Telehealth: an opportunity to increase access to early medical abortion for Australian women

Telehealth offers an opportunity to address limited access to early medical abortion during COVID-19 and beyond

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.[1] 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.[2,3] Many women are also unaware of the availability of EMA and the current gestational limit of 63 days.[4] They also face difficulties navigating the health system to find an EMA provider, particularly when they encounter conscientious objections.[4,5] 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.[5]

The current coronavirus disease 2019 (COVID-19) pandemic has further 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 and domestic violence.[6] 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.[6] In addition, flight restrictions may have curtailed the ability of clinicians to travel to rural areas to provide surgical abortion services.

Delivering EMA through telehealth has been shown to be safe, effective and acceptable to women, both internationally and in Australia.[7–9] Originally championed by Women on Web (www.womenonweb.org), telehealth delivery of EMA was used to provide abortions clandestinely in countries where they were illegal, such as in Ireland prior to decriminalisation.[10] It has now, however, been implemented in many countries worldwide, irrespective of whether restrictive or non-restrictive abortion laws exist, to provide abortion care to women and improve access to women geographically isolated from EMA services.[9]

Using telehealth to deliver EMA offers an opportunity to address many of the barriers to EMA provision in Australia. It removes the necessity for proximity between the provider and patient, an issue of particular importance for women living in rural and regional areas where there are fewer abortion providers.[5,7] The need to travel to appointments far from home, especially when more than one appointment might be required, can result in women moving past the 9-week gestational limit and preclude them from being able to undergo an EMA.[5,7] 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.[5,8]

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.[11] With these item numbers in place, all EMA providers are able to use telehealth to deliver this service at a potentially reduced cost to women. Before COVID-19, telehealth item numbers had very restrictive criteria and could only be billed if the patient lived in a very rural area (Modified Monash Model 6 or 7 location), had an existing clinical relationship with a GP telehealth provider (defined as three face-to-face consultations in the previous 12 months) and lived at least 15 km by road from the GP.[12] These restrictions unfairly excluded many women in metropolitan or regional areas, particularly young women (who comprise the largest demographic using abortion services), as this demographic does not necessarily attend GPs on a regular basis. It is imperative therefore that MBS-funded telehealth remains implementable by all GPs so that women are not disadvantaged, and that telehealth abortion can remain accessible via Medicare.

Recent restrictions to the temporary MBS item numbers for telehealth GP consultations, which came into effect on 20 July 2020 — 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[13] — will greatly reduce women's access to EMA. 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

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various forms of disadvantage, such as family violence and unemployment. 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.

In addition, other measures are required to optimise the ability of telehealth to improve access to EMA for all Australian women. Firstly, 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.

Secondly, as outlined in a consensus statement on EMA developed by a coalition of key stakeholders (ie, the National Health and Medical Research Council's Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care [SPHERE]) and clinician experts,[14] changes are required to current Therapeutic Goods Administration (TGA) and Pharmaceutical Benefits Scheme (PBS) provisions restricting the prescription of MS-2 Step (mifepristone and misoprostol) to up to 63 days' gestation.[15] 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.[16] Guidance from the United States, Canada and the United Kingdom all concur.[17–19] Increasing gestational limits for prescribing EMA will not only align Australia with international guidance but will also provide a greater window of opportunity for women to access this service. However, this change requires an application to be made to the TGA, and if TGA approval of the extended indication is successful, a subsequent application to the Pharmaceutical Benefits Advisory Committee for subsidy of the extended indication would be required. This is a costly and time-consuming exercise.

Thirdly, modifications are required to EMA protocols, particularly during the COVID-19 pandemic. Internationally, "no-touch/no-test" protocols have been devised and endorsed to minimise the risk of COVID-19 transmission between patients and providers and circumvent delays created by closed health services (ie, sonography).[19,20] In the Australian context, 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.[21]

The SPHERE coalition has additionally recommended that, during the COVID-19 pandemic, while ultrasound is highly desirable for all women having a telehealth EMA, 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.[14] However, the consensus statement emphasises that women should be carefully screened for risk factors for ectopic pregnancy. This requires an assessment as to whether an accurate gestational age can be estimated from the woman's history; a discussion regarding the risks of foregoing a pre-procedure ultrasound as part of the consent process and supported by written information; and a robust follow-up pathway.[14] If the gestation is unable to be accurately identified, or there are red flags for ectopic pregnancy, then an ultrasound assessment must be arranged.[14]

Finally, abortion has been decriminalised in every state and territory in Australia except South Australia,[1] where 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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