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ALLIANCE AUSTRALIA

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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100,
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12 December 2022

To Whom It May Concern,

RE: FPAA submission to Senate Standing Committees on Community Affairs in response to inquiry on universal access to reproductive healthcare

I write to you on behalf of Family Planning Alliance Australia (FPAA), the nation's peak body for reproductive and sexual health services. The primary members of FPAA are not-for-profit Family Planning Organisations (FPO) from each State and Territory of Australia, including:

- Sexual Health Quarters (WA)
- Sexual Health Victoria
- True Relationships & Reproductive Health (QLD)
- Sexual Health and Family Planning ACT
- SHINE SA
- Family Planning NSW
- Family Planning Welfare NT
- Family Planning Tasmania

We appreciate the opportunity to provide a submission in response to the inquiry on universal access to reproductive healthcare. The attached submission is written by the FPAA in response to the Committee Terms of Reference. We consent to this submission being published on the inquiry website and shared publicly online.

If you have any questions about this submission, please contact me at Debra.Barnes@shq.org.au or 08 9227 6177. Thank you for your consideration of our submission.

Sincerely,

Debra Barnes
Chairperson, Family Planning Alliance Australia
CEO, Sexual Health Quarters

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Submission to the Senate Standing Committees on Community Affairs in response to the inquiry on universal access to reproductive healthcare.

Statement on universal access to reproductive healthcare

> *By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. – UN Sustainable Development Goal 3.7.*

Bodily autonomy is a basic human right. FPAA regard universal access to reproductive healthcare as fundamental to bodily autonomy; enabling all people to make reproductive choices and decisions without geographical, social, cultural, legal, religious, economic or political barriers. Enabling universal access to reproductive healthcare has the profound capacity to improve:

- Community health and well-being
- Community cultures of inclusion and safety
- Workforce participation, economic output and strengthened economy

Prioritisation of universal access to reproductive healthcare, including contraception and abortion, is particularly pertinent during the current economic climate, and with communities continuing to experience the health, social and economic impacts of the COVID-19 pandemic and associated restrictions[1-4].

Universal access requires the Federal and State governments' commitment to recognise:

- Contraception and abortion as essential health care for all.
- Contraception and abortion as essential preventive health measures and services that must be appropriately funded.
- The intersecting structural barriers to safe, inclusive reproductive healthcare that are underpinned by pervasive gender inequity. Some of the key systemic barriers relate to geographic location[5-8]; country of origin, citizenship, length of residency or visa[9-11]; gender, sex characteristics or sexual identity[12]; ability/disability; occupation; socioeconomic status[8]; and English and health literacy.

Federal government policy and funding actions to meet the goal of universal access need to be fundamentally guided by reproductive justice so that women and people with a uterus have: (1) the right to have a child; (2) the right to not have a child; and (3) the right to parent a child/children in a safe and healthy environment. This means that throughout a person's lifespan, they are empowered to make decisions about their body, sexuality, sexual health and reproduction without socio-cultural, economic, legal or political barriers. This includes a person's unimpeded access, if and when needed, to safe and inclusive:

- Health education and comprehensive relationships and sexuality education
- Period products, information and support; including early management of period pain and diagnosis and management of endometriosis
- Gender affirming care
- Contraception
- Abortion care and support
- Pre-natal, peri-natal and post-natal care and support
- Infertility and miscarriage care and support
- Menopause care and support
- Health, educational, work and community environments that accommodate, without bias, needs associated with the above.

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FPAA recommendations

Universal access to reproductive healthcare is essential. The FPAA support this important Inquiry with a series of recommendations that are summarised below and discussed in further detail throughout this submission.

1. **Establish a national taskforce** to develop and monitor a comprehensive plan to deliver the National Women's Health Strategy's commitment to universal access to sexual and reproductive health care. This national taskforce must include representation from all States and Territories, and consultation with service providers and people with lived experience across metropolitan, regional, rural and remote locations. This taskforce should be inclusive of Aboriginal and Torres Strait Islander people, people with disability, migrant and refugee communities and gender and sexually diverse people. A comprehensive plan with specific and achievable targets is essential for progress, accountability and visibility that instills confidence among the community and health workforce.

2. **Ensure *affordability* of reproductive health services, including abortion and contraception:**
   - Contraception (including long acting reversible contraceptives; LARC) free of cost to all people under the age of 25.
   - Abortion services free of cost to all individuals.
   - Comprehensive review of Medicare items and rebates, and PBS coverage for contraception.

3. **Ensure *availability* of essential reproductive services**
   - Appropriate remuneration and reimbursement for GPs providing LARC and medical abortion care.
   - Appropriate remuneration and reimbursement for nurse-led contraceptive and medical abortion care.
   - Amendment to the medical abortion Risk Management Plan and regulatory reforms for medical abortion medications that will improve abortion access and equity.
   - Streamlining TGA approval processes to enable a broader choice of contraceptive options.
   - Greater inclusion of reproductive healthcare in pre-service medical education.
   - Strong investment in reproductive health training for the current health workforce.
   - A focus on workplace retention strategies; particularly in regional and remote locations.

4. **Ensure *safety and equity of access* to reproductive services**
   - Harmonisation of abortion laws across Australia.
   - Medicare funding for telehealth delivery of medical abortion.
   - Funding for fly-in fly-out abortion and LARC services for regional and remote communities.
   - Review of Medicare rebates and item numbers for transgender and gender diverse people.
   - Further funding for comprehensive sexuality education in-schools and community settings to improve sexual health literacy.
   - Further funding for clinical guidelines and professional development opportunities in providing safe, inclusive and culturally appropriate reproductive healthcare.
   - Comprehensive review and public consultation on the introduction of reproductive health leave.

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FPAA response to Senate inquiry Terms of Reference (ToR)

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;**

Barriers

- TGA processes are lengthy and expensive. This significantly delays community access to new contraceptive options. For example, the 12-month vaginal ring and desogestral mini pill are readily available in parts of Europe Asia and US. The desogestrel mini pill has low-cost generic versions that are available world-wide. However, it is not accessible within Australia.
- Australia has a low uptake of LARCs compared to other countries[13-15]. The cost of LARCs are prohibitive for many people[8], particularly those without Medicare access. Lower cost versions of Mirena IUD are available in other countries, but not within Australia. In addition, Mirena IUDs are licensed for 5 years in Australia, compared to 8 years in the US[16], creating increased cost for Australian consumers.
- Health providers are not adequately remunerated and reimbursed for LARC procedures and are out of pocket when providing bulk-billed services. This is not sustainable.
- Nurses, midwives and nurse practitioners are not funded by Medicare to provide and/or support contraceptive services despite having capacity to do so.

Enablers

- Enable a more comprehensive and affordable **choice** of effective contraceptive options in Australia by:
  - Streamlining TGA approval processes for new contraceptives.
  - Increasing PBS coverage to include the new progestogen-only pill with 24-hour window and copper IUD (including copper IUD use as emergency contraception).
- Enable community **access** to safe and reliable contraceptive options by:
  - Providing contraception (incl. LARC procedures) free of cost to all people under the age of 25.
  - Increasing Medicare rebates for LARC procedures and equipment across the board.
  - Approving Medicare funding for nurse-led services and support.
  - Approving lower-cost generic versions of Levonorgestrel-releasing IUDs.
  - Enabling pharmacists to prescribe oral contraceptives within a framework supported by doctors and nurse practitioners.
- Draw on evidence regarding safety and efficacy of extended scripts of the oral contraceptive pill for people without contraindications; and educate practitioners that people without contraindications can be prescribed the oral contraceptive pill or vaginal ring without need to review for 12 months.
- Invest more resources into LARC accessibility rather than emergency contraceptive pills. LARC has a much higher efficacy rate in preventing pregnancy at a community level than emergency contraception.

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

Access to termination of pregnancy should be on the basis of health care need and should not be limited by age, socioeconomic disadvantage, or geographic isolation[17].

The inequities in reproductive healthcare access, particularly in regional, rural and remote areas, are well recognised. Access to abortion services, in particular, is described by medical professionals as "A huge lottery" and reliant on local champions. In Australia, around one quarter of all pregnancies are unplanned, and one-third of these pregnancies end in abortion.[18] Unplanned pregnancy occurs more frequently in non-urban areas[19], yet access to abortion services in regional, rural and remote Australia is disproportionately limited by fewer abortion providers and longer distances required to access services[20].

Unintended pregnancies are correlated with a range of negative physical and mental health, economic and social outcomes[21]. When an abortion is sought but denied, individuals are more likely to experience ill health, psychological stress, poverty and negative impacts on development of existing children[22].

Abortion is a time-critical procedure that increases in complexity and risk with gestation[23]. Despite this, abortion access in Australia is limited and inequitable, with many individuals facing significant and intersecting financial, social, geographical and health provider hurdles to access necessary information, support and medical care[24]. Addressing these barriers to abortion care is critical in enabling universal access.

Barriers

- Legal: people around Australia are currently unable to access the same abortion care, rights, or education due to State-based legislative variations that determine the settings and circumstances by which abortion can be performed, and the information that is required to be recorded. These legislative variations are inequitable and confusing, making access to abortion services more difficult and daunting.
- Medical:
  - An ultrasound prior to medical abortion is mandated by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and recommended in TGA-approved MS 2-Step abortion medication product information[25]. This requirement was removed during the COVID pandemic and is not an essential prerequisite in many international guidelines[25]. Ultrasound requirements can delay or prohibit access to a medical abortion due to out-of-pocket costs or difficulties accessing a service, particularly in regional and remote locations.
  - In Australia, a gestational limit of 63 days is applied to use of MS 2-Step, despite its known safety and efficacy of up to 70 days gestation, and approval for use up to 70 days gestation in the US and UK[25].
- Workforce:
  - Low number of abortion providers in Australian primary care and hospital settings; and disproportionately low numbers in regional, rural and remote locations.
  - Low proportion of pharmacists dispensing abortion medication.
  - Very limited inclusion of abortion in undergraduate and postgraduate medical training; resulting in a large proportion of doctors not being competent or confident in providing abortion care[24].
  - Existing models of nurse and midwife led care do not include authority to provide abortion medication.
  - Absence of reliable and accurate national abortion data; limiting workforce planning.
  - Professional stigma and conscientious objection: an Australian study estimated 15% of health professionals conscientiously object to abortion[26] and therefore do not offer it to patients.

- Financial: limited availability of publicly funded abortion services, particularly in regional and remote locations, and significant out-of-pocket costs for private care[24].
- Geographical: lack of abortion services within reasonable geographical proximity necessitates longer-distance travel and can delay or prohibit abortion access.
- Service accessibility: limited supports available to facilitate abortion access for those with additional needs, e.g., relating to low English literacy, restricted mobility or young age.
- Religious barriers: reluctance of faith-based hospitals to provide abortions unless medically indicated.
- Social barriers: stigma and prejudice associated with abortion that can inhibit individuals from seeking care; and deter health professionals from seeking training to provide abortions[24].

Enablers

Access to abortion can be facilitated through the following actions:

- Legal: harmonisation of abortion laws across Australia to create service and access consistency and transparency for healthcare providers and consumers of reproductive health care. We applaud recent discussions between State/Territory Ministers for Women regarding a national approach to abortion law.
- Medical: amending risk management plans and regulatory reforms for medical abortion medications to improve access to abortion services. This includes:
  - TGA approval to extend MS-2 Step use from 63 to 70 days gestation, in line with international practice[25].
  - Review of RANZCOG requirements for ultrasound prior to medical abortions, such that people experiencing significant barriers can proceed without ultrasound unless clinically indicated[25].
- Workforce: refer to item C below.
- Financial: free-of-cost abortion services for all individuals, including those without Medicare access, via primary care and public hospitals. Pregnancy miscarriage care is free of cost via public hospitals; abortion care needs to be the same.
- Faith-based hospitals that receive public funding must be expected to provide a full suite of sexual and reproductive services, including abortion.
- Geographical:
  - Medicare-funded telehealth delivery of medical abortion services.
  - Fly-in fly-out services for regional and remote communities.
- Service awareness and accessibility:
  - Funding abortion information and support services, such as 1800 My Options in Victoria and the Pregnancy Choices helpline and website in NSW, Australia-wide.
  - A 24-hour government funded national help line for those undergoing medical abortion.
  - Progressing with plans to remove requirements for pharmacists to undertake additional training and registration to dispense MS-2 Step.

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;

Barriers

The workforce-related barriers to timely, inclusive and high-quality reproductive care are described in the sections above. Reproductive health services are well-recognised to be under-resourced and fragmented, particularly in regional, rural and remote Australia. This under-resourcing perpetuates access inequities, increases risks to patient safety, and feeds back into the exhaustion experienced by health professionals.

Enablers

Critical services including abortion and contraceptive care can be safely provided by a range of health care practitioners. However, significant investment is needed in capacity building for both pre-service and active health professionals. We propose the following recommendations for building and retaining a strong multidisciplinary reproductive healthcare workforce:

- Increasing the scope of practice for nurse practitioners, nurses and midwives; and recognising this through Medicare funding. This will require standardised, evidence- and competency-based reproductive health training across all pre-registration nursing and midwifery courses, equipping nurses to support and provide reproductive health services including abortion and contraception.
- Investment in pre-service medical education through greater inclusion of reproductive health in undergraduate degrees and postgraduate training programs, including medicine, general practice, nursing, midwifery, obstetrics and gynaecology. Education providers may benefit from partnering with community-based providers of reproductive health care in addition to hospitals.
- Investment in clinical guidelines and medical publications that normalise abortion as health care and reduce abortion stigma. Abortion continues to be framed in medical education as an ethical issue.
- Investment in subsidised education pathways accredited by reproductive health peak bodies to upskill the current health workforce.
- RACGP development of a GP sub-specialty in sexual and reproductive health that recognises specialist skills developed by doctors undertaking the FPAA Sexual and Reproductive Health Certificate.
- Greater collaboration between hospital gynaecology departments and FPAA agencies to minimise wait times for critical services.
- Financial incentive for primary care practitioners to provide LARC services, to address long wait times in some areas for services such as IUD or Implanon insertions. Current Medicare rebates do not sufficiently cover the costs associated with LARC services and equipment, and some health service providers are out of pocket when providing bulk-billed services for clients in need.
- Greater financial incentive, training opportunities and workplace flexibility options to address challenges of healthcare recruitment and retention in regional, rural and remote locations.
- Establish specific Medicare numbers for abortion care, to enable accurate tracking of services provided, and workforce planning.

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

Barriers

Best practice models address the systemic barriers to healthcare access. Barriers include the prohibitive costs of healthcare, restrictions on access to Medicare, lack of services provided in languages other than English, and lack of culturally safe and appropriate services.

Enablers

A best practice approach to reproductive healthcare is culturally responsive, inclusive, safe and accessible for at-risk and marginalised communities. This includes:

- Medicare access for all individuals.
- Using a critical intersectional lens to identify and address barriers to reproductive healthcare access. The following questions need to be asked: Are people able to navigate and access our health care systems? Do they feel safe accessing services? Are they informed and empowered to make choices for their health without coercion, judgement or shame?

- Bringing culturally appropriate reproductive health care into mainstream programs by collaborating with migrant and refugee women's organisations to develop best practice guidelines for culturally responsive service delivery. This must include cohesive models of collaboration between primary and secondary care to facilitate a safe, supported care pathways.
- Sustainable funding for refugee and migrant women's reproductive health programs, in recognition that 51.5% of Australia's population have migrated or sought refuge from another country.
- Ongoing investment to support and develop a professionally recognised and appropriately remunerated bilingual, bicultural health workforce to meet the needs of our multicultural Australian population.
- Further engagement with Aboriginal and Torres Strait Islander communities to establish sustainable culturally appropriate and safe healthcare models that facilitate access.
- Prioritisation of workforce retention initiatives, particularly in regional and remote locations, to enable longer-term therapeutic relationships to be established between healthcare providers and Aboriginal and Torres Strait Islander communities.
- Inclusion of cultural sensitivity training in undergraduate, postgraduate and current workforce education programs; to actively address pervasive stigma and shame associated with reproductive health services.

e. sexual and reproductive health literacy;

Sexual and reproductive health literacy begins in early childhood and continues throughout the lifespan. Comprehensive sexuality education (CSE) provided through schools, community and families offers a foundation from which young people develop sexual and reproductive health literacy.

Barriers

The Australian Curriculum includes components of CSE; however, these guidelines are ambiguous, open to interpretation and omit key topics. Australian research shows that young people perceive school based CSE as valuable; however the inclusion, quality and relevance of CSE teaching is inconsistent. This may be attributed in part to lack of specific CSE guidelines within Curriculum. Other contributing factors include teacher skills and confidence to teach CSE, absence of school policies and a non-supportive school culture.

Enablers

FPAA advocate for the inclusion of CSE within the Australian Curriculum and community-based educational programs, based on the following principles[27]:

- Explicit and specific inclusion of CSE across the Australian Curriculum from F-12 supports young people to develop the life-long knowledge, skills and attitudes needed to experience positive, respectful and healthy relationships and optimal reproductive health.
- CSE should be accessible to all young people irrespective of their age, ability, socio-cultural context and/or engagement with mainstream schooling; including young people with disability, and those disengaged from mainstream schooling. Parallel community based CSE programs are vital, to ensure young people outside of mainstream schooling are afforded the same opportunities for learning and support.
- High quality professional development programs for school leaders, teachers, health and welfare professionals are critical, to ensure they are equipped with the knowledge, skills and confidence to provide CSE in accurate, responsive and supportive ways both in and out of the classroom.
- CSE training should be included in all pre-service teacher tertiary education.
- Government funding is essential to enable effective integration, implementation and evaluation of CSE within schools and the broader community.

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

The inclusion, safety and protection of human rights of people with disability is fundamental to any strategies designed to enable universal access to reproductive healthcare.

> *YWGwD [young women, girls, feminine identifying and non-binary people with disability] across Australia and the world face severe barriers to fulfilling their sexual and reproductive health and rights (SRHR).[11] SRHR encompass the ability to make free and informed choices about ones' own body, sexual and reproductive health, intimate relationships, and parenting.[12] This includes the right to sexual pleasure, expression of sexual identity, association, equity, privacy, freedom, autonomy and self determination* - Women With Disabilities Australia, 2022, p.15[28].

Barriers

People with disability experience severely restricted access to safe, inclusive, accessible reproductive health care due to numerous systemic barriers including:

- Medical ableism and dominance of the medical model that positions disability as a deficit that need to be fixed, and a justification for restriction or denial of human rights[28]. Women with Disabilities in Australia's recently released report revealed that most young women and girls do not make their own decisions about menstruation and contraception. Parents, guardians and doctors are making these decisions on behalf of women with disability, with no strategies in place to improve their understanding of their reproductive choices and rights[28].
- Insufficient reproductive health information, resources and services that meet the needs of people with disability and enable them to make informed choices about their health and wellbeing.
- Lack of health professional skills in providing safe, inclusive care for people with disability, including communicating with people with cognitive and intellectual disability.
- Difficulties associated with having a carer or family member assist with help seeking, making decisions, and/or having assessments or procedures that are sensitive in nature.
- Prohibitive out of pocket costs for reproductive health services.

Enablers

- Investment in disability-inclusive reproductive health education in undergraduate and postgraduate training, including medicine, general practice, nursing, midwifery, obstetrics and gynaecology.
- Investment in clinical guidelines and professional development on safe, inclusive care for people with disability, including legal aspects of care, human rights approaches and supported decision making.
- Development of a national strategy in consultation with people with disability to improve access to safe, inclusive and comprehensive reproductive healthcare and information.

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

Transgender and gender diverse (TGD) people report great difficulty accessing safe, supportive, quality care from clinicians, and long wait times for gender affirming hormone therapy. In the *Australian Trans and Gender Diverse Sexual Health Survey,* 56% of participants described their access to medical gender affirming care as 'OK', 'poor' or 'non-existent'[29].

Barriers

- Stigma and prejudice within medical professions. In the Australian *TRANScending Discrimination in Health and Cancer Care* survey, 69% of TGD respondents had not sought medical care due to inability to find a doctor they are comfortable with; and 1 in 5 had been refused general healthcare[30].
- Lack of professional training in TGD reproductive healthcare. Australia is experiencing an exponential demand for TGD healthcare across primary and specialty services, and capacity building is urgently needed[29-32].
- Prohibitive costs of reproductive care, including hormonal and surgical gender affirming care, fertility preservation, contraception and abortion.

Enablers

- Inclusion of gender-neutral Medicare item numbers to increase access to reproductive health services.
- Publicly funded reproductive health services, including contraception, abortion and gender affirmation.
- Appropriate use of gender language in government and medical policy and resources.
- Inclusion of gender diversity in all levels of health care education, enabling healthcare providers to develop competency and confidence to provide safe, inclusive and unbiased care.
- Investment in gender-inclusive clinical guidelines and resources for health professionals that normalise gender diversity and provide guidance on inclusive care.

h. availability of reproductive health leave for employees

It is increasingly recognised that women and people with uteruses wear disproportionate costs of reproduction. Reproductive health-related needs, in most circumstances, do not reflect illness that justifies use of allocated personal leave. Menstruation, contraceptive care, fertility care, pregnancy, miscarriage, abortion and post-natal care are a part of daily living for many women and people with a uterus and are highly valuable for our community. However, the burden of reproduction and its impact on workforce participation is largely unrecognised in health and workplace policies. Lack of access to paid leave for reproductive health increases the already high cost of care.

FPAA supports the view that reproductive health leave has the capacity to improve women's well-being and address barriers to workforce participation. We recommend that the federal government:

- Evaluate existing reproductive health leave policies and invest in research to explore the feasibility and impact of reproductive health leave on women's and people with uterus's engagement in the workforce
- Undertake a public consultation on reproductive health leave to establish community interest and support.

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