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MEDIA RELEASE

EARLY MEDICAL ABORTION: TELEHEALTH RESTRICTIONS DISCRIMINATORY

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TELEHEALTH offers an opportunity to address limited access to early medical abortion during COVID-19 and beyond, according the authors of a Perspective published online today by the *Medical Journal of Australia*.

“Access to early medical abortion (EMA), using mifepristone followed by misoprostol to end an early pregnancy, remains a challenge in Australia, especially for women from vulnerable groups and those living in rural and regional areas,” wrote Professor Danielle Mazza, Head of the Department of General Practice at Monash University, and colleagues.

“Low numbers of general practitioner providers, lack of peer networks to support the establishment and ongoing provision of EMA services, and stigma are real barriers as is a broader lack of knowledge regarding medical abortion among health professionals.

“Many women are also unaware of the availability of EMA and the current gestational limit of 63 days. They also face difficulties navigating the health system to find an EMA provider, particularly when they encounter conscientious objections.

“Women can also face other barriers such as needing to travel to access services, take time off work or find childcare, and many need to source financial support to meet the costs.”

Delivering EMA through telehealth has already been proven to be safe, effective and acceptable to women – “not only does the telehealth delivery of EMA reduce the need for patients to travel but it also increases the capacity of existing providers to deliver services to women from a larger geographical area” – but the current COVID-19 pandemic has highlighted existing barriers to accessing EMA services in Australia.

“During the pandemic, there has been an increase in the demand for abortion because of a rise in unplanned pregnancies,” Mazza and colleagues wrote.

“Increases in domestic violence, financial insecurity and delays in accessing abortion services, due to travel restrictions or other pandemic-related stressors, means that women are often presenting for an abortion at a later gestational age.”

The availability of Medicare Benefits Schedule (MBS) telehealth item numbers, introduced as part of the government’s response to the pandemic, has meant that, for the first time, telehealth EMA can be delivered through Medicare to eligible patients. However, since 20 July 2020, the government has imposed restrictions on the temporary MBS items for telehealth GP consultations – “namely restricting eligibility to only those who have visited the GP or practice in the previous 12 months or those who have been referred by a specialist except for where there is a current lockdown in place”.

“Placing restrictions on the eligibility criteria for MBS-subsidised telehealth services severely affects women’s access to GPs who can provide EMA, and discriminates against women who have not recently engaged with a GP due to various forms of disadvantage, such as family violence and unemployment,” Mazza and colleagues wrote.

“Exemptions to the restrictions have already been identified for people who are homeless and for children aged less than 12 months. Therefore, a further exemption should also be issued so that registered prescribers of medical abortion are able to use MBS telehealth item numbers for the benefit of Australian women.”

Mazza and colleagues also suggested other measures which would optimise the ability of telehealth to improve access to EMA for all Australian women:

- a national hotline or online platform, similar to the 1800 My Options service (www.1800myoptions.org.au) in Victoria, which directs women to local abortion service providers, is required to assist women to identify an appropriate provider;
- changes are required to current Therapeutic Goods Administration and Pharmaceutical Benefits Scheme provisions restricting the prescription of MS-2 Step (mifepristone and misoprostol) to up to 63 days’ gestation – these criteria are outdated and discordant with current evidence demonstrating that EMA up to 70 days’ gestation is comparable in safety and efficacy to 63 days’ gestation or less;
- modifications are required to EMA protocols, particularly during the COVID-19 pandemic – the Royal Australian and New Zealand College of Obstetricians and Gynaecologists has already advised that a clinician may appropriately decide not to administer anti-D IgG before 10 weeks for the medical management of abortion, particularly when an additional visit may increase exposure of women and staff to COVID-19;
- in situations where obtaining an ultrasound is a significant barrier or poses a significant risk during the COVID-19 pandemic, EMA may proceed without the necessity of ultrasound assessment but only after careful screening for risk factors for ectopic pregnancy and where an accurate gestational age can be estimated from the woman’s history;
- in South Australia mifepristone can only be supplied in a hospital setting – this precludes South Australian women from being able to access EMA through community-based providers such as GPs or via telehealth; the relevant South Australian legislation therefore requires a change.

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