93 %) are medical abortions performed under nine weeks of pregnancy (84 %). Abortions are offered at about 130 gynaecological departments and specialised public and

private gynaecological clinics, but not at the primary care level. The Swedish Abortion Act (1974) permits on request abortions to 18 weeks' gestation, and between 18 to 21+6 upon permission from the National Board of Health and Welfare (Hulstrand 2022). Abortions from 22 weeks are only available in the vary rare cases when the foetus cannot be carried to term, a major weakness in the Swedish model.

New Zealand

New Zealand law was decriminalised in 2020 with a 20-week gestation limit to on request abortions. DECIDE is an excellent policy development. It appears as though ultrasound will only be required where it is deemed necessary, and the medications are either couriered to patients directly or sent to their local pharmacy. This service is free to NZ residents, but expensive ($950 NZD) to non-residents. A major barrier identified in the literature is a lack of second and third trimester abortion providers and services (Whiting et al. 2022).

Many thanks again for providing me with the opportunity to present evidence at the public hearing and to write a supplementary response to the questions.

All the best with the tight turnaround; I look forward to reading the report. Please do not hesitate to contact me if I can provide you with any additional information.

Kind Regards

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