LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING
Mr Johnathan Davis (Chair), Mr James Milligan MLA (Deputy Chair),
Mr Michael Petterson MLA

Submission Cover Sheet

Inquiry into Abortion and reproductive choice in the ACT

Submission Number: 52

Date Authorised for Publication: 15 November 2022

AUSTRALIAN MEDICAL ASSOCIATION (ACT) LIMITED
PO Box 560 CURTIN ACT 2605
P I 02 6270 5410
F I 02 6273 0455
[redacted]
W I www.ama-act.com.au

Standing Committee on Health and Community Wellbeing
ACT Legislative Assembly
London Circuit,
CANBERRA, ACT 2601

Inquiry into Abortion and Reproductive Choice in the ACT

Thank you for the bringing this inquiry to our attention. The following material may be of assistance to the Committee.

AMA Position Statements

By way of background, we refer to the following AMA Position Statements on reproductive medicine and associated matters:

Sexual and Reproductive Health

Guiding Principles

To support better sexual and reproductive health outcomes, the AMA believes that polices, programs and service delivery should be informed by the following principles:

- National policy leadership to drive strategic coordination and a commitment to improving and sustaining better sexual and reproductive health outcomes.
- A population health approach that addresses the social determinants of sexual and reproductive health.
- Recognition of the right to sexual and reproductive health that implies that people are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or unwanted pregnancy, and with the ability to regulate their fertility without adverse or dangerous consequences.
- A comprehensive approach that includes disease prevention, sexual and reproductive health promotion, and early intervention.

- A focus on healthy relationships as a central part of sexual and reproductive health, and recognition that this requires a positive and respectful approach to sexuality and sexual relationships, and confidence in negotiating boundaries and making informed choices.
- Acknowledging diversity and recognising the needs of all persons regardless of age, ethnicity, sexual orientation, gender identity, disability, geographic location, financial means, and any other status.
- A focus on reducing inequities in sexual and reproductive health outcomes, and improving access to relevant information and services for at risk or vulnerable population groups.
- Development of evidence based and accountable policies and programs that are underpinned by research, systematic data collection, and ongoing evaluation and monitoring.
- Support for the central role of medical practitioners in supporting sexual and reproductive health through the provision of non-judgmental, confidential and quality care.

Ethical Issues in Reproductive Medicine

Introduction

- Patients have the right to make their own decisions about reproduction and the use of available reproductive medicine. Access to reproductive medicine should be free from political or religious interference.
- Reproductive medicine has an evolving and expanding role in health. In addition to the more traditional clinical services known as 'family planning' – contraception, sterilisation and abortion – reproductive medicine now encompasses many other roles. These include not only female and male infertility and their diagnosis and management but increasingly the management of inherited diseases. Assisted reproductive technologies (ART) such as in vitro fertilisation (IVF) techniques are employed to provide options for carriers of genetic mutations, for fertility preservation in cancer and newer services such as egg freezing.
- A patient who seeks or has undertaken any form of reproductive medicine should not be subject to discrimination or stigmatisation.
- A patient must not be forced or coerced into undertaking (or not undertaking) any form of reproductive medicine.
- Doctors who choose to provide clinical services, or conduct research, in reproductive medicine should not be subject to discrimination or stigmatisation.
- Doctors who have conscientious objections should not be expected to participate in clinical or research activities to which they have an objection. A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection,

however, directly affects patients and the doctor has an obligation to inform the patient of their objection and minimise disruption to patient care. In an urgent situation where other care is not available (for example, complications of an abortion in a rural area), there is a clear obligation to provide and continue care for the patient until such time as other options are available. Doctors must never use a conscientious objection to intentionally impede patients' access to care.

- Clinical research into reproductive medicine should be conducted within the prevailing ethical, social, medical and legal frameworks.
- There should be uniformity and clarity of all legislation related to reproductive medicine. Doctors should be familiar with relevant State, Territory and Commonwealth legislation.

Code of Ethics

The AMA Code of Ethics generally informs the development of position statements.

Copies are also attached.

Terms of Reference

We have been provided with a copy of Dr Melanie Dorrington's submission and support her comments both generally and in regard to the terms of reference.

Accessibility of abortion and reproductive choice

While information on large local providers offering termination of pregnancy (such as Marie Stopes International) can be found on the internet, cost considerations can mitigate against use of their services. Marie Stopes charges the same fee for either medical or surgical termination of pregnancy.

In these circumstances, pregnant people may face a difficulty of easily and quickly locating general practitioners who provide medical termination of pregnancy (MTOP).

MTOP service providers in General Practice are hard to capture, and while limited information is available through Health Pathways, informal groups of GPs assist in identifying capacity within the local GP network.

Some of the issues that have been raised by AMA members include:

- Access to dispensing pharmacies.

  GPs report that, in the past, they have encouraged pharmacists to undertake the additional training needed to dispense MS2step and then maintain stock. GPs also report that it may be necessary to call around to pharmacies to determine if there is a trained pharmacist and a requisite stock is available

  Some GPs report they have worked with local pharmacies to encourage pharmacists to undertake the required training.

- Difficulty in accessing imaging has also been reported as restricting MTOP in general practice.
- Adequate after-hours care is likewise an issue although GPs report that the Marie Stopes hotline provides a good safety net, if required.

Training

A key part of improving access to abortion and reproductive choice for people in the ACT is having a sufficient number trained medical practitioners available.

GPs report that there are very significant wait lists for Long-Acting Reversible Contraception (LARC) training in Canberra. In particular, Mirena courses need more funding so GPs that are interested can undertake the training. Some GPs report that they have attend courses in Melbourne in order to access the training.

Sexual Health and Family Planning ACT (SHFPACT) is the only local trainer and has limited resources. During COVID training was also significantly impacted to the point where limited or no training was offered during 2020 and 2021.

After undertaking the training, supervised clinical placements are required and, for GPs, these would need to be sourced privately and lead to more time away from their usual place of work and more cost.

Some GPs suggested there may be options for supervised clinical placements within Canberra Health Services.

Affordability of abortion and reproductive choice

With relatively low GP bulk billing rates in the ACT, only one local provider of surgical termination of pregnancy and few GPs offering MTOP services, pregnant people often face direct and indirect cost barriers to accessing termination of pregnancy.

Low Medicare rebates, combined with the financial pressures many GPs are under make bulk-billing a very difficult option, particularly considering the multiple visits required for care and the potential for further follow up.

GPs have raised the option of support for 'gap' payments, in part or whole, rather than pushing the responsibility back on to the GP.

Thank you for bringing this matter forward.

Yours Sincerely,

[redacted]

Peter Somerville
Chief Executive Officer
AMA (ACT) Ltd