Equitable access to abortion care is still not a reality in Australia

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The 2023 Senate inquiry into universal access to reproductive health care identified major structural barriers to abortion care in Australia.[1] However, in the absence of a national abortion registry, it is unclear whether access is equitable and what factors influence the provision of abortion care. In two articles published in this issue of the *MJA*, researchers report large population-based studies that investigated these questions in Victoria.

Marzan and colleagues[2] undertook a retrospective population-based analysis of Victorian Admitted Episodes Dataset data for hospital admissions for abortion during 2012–22 and Pharmaceutical Benefits Scheme (PBS) data for mifepristone–misoprostol (MS-2 Step) dispensing for outpatient early medical abortion during 2015–22. The authors specifically examined changes in the numbers of abortions prior to and during the coronavirus disease 2019 (COVID-19) pandemic. Their main findings were that the numbers of abortions undertaken in metropolitan and private hospitals dropped significantly during the pandemic (but not of those in public hospitals), but these declines were offset by the rise in the number of outpatient early medical abortions.[2] Their finding indicates that early medical abortion was an essential alternative to hospital-based abortion care, ensuring access during the COVID-19 pandemic. This is consistent with reported changes in the use of the 1800MyOptions service, a phone information service for sexual and reproductive health in Victoria, that indicated increased demand for pregnancy counselling and an increase in referrals for telehealth consultations regarding early medical abortions during the pandemic.[3]

Edvardsson and colleagues investigated factors associated with a history of induced abortion among women who gave birth in Victoria during 2010–2019, based on data in the Victorian Perinatal Data Collection.[4] They found that women living in regional and remote areas were less likely than those residing in major cities to have previously had abortions. However, the proportion who reported previous abortions increased across the study period among women living in non-urban areas and declined in metropolitan areas.[4] This difference makes it clear that abortion access is still not equitable across geographic regions. The use of long acting reversible contraception (LARC) may help explain the decline in reports of abortion among women in urban Victoria, as LARC can result in longer, safer inter-pregnancy intervals, fewer unintended pregnancies, and fewer repeat abortions.[5] However, the number of health professionals familiar with, and able to provide, LARC can be quite low outside major cities, perhaps contributing to higher rates of unintended pregnancies in regional than urban areas,[6] as well as the increase in the number of women reporting prior abortions in non-urban areas described by Edvardsson and colleagues.[4]

Support from peak bodies and the government for providing equitable access to early medical abortion has increased. In July 2023, Marie Stopes Health Australia successfully persuaded the Therapeutic Goods Administration (TGA) to deregulate the prescribing and dispensing of MS-2 Step.[7] It could previously be prescribed only by certified medical practitioners and dispensed by specifically registered pharmacists. Since 1 August 2023, MS-2 Step can be prescribed by any general practitioner or appropriately qualified health care practitioner, and dispensed by any pharmacist.[7] Further, the continued availability until June 2024 of Medicare telehealth items for sexual and reproductive health services[8] means that all early medical abortion providers can deliver this service at reduced cost to eligible women, regardless of where they reside. Early medical abortion can be unaffordable for some women, but the Australian Capital Territory government will spend more than $4 million over four years to provide all residents access to free abortion services, including for women without Medicare cards.[9] Finally, the Royal College of Australian and New Zealand Obstetricians and Gynaecologists (RANZCOG) recently published evidence-based clinical guidelines for abortion care[10] that support early medical abortion (until ten weeks' gestation) without anti-D administration, and abortion to fourteen weeks' gestation without ultrasound examination, eliminating requirements that had previously delayed timely access to abortion.

Despite these significant strides in improving access to an essential service, more is needed. New clinical guidelines support medical abortions at up to 24 weeks' pregnancy,[11] but women cannot circumvent state laws that stipulate different gestational limits and provider restrictions, nor, importantly, limited hospital support. As Marzan and colleagues report, the number of public hospital-based medical abortions did not change during the COVID-19 pandemic, while that of outpatient early medical abortions increased.[2] Many publicly funded hospitals offering maternity care do not provide abortion services, or have no clear referral pathways for timely abortion care.[1] The recent announcement by the Victorian Minister for Health that three more public hospitals will now provide surgical abortions[12] is therefore a welcome response to inequitable access to abortion services and supporting women who prefer surgical abortions. However, more work is needed to determine how hospitals may better support primary care in the areas they serve, including clear referral pathways that facilitate timely specialist assessment and management for women at high risk of complications.[13] Further, given the deregulation of MS-2 Step prescribing and dispensing, task-sharing and primary care nurse-led delivery of early medical abortion and LARC[14] might increase access to these services for women living in abortion deserts.[15]

Improving the health literacy of women, particularly those from culturally marginalised groups, is germane to reducing inequities in access to early medical abortion in Australia. As Edvardsson and colleagues report, women from North Africa, the Middle East, and South-East Asia are less likely to report past abortions than women born in Australia.[4] These differences

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might be explained by underuse of sexual and reproductive health services because of unfamiliarity with the Australian health system, poor health literacy, lack of knowledge about telehealth medical abortion care, financial constraints, language barriers, and confidentiality concerns.[16] Providing sexual and reproductive health care can be complicated by sensitivity about the topic in some cultures, particularly when coupled with inadequate cultural safety in Australian health care.[16] Training general practitioners in cultural competence when providing early medical abortion and ensuring access to multilingual resources and interpreters could improve understanding of abortion care among marginalised women in Australia.[16] Finally, increasing financial support for sexual and reproductive health care workers serving culturally and socially marginalised women could also make abortion more accessible.[1]

Marzan, Edvardsson, and their colleagues[2,4] have described improvements in accessibility to abortion services through primary care and telehealth, but much remains to be done to achieve equitable access for all Australian women. A national abortion registry would support research into the use of abortion services by geographically isolated and ethnically diverse groups of women. Were all the recommendations of the recent Senate Inquiry adopted, equitable access to abortion could finally become a reality in Australia.

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