Submission to

Inquiry into Universal Access to Reproductive Healthcare

December 2022

As a provider of specialised reproductive health care in Victoria, cohealth welcomes the opportunity to contribute to the Senate Community Affairs References Committee inquiry into Universal Access to Reproductive Healthcare.

cohealth recognises that women and people with a uterus[1] have the right to control their own body. Access to safe abortion is a universal reproductive and human right, and a key element in reproductive and overall health. Women and people with a uterus have a right to decide if, when, and how many children they have, and access to affordable, timely and safe contraceptive and abortion services is vital to achieving that.

The target of universal and equitable abortion and reproductive health access is enshrined in the National Women's Health Strategy 2020-2030.[2] Despite this, women, girls and people with a uterus still face barriers to accessing sexual and reproductive health care. These are recognised in the National Women's Health Strategy 2020-2030 which commits the government to 'Remove barriers to support equitable access to timely, appropriate and affordable care for all women, including culturally and linguistically sensitive and safe care', and to:

> *Work towards 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, including contraception and options for addressing unplanned pregnancies, including access to termination services.*[3]

To reduce these barriers and ensure that women and people with a uterus have equitable access to sexual and reproductive healthcare, cohealth recommends that:

1. The Australian Government ensures that approved contraceptives are equally accessible.
2. The Australian Government increase investment in promoting the uptake of long-acting reversible contraception
3. Federal, state and territory governments must ensure that abortion care is free to all who need it. This includes requiring all public hospitals to provide non-

[1] cohealth acknowledges gender diversity and promotes gender equality. While the terminology used throughout this submission generally refers to women, this is not intended to exclude trans, non-binary, agender, intersex and other gender diverse populations.
[2] https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030
[3] National Women's Health Strategy 2020-2030 page 24 https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030

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care for all

judgemental sexual and reproductive health services, including abortion care, particularly those in regional, rural and remote areas.

4. Federal Government provide funding to support a nurse-led model of service delivery across Australia
5. The Federal Government increase the MBS rebate for LARC, and retain the telehealth item numbers for sexual and reproductive health consultations.
6. That Federal, state and territory governments explore options to improve the sexual and reproductive health education and training of the workforce, and to broaden the workforce to reflect the communities it works with.
7. That Federal, state and territory governments invest in broad based sexual and reproductive health literacy campaigns, in partnership with diverse communities.
8. The Federal Health Minister progresses work with state and territory Health Ministers to develop consistent abortion laws across the nation.

About cohealth

cohealth is one of Australia's largest community health organisations, delivering care from over 30 locations across the inner, north, and west of Melbourne as well as statewide services across Victoria. cohealth provides integrated general practice, medical specialist, dental, allied health, mental health, alcohol and other drug, counselling, family violence, and social support services to more than 50,000 people each year.

People using cohealth services typically experience social disadvantage and are consequently marginalised from mainstream health services or require a higher level of care and support – such as people who are experiencing homelessness, mental illness, people who use alcohol and other drugs, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, recently released prisoners, LGBTIQ communities and people with chronic and complex health conditions.

cohealth operates a Victorian government funded specialised Sexual and Reproductive Health Hub (SRHH) with sites in Laverton, Footscray and Fitzroy. These community-based hubs provide a range of sexual and reproductive health services including:

- information to women about all forms of contraception and termination of pregnancy options
- clinical services to women who choose long-acting reversible contraception (LARC) methods
- clinical services to women who opt for medical termination of pregnancy
- referral pathways for women who require surgical termination of pregnancy
- provide sexual health testing, treatment and support.[4]

cohealth's SRHH is operated as a nurse-led model. Qualified Sexual and Reproductive Health (SRH) Nurses work in collaboration with a General Practitioner (GP) and Sexual

[4] https://www.health.vic.gov.au/populations/improving-womens-health

Health Physician to provide bulk billed nurse-led comprehensive contraception and early medical abortion (EMA) services. Recognising the diverse population of the area interpreting is available, and longer appointment times allow women and people with a uterus the time they need to fully consider their options and decisions.

When a client attends the SRHH, the SRH nurse undertakes a comprehensive discussion about all aspects of their sexual health, including cervical screening and sexually transmitted infections. Ongoing sexual health promotion is a key part of the SRHH's work, as the team works with communities who experience disadvantage and have limited access to education and healthcare. The SRHH is based on a philosophy of empowering women to take control of their sexual and reproductive health.

In addition, GPs and nurses at other cohealth sites provide extensive reproductive healthcare as part of their usual primary health care work.

Response to the 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'

As a provider of sexual and reproductive health services, cohealth clinicians are acutely aware of the various barriers faced by women and people with a uterus in obtaining affordable and timely care. These include:

- Out of pocket costs of health services and medications. This is an even bigger barrier for people who are not eligible for Medicare.
- Too few providers of sexual and reproductive health care, limiting ability to obtain care in a timely manner.
- Lack of care close to home, meaning people have to travel to services. The financial and time costs for people from region, rural and remote areas can be substantial.
- Lack of accurate, accessible information about available services.
- Inadequate childcare for women with caring responsibilities who are accessing treatment.
- Stigma and social norms.
- Limited culturally appropriate services.
- Tactics of anti-choice campaigners, who seek to influence women's choices through misinformation and intimidation.

cohealth strives to address these barriers in a model of care provided by our sexual and reproductive health services. Our responses in this submission are based on the experiences of our clinicians and the clients who use our services, particularly in relation to termination and contraception care.

a. Cost and accessibility of contraceptives, including:

i. PBS coverage and TGA approval processes for contraceptives

The varying treatment of similar contraceptives, specifically Intrauterine devices (IUDs), is an anomaly in the system that needs to be rectified. The hormonal IUD is available on the Pharmaceutical Benefits Scheme (PBS), while copper IUDs are not. As a result, copper IUDs can cost $100 or more, making them prohibitive for some women, and deterring them from using this very effective method of contraception. cohealth clinicians speak with women who would prefer a copper IUD as non-hormonal contraception, but are unable to afford the cost. Women should be able to choose the method of contraception that best suits their health and personal needs, rather than be restricted due to affordability.

Recommendation:

1. The Australian Government ensures that approved contraceptives are equally accessible.

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

Long-acting reversible contraception (LARC) options are one of the most effective and long-lasting contraception options, being over 99% effective. Despite this, community understanding about LARC, and uptake of this method, is still limited.

Research with young women and health care providers about the barriers to the uptake of LARC[5] has identified norms, misconceptions, bodily consequences, and LARC access issues as barriers experienced by both groups. Young women also identify a perceived lack of control over hormones entering the body from LARC devices as an additional barrier. Healthcare professionals also raised limited confidence and support in LARC insertions as an additional barrier.

The same research identified strategies to increase LARC uptake: to increase contraceptive knowledge and access through increasing nurses' role in contraceptive provision and education, improving sex education in schools, and educating parents.

This is confirmed by the conversations cohealth clinicians have with clients attending our Sexual and Reproductive Health services. A significant part of their work is educating people on the facts about contraception, and correcting negative views heard via hearsay, social media and the like.

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[5] Garrett, C.C., Keogh, L.A., Kavanagh, A. *et al.* Understanding the low uptake of long-acting reversible contraception by young women in Australia: a qualitative study. *BMC Women's Health* **15**, 72 (2015). https://doi.org/10.1186/s12905-015-0227-9

Discussion of contraception options is a key part of conversations cohealth sexual and reproductive health practitioners have with women as part of early medical abortion (EMA) care. One in seven women who have EMA will re-present with an unplanned pregnancy in the next 12 months without LARC.[6] Given this, discussion of contraception, particularly LARC, is a standard part of follow up conversations after an EMA as clients are better able to absorb the information at this time. The choice of contraception always sits with the client, but cohealth maintains that they should be presented with complete and accurate information to make an informed decision. It is vital that clients are directed to reliable information and websites and discouraged from randomly searching on the internet.

cohealth recommends that there is increased investment in promoting the benefits of LARC, through providing accurate and accessible communication and messaging to women and people with a uterus and to health professionals. This aligns with a key aim of the National Women's Health Strategy 2020-2030. Communication campaigns need to be developed in partnership with diverse communities to ensure that it is delivered in culturally appropriate ways, in community languages.

Recommendation:

2. The Australian Government increase investment in promoting the uptake of long acting reversible contraception

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

cohealth supports the ready availability of all forms of contraception, including over the counter options, and welcomes initiatives that improve access, particularly those that reduce cost barriers, to ensure they are affordable to everyone.

cohealth particularly encourages the Government to investigate measures to increase the uptake of LARC. These are the most effective methods of contraception, but currently uptake is relatively now in Australia. A range of issues contribute to this, including cost to patient and provider; lack of community awareness; and limited knowledge by some health care providers (see Terms of Reference a(ii) above and b below for more detail).

[6] cohealth data

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

Women and people with a uterus face significant barriers to accessing reproductive healthcare, particularly affordable care close to home. Women using cohealth's Sexual and Reproductive Health Service particularly talk about the barriers to services such as early medical abortion (EMA) and long-acting reversible contraception (LARC). Our comments in this section focus on these services.

- High out of pocket cost of services
    - Both LARC and EMA can have out of pocket costs of up to $500 - $600 at private clinics, making them unaffordable for women on low incomes.
    - These costs are even higher for women who are not eligible for Medicare and can be a significant barrier for women from already vulnerable groups, particularly those from asylum seeker backgrounds. For these women an EMA will cost approximately $1,000.
    - When services are unavailable locally, particularly for women from regional, rural and remote communities, women are forced to travel to receive the care they need. Travel and accommodation increase the costs, along with time away from work and caring responsibilities. There is an urgent need for government assistance with travel, accommodation and childcare (if required) costs, including for a support person where support is needed to ensure trauma informed, culturally safe care.
- Limited GPs and pharmacists providing EMA and LARC:
    - Only a small proportion of GPs and pharmacists provide EMA care. In December 2020, only 2,841 of 29,017 registered GPs (1%) were active prescribers of MS-2 Step (the medications used for EMA), and 5,347 of 32,393 registered pharmacists (16%) were active dispensers.[7]
    - Similarly, GP knowledge regarding the efficacy and appropriate use of LARC is limited,[8] meaning women are often not informed about it as a form of contraception, contributing the relatively low uptake of LARC in Australia.
    - Compounding limited provider knowledge is the inadequate Medicare rebate for services. Both LARC and EMA require specialised training and longer consultations, with EMA requiring significant preparatory work and follow up care. These are not adequately covered by the Medicare rebate, so GPs do not find it financially viable to provide these services, or to bulk bill patients.
        - For example, the Medicare rebate for the IUD insertion (approx $80) barely covers the cost of the consumables (IUD pack approx

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[7] https://www.mja.com.au/journal/2021/215/8/early-medical-abortion-services-provided-australian-primary-care

[8] https://www1.racgp.org.au/ajgp/2021/december/long-acting-reversible-contraception

        $40),[9] and certainly not the other associated costs of the procedure such as specialised training, consultation and counselling time, particular sterile instruments and materials, and having an assistant, often a nurse, on hand. On top of those costs, some patients need 30 minutes after the procedure to rest before leaving the clinic.[10]
    - Copper IUDs are not covered on the Pharmaceutical Benefits Schedule, making them more expensive for women.
- These costs act as a disincentive to GPs and pharmacists to seek the necessary training and authorisation to provide services.
- Hospitals can choose whether or not they provide abortion care, so not all hospitals provide it. This particularly limits access for women in rural and regional areas.
- While nurses provide excellent sexual and reproductive health care, the Medicare system doesn't recognise this and restricts their eligibility to claim rebates.
- Culturally safe services, provided in a women's language can be particularly difficult to access.

As a result of these barriers, women can be forced to travel long distances to receive a service. At cohealth's Laverton service at least one woman has travelled from as far away from South Australia to receive the care she needed.

The introduction during COVID-19 of Medicare item numbers for telehealth consultations for sexual and reproductive health issues, without the need for the patient to have an existing relationship with the GP, provided enormous benefits. The continuation of these item numbers has been vital for improving access to sexual and reproductive health services. Follow up appointments after EMA or LARC insertion can be brief, and people who feel well may not attend if they have to do so in person. Telephone appointments overcame the barriers of distance, need for childcare, time off work, to ensure high quality care if provided to everyone. Telephone consultations, in particular, are vital for women who do not have access to the technology needed for video consultations. It is critical that these telehealth item numbers continue.

cohealth's SRHH, one of eleven funded by the Victorian Department of Health,[11] helps address these barriers. By providing timely, bulk-billed, nurse led care, the service is affordable for women. In the nurse-led model of care, a qualified sexual and reproductive health nurse works with GPs and a Sexual Health Physician to provide nurse-led EMA and comprehensive contraception services. The nurse is the main contact for women, responding to enquiries within 24 hours, with a phone call with women where their needs and options are discussed, along with requirements for blood tests and ultrasounds for EMA. The nurse conducts most of the hour-long

[9] https://www1.racgp.org.au/newsgp/professional/rebate-increase-for-iud-insertion-called-out-as-in
[10] https://www.abc.net.au/news/2022-03-02/iud-insertion-medicare-rebate-increase-doctors-push/100872878
[11] https://www.health.vic.gov.au/populations/improving-womens-health

EMA appointment, including taking the patient's history and explaining the procedure. The GP provides the medication prescription. The nurse provides follow up care after the procedure, including an in-person appointment where contraception options, including LARC, are discussed. Interpreters are available for women who need them.

This model of care has proven to provide an effective model of care, supporting the time and attention women require, while making best use of GP time. However, it relies on the funding received from the Victorian Department of Health to enable its operation. cohealth recommends that this model of care be rolled out across Australia, and urges the Federal government to provide funding to enable this.

It is critical that women be able to obtain the care they need promptly, close to home and that cost is not a barrier.

Recommendations:

3. Federal, state and territory governments must ensure that abortion care is free to all who need it. This includes requiring all public hospitals to provide non-judgemental sexual and reproductive health services, including abortion care, particularly those in regional, rural and remote areas.
4. Federal Government provide funding to support a nurse-led model of service delivery across Australia
5. The Federal Government increase the MBS rebate for LARC, and retain the telehealth item numbers for sexual and reproductive health consultations.

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

cohealth supports measures to increase the number of reproductive healthcare providers to improve access. Women travel a distance to come to cohealth's Sexual and Reproductive Health Hub as services are not available in their own area. Even in our own service there is a need for back up support for our SRH nurse when she is not available. While the current nurse can support the training of other nurses, it takes her away from the busy work of the clinic.

An excellent example of supporting workforce development to increase access to reproductive healthcare services is the Royal Women's Hospital's Sexual & Reproductive Health Clinical Champion Network.[12] The Clinical Champion Network is a state-wide program that aims to improve access to safe and effective medical

[12] https://www.thewomens.org.au/health-professionals/clinical-education-training/abortion-and-contraception-education-training#:~:text=The%20Clinical%20Champion%20Network%20is,regional%20hospitals%20and%20primary%20healthcare.

and surgical abortion and long-acting contraception care by increasing training and capacity within outer metro, regional hospitals and primary healthcare. The Clinical Champions Network (CCN) also supports the Sexual and Reproductive Health Hubs across Victoria. The CCN provides training, secondary consultation, evidence dissemination and support and advice on organisational change to enable provision of abortion and LARC direct service in primary care and publicly-funded hospitals.

The CCN could be scaled up and rolled out nationally to support workforce development, the expansion of sexual and reproductive health services and improved access.

While promoting training and credentialing is important, improving the financial viability for providers is also a critical factor to encourage practitioners to provide sexual and reproductive health care. The nurse-led model of care has proven to provide high quality care, and has significant potential to improve access, but needs to be financially supported and extended.

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

It is vital that clear values and principles underpin the provision of sexual and reproductive healthcare, including that it is:

- Trauma informed
- Culturally safe and inclusive
- Non-judgemental
- Patient centred, with treatment decisions always the woman's choice
- Fully informed

Best practice approaches also mean that women have the time they need to discuss their options, ask questions and decide on the option that works for them. Adequate time is fundamental to the nurse-led model of care.

There is also a need for more emphasis in undergraduate courses for doctors, nurses and community health worker on sexual and reproductive healthcare, along with trauma informed and culturally safe care. Along with improving the knowledge of the mainstream workforce, it is also important to ensure that the sexual and reproductive healthcare workforce reflects the community it works in. This can be assisted by supporting the training, qualifications and employment of diverse communities through grants and scholarships, mentoring and employment programs. Emerging workforces, such as peer workforce and bi-cultural workers have the potential to play a valuable role in the promoting and delivering sexual and reproductive healthcare and should be considered in all workforce development plans.

Recommendation:

6. That Federal, state and territory governments explore options to improve the sexual and reproductive health education and training of the workforce, and to broaden the workforce to reflect the communities it works with.

e. Sexual and reproductive health literacy

Improving sexual and reproductive health literacy of both the community and the health workforce is vital. cohealth practitioners regularly observe the impact of people relying on social media for their health information, resulting in misinformation and misconceptions about various forms of contraception. A significant part of the work of the Sexual and Reproductive Health Hub is educating people on the facts about contraception, and correcting negative views heard via hearsay and social media.

Sexual and reproductive health literacy needs to be addressed in diverse ways, including: increased school based education[13]; community education campaigns, both broad based and targeted to specific groups; greater emphasis in undergraduate medical, nursing and other health related courses; and expanded opportunities for training and education for qualified health practitioners. Dedicated funding needs to be allocated for community education activities.

Diverse communities must be partners in sexual and reproductive health literacy work to ensure that it responds to the particular needs of different communities and is provided in ways that will maximise uptake.

In Victoria the 1800MyOptions[14] service provides excellent sexual and reproductive health literacy work, and could be expanded nationally.

Recommendation:

7. That Federal, state and territory governments invest in broad based sexual and reproductive health literacy campaigns, in partnership with diverse communities.

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

cohealth directs the Committee's attention the work Women with Disabilities Victoria has done in this area, including a valuable Sexual and Reproductive Health project

[13] https://www.tandfonline.com/doi/abs/10.1080/14681811.2022.2103110?journalCode=csed20
[14] https://www.1800myoptions.org.au/

for health workers[15], and the Experts in our Health project, where women with disabilities applied their lived experience to co-design and promote accessible health resources to women with disabilities through workshops across Victoria.[16]

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

Transgender people, non-binary people, and people with variations of sex characteristics face additional barriers accessing sexual and reproductive health care, and their reproductive health needs are often overlooked. Barriers include: limited dedicated services; fear of being discriminated against; lack of education and understanding among mainstream healthcare providers; and transphobia. Cost of services can be a barrier, given the lower socio-economic status of trans and gender diverse communities stemming from experiences of discrimination in education and employment.

Sexual and reproductive healthcare services and the clinicians who work in them must be welcoming of trans and gender diverse people and sensitive to their needs, so they can access the healthcare they require. Improved education, in undergraduate courses, specialist studies and ongoing professional development is vital.

i. Any other related matter.

While abortion is, in the main, legal in all Australian states and territories, each state and territory has their own laws.[17] This leads to inconsistent availability of abortion across the country, and contributes to the 'postcode lottery' that women experience. There is a clear need for abortion laws across Australia to be harmonised, that the Federal Government should continue to drive.

Recommendation:

8. The Federal Health Minister progresses work with state and territory Health Ministers to develop consistent abortion laws across the nation.

cohealth would welcome the opportunity to discuss this submission and our perspectives on universal access to reproductive health. Please contact Jane Stanley, Advocacy and Policy Advisor on jane.stanley@cohealth.org.au

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[15] https://www.wdv.org.au/our-work/our-work-with-organisations/sexual-and-reproductive-health-2/
[16] https://www.wdv.org.au/our-work/our-work-with-women/experts-in-our-health/
[17] https://www.mariestopes.org.au/advocacy-policy/abortion-access-scorecard-australia/