Framework for Abortion Access in NSW

October 2020

This document was prepared by
Family Planning NSW
Women's Health NSW
Chair of Sexual and Reproductive Health Special Interest Group of RANZCOG

Contents

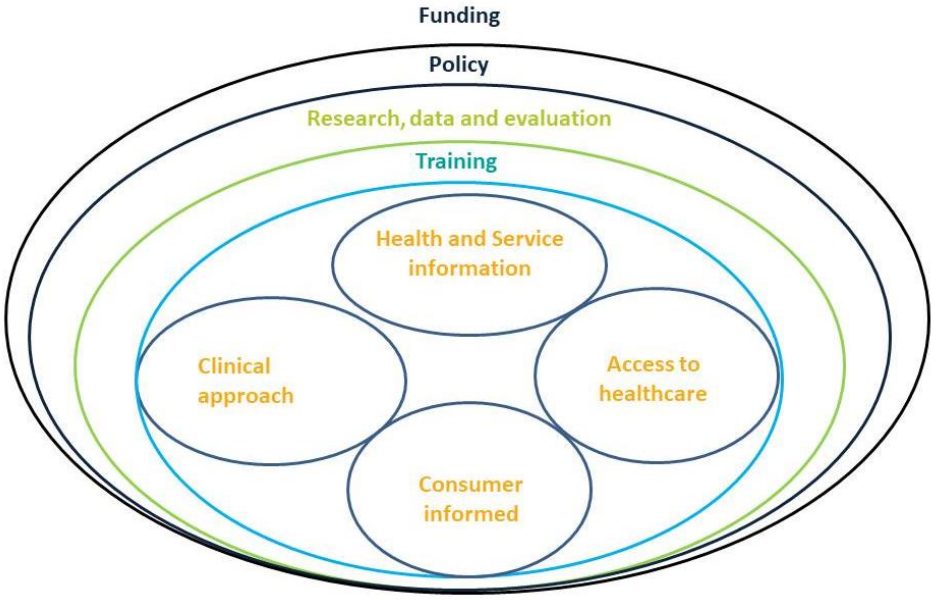
Abortion Access in NSW

In NSW, abortion was removed from the criminal code in October 2019 with the passage of the *Abortion Law Reform Act 2019*. Following decriminalisation of abortion in NSW, achieving equity of access to abortion for all women is critical. At the present time, there is a demonstrable lack of equitable access to abortion in NSW with little public health system provision. To redress this will require clarification of current service availability and clinical pathways across the state and how these could be improved. Service options must include both medical and surgical abortion and, subject to legislation, ensure the decision to have an abortion as well as the method of abortion is the woman's choice. Importantly this choice should not only be limited to women in higher socio-economic brackets or living in urban areas.

Aim and purpose

This Scoping Paper maps current healthcare services and settings where abortion services are delivered in NSW and describes a proposed model for medical and surgical abortion service delivery. The proposed model includes access to services for women who are socially, economically and geographically disadvantaged, delivered by health practitioners who have completed competency-based training.

Part 1 describes current access to abortion in NSW, including the current gaps. Part 2 proposes a model for expanding access to abortion services in NSW. Both parts cover health and service information; clinical approach; training and support; and research, data and evaluation.



Part 1 – Current abortion access and gaps

In Australia, approximately one in three women will access abortion services in their lifetime.(1) Even with access to comprehensive sexuality education and contraception, there will be a continuing need for abortion services. Experiences of unintended pregnancy, for a variety of reasons including contraception failure, are common.(2)

In 2015, a survey of Australian women aged 18 to 45 years found that one in four (26%) had experienced an unintended pregnancy in the past ten years and that 30.4% of women with an unintended pregnancy had had an abortion.(3) Another Australian survey of women and men aged 18 to 51 years found 40% had experienced an unintended pregnancy. Unintended pregnancy was associated with living in a rural area, having experienced sexual coercion, being socio-economically disadvantaged and, (for men), being born overseas.(2) The women were more likely to seek an abortion if they had experienced sexual coercion or were socio-economically disadvantaged.(4) For women, who have experienced pregnancy coercion, sexual assault and domestic and family violence, pregnancy may be unavoidable.

There is a clear link between unintended pregnancy and domestic violence.(5) In Australia women who are young, pregnant, separating from a partner, or experiencing financial hardship are more likely to be physically or sexually abused.(6) For some women pregnancy is associated with the onset of

violence from a formerly non-violent partner, for others there is a continuation or escalation of violence from already violent partners.(7) Women experiencing violence are more likely to seek termination of pregnancy to remove themselves from violent relationships and to avoid bringing children into an abusive environment.(8) Given the controlling nature of domestic violence, including the abuser's control of reproductive health and finances, women who experience forms of violence can take longer to access abortion and significantly increasing costs.(9) Later attempts to access abortion services may also result from the abuser's controlling behaviour, and delay may be further exacerbated because of the time women need to remove themselves from the relationship before being able to access help.(8)

While legislation changes in NSW enable access to abortion services, availability of services needs to be urgently addressed. Increasing access to low- and no-out-of-pocket cost services for economically disadvantaged women and for women in rural areas are the highest areas of need. Throughout this document, we refer to women, however, we acknowledge that the content is also relevant for transgender men and people who identify as non-binary.

Health and service information

Currently, information and health promotion material about pregnancy options and abortion types is available via the Family Planning NSW website, Health Direct, Women's Health Centres, Marie Stopes Australia as well as other sources.

NSW Health also provides some information for women to access abortion. The NSW Health website directs potential clients to services where they can discuss their options. Figure 1 contains the text on the NSW Health website to guide women who are considering an abortion.(10)

Where do I start and who do I speak to?

You do not need a referral to access termination of pregnancy services but it may be helpful to visit a GP to confirm how many weeks pregnant you are.

No matter how many weeks pregnant you are, you can call the NSW Pregnancy Options Helpline on **1800 131 231** to find out about termination of pregnancy service providers in NSW that meet your specific needs, as well as information on non-judgmental and unbiased pregnancy options counselling.

For more information you can:

- Talk to your local doctor
- Talk to your local Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation
- Contact the local women's health centre. Please refer to listing of Women's Health Centres across NSW.
- Talk to a Social Worker at the local hospital
- Contact the Family Planning NSW Talkline on 1300 658 886, Monday to Friday, 8:30am-5pm
- Visit the Family Planning NSW website and read helpful resources:
    - Pregnant? Working through your options
    - Pregnancy Options (for culturally and linguistically diverse)
    - Unplanned pregnancy-abortion

Figure 1: NSW Health website information to guide women who are considering an abortion

However, currently, women are not able to easily locate abortion service information themselves. A Google search does not result in a list of NSW abortion service options. Further, information about abortion costs is not publicly advertised by services in NSW. Notably, women must navigate a vast array of online information which includes a variety of sources of misinformation. For example, it can be difficult for the public to know which General Practitioners (GPs) are willing to provide medical abortion (as some are conscientious objectors) and the cost.

This could be particularly challenging for women from diverse cultural backgrounds, who may have lower levels of English language literacy. There is also a known lack of service information for rural women in NSW.(1) Coupled with stigma, a lack of information and assistance from GPs to navigate the health system results in great difficulty making contact with services.

Information available online requires internet access and for some women there is limited or no online access because of connectivity/ affordability issues. Further, information provided requires a reasonable level of literacy.

Access to age-appropriate comprehensive sexuality education, both in schools and in communities, would assist in both decision making about practising safe sex to avoid unplanned pregnancy and to assist in understanding pregnancy options.

Clinical approach

There are two types of abortion available in Australia: medical and surgical. These are briefly described below and are summarised in Table 1.

Medical abortion
Early medical abortion in NSW and across Australia can be provided up to 63 days (9 weeks) gestation by registered medical practitioners, including GPs, who have undertaken mandatory online training and by certified gynaecologists or other specialists. The woman usually has an ultrasound before having a medical abortion to confirm the gestation of an intrauterine pregnancy and a baseline blood test. An early medical abortion requires two steps: first, the mifepristone tablet is taken, followed by misoprostol tablets taken 36-48 hours later. After taking these tablets, the woman will experience a process similar to a miscarriage. Clinical staff will discuss what to expect during the medical abortion and provide a 24-hour advice number for support. The management of serious complications such as haemorrhage and severe infection, while rare, requires access to 24-hour emergency care. Continuing pregnancy or retained products of conception may require surgical intervention in a hospital, day procedure unit or clinic.

Surgical abortion
Surgical abortion in NSW is carried out in a clinic by trained registered medical practitioners, including GPs and some primary care providers and obstetricians and gynaecologists. Before the abortion, the woman will usually have an ultrasound to confirm the gestation of the pregnancy. Most surgical abortions are performed under sedation or a light anaesthetic. The woman will need to be at the clinic for about four hours, although the procedure itself takes about 15 minutes. It is generally a low-risk procedure when done under 13 weeks of pregnancy.

After the first trimester, the abortion procedure becomes more complex. There is a need for preparation of the cervix and from 16 weeks the abortion procedure can involve medical appointments over two consecutive days. Surgical abortions up to 22 weeks do not need to occur in a full hospital theatre - they can also occur in a day procedure unit.

Later abortions, over 22 weeks gestation, are mostly performed for serious medical reasons (e.g. severe foetal abnormalities, complex maternal conditions or very complex psychosocial issues) requiring a multidisciplinary team approach. After 22 weeks of pregnancy, the NSW law requires that an abortion must occur in a hospital or approved health facility by a specialist medical practitioner who has consulted with another medical practitioner.

Table 1: Medical and surgical abortion

Medical abortion up to 9 weeks	First Trimester surgical abortion
• Failure rate (continuing pregnancy and incomplete abortion requiring surgery) up to 5% (11, 12) • Can be undertaken from 4 weeks after the last menstrual period (usually from 5 to 6 weeks) • The process occurs in the privacy of home • Surgical instruments not required • No anaesthetic • Medications are self-administered • Abortion process lasts 1-2 days • Generally requires two clinic visits (except for telehealth services). Many services follow up by phone without the need for a second clinic visit. • Pain ranges from mild to severe • Bleeding may be heavy or prolonged.	• Failure rate (ongoing pregnancy and incomplete abortion requiring reaspiration) up to 2% (11) • Available from around 5 weeks since the last menstrual period. • Procedure performed at day procedure unit; usually under IV sedation / GA although can be performed under local anaesthetic • Instruments inserted into the uterus • A trained doctor performs the procedure • The procedure takes 5-10 minutes with a recovery time of up to 3 hours • Can be completed in one visit. Later term surgical abortions usually require 2 visits and have higher complication rates • Pain and bleeding are typically less than a medical abortion

Access to healthcare

Access to abortion can be by medical or surgical methods and occurs in a range of settings, including early medical abortion by telehealth.

Abortions are available through the:

- private sector (community-based GPs / private clinics / private hospitals);
- Not-for-profit NGOs (such as Family Planning NSW, Women's Health Centres, Marie Stopes Australia) and
- public hospitals in NSW.

Access to both early medical and surgical abortion is primarily available via the private/ NGO sector in NSW. Consideration of the role of the public system is needed to ensure an integrated approach that facilitates access for disadvantaged women.

Table 2 summarises the current abortion service settings and their financing arrangements. It also describes the types of abortion services provided, access in rural areas, and low- or no-cost availability.

Table 2: Summary of abortion service settings and financing arrangements

Service setting	Financing arrangements	Medical abortion	Surgical abortion	Rural availability	Low- or no-cost availability
Private clinics (e.g. Clinic 66, The Private Clinic)	MBS, PBS and private billing	✓	✓	Limited	Limited
Marie Stopes Australia (NGO)	MBS, PBS and private billing* and donations	✓	✓	Limited	Limited
Family Planning NSW (NGO)	Grant funding, MBS, PBS, private billing* and donations	✓	✓	Limited	✓
Women's Health Centres	Grant funding, MBS, PBS and donations	✓	×	Limited	✓
Medical specialists in private practice (e.g. private gynaecologists)	MBS, PBS and private billing	✓	✓	Limited	Limited
General Practice	MBS, PBS and private billing	✓	×	Limited	Possible via bulk billing
Private hospitals	Private billing[1]	✓	✓	Limited	Unknown
Public hospitals	NSW Health	✓	✓	Limited	✓
Tele-abortion services	MBS, PBS, Private billing	✓	×	✓	✓[2]

[1] may include private health insurance (PHI) rebates if in a licensed and accredited facility.
[2] subject to telehealth MBS item continuance following COVID-19

Private clinics

Currently, access to services for abortion in NSW is highly variable across the state. Most abortions in NSW are performed in private clinics in large urban areas - a referral is not needed.

Community-based clinics

Family Planning NSW provides medical abortion up to 9 weeks (63 days) and since April 2020 is providing surgical abortion up to 13 weeks (12^{+6}). Some Women's Health Centres also provide medical abortion services up to 9 weeks.

Between 9 to 22 weeks, surgical abortions are mainly provided in community-based clinics (including not-for–profits / private clinics / day surgeries). However, these services are limited in number and geographical spread, and they generally incur a significant cost.

Some private clinics and Marie Stopes Australia provide surgical abortion services up to 20 or 22 weeks. Availability is limited and cost is high. Women accessing abortion from 22 to 24 weeks via

Marie Stopes currently travel to Melbourne - incurring significant healthcare costs ($7,500) and the cost of travel and accommodation for two people (if including a support person) is also high.

Currently, there are no specific abortion clinics for gender and/or sexuality diverse people and vulnerable migrants or young people, Aboriginal and Torres Strait Islander people can access ACCHOs and Aboriginal Medical Services, which are highly important for women especially in rural areas, however, services for abortion are not uniform across NSW.

Medical specialists in private practice
Some specialists provide medical and surgical abortions in private settings responding to individual cases.

General Practice
General Practitioners and any other registered primary care medical practitioner can, once they meet the mandatory online training requirements, provide medical abortion up to nine weeks gestation, though numbers of GPs providing this are currently low.

Public and private hospitals
Within public and private hospitals, multidisciplinary teams provide comprehensive care for later-term abortions (post 20 weeks) including abortions for foetal abnormality and for medically and psychosocially complex presentations. However, access varies by LHD and by hospital. Earlier abortions for complex cases may also occur, but access is highly variable, and no public-facing pathways exist for this. All gestational stages need to be catered for, including medically and psychologically complex earlier and later gestations.

Tele-abortion
Currently, tele-abortion is provided by four services in NSW: Clinic 66, Marie Stopes Australia, Blue Water Medical and Family Planning NSW. The services have varying eligibility criteria which are designed to manage risk (Table 3). GPs also provide telehealth.

Table 3: Tele-abortion referral criteria in NSW

	Age	Phone only OK?	Can use interpreter?	Up to gestation	Distance form 24/7 emergency medical care
Blue Water Medical	Over 14 years	Yes	Yes	< 8 weeks	30 minutes
Clinic 66	Over 16 years	Yes	No, must speak English	< 9 weeks	2 hours
Family Planning NSW	Over 16 years	Yes	Yes	< 9 weeks	2 hours
Marie Stopes Australia	Over 16 years	No, internet is also required	No, must speak English	< 8 weeks	2 hours

While telemedicine is available statewide, access to medical abortion via this method prior to COVID-19 was limited by the referral criteria, high out-of-pocket costs and the availability of registered dispensers in local rural pharmacies (Marie Stopes and Blue Water Medical send the pharmaceuticals in the post. Clinic 66, and Family Planning NSW require women to collect the drugs from a pharmacy). The introduction of the COVID-19 MBS items for telehealth have reduced the out-of-pocket costs for clients. However, due to recent changes to COVID-19 MBS items for telehealth access is restricted to a regular GP or practice where the patient have been active within the past 12 months or through a referred non-GP specialist. The availability of dispensers in local pharmacies remains a challenge, especially in rural and remote areas.

Other settings
To expand access to no out-of-pocket-cost medical abortion and in rural areas, other services that could potentially play a role include Women's Health Centres, Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations Services.

Gaps in healthcare access

Currently, the largest gaps in access are to fully publicly funded, or subsidised abortion services, for financially disadvantaged women and to those living in rural and remote areas.

Access to affordable services

Abortion mainly takes place in NSW in private settings. Some women have significant difficulty paying for these services. In 2015, an Australian study of women seeking abortion (83.8% were within 9 weeks, and 96.3% were in their first trimester), found two-thirds of women needed financial assistance from others.(13) In addition, indirect costs include travel and accommodation, GP referrals and medical tests, childcare and lost wages. The median cost for indirect expenses was $150.(13) Another Australian study with rural women found some borrowed funds so they could access an abortion.(1)

Costs for abortion services include the cost of the consultation and procedure, the medication (for medical abortion) and the cost of aftercare. Having an abortion can incur large out-of-pocket costs, even though medications for a medical abortion are listed on the PBS (MS-2Step) and surgical abortion is a rebatable procedure under Medicare. Out-of-pocket gap fees are unaffordable for some women.

Table 4 provides an indication of current total fees and gap fees to access an abortion. The costs increase for later-term abortions. To obtain the medications required for medical abortion, the Pharmaceutical Benefits Scheme patient charge for the MS-2Step composite pack is currently $41.00. For a healthcare card holder the cost is $6.60.

Table 4: Cost to access abortion services in NSW

Procedure type and gestation	Out-of-pocket costs if Medicare eligible[1] ($)	Out-of-pocket costs if Healthcare Card holder ($)	Medicare Rebate ($)
Medical abortion			
Medical abortion (face-to-face)	0 – 555	0 - 535	0 – 182
Tele-abortion	0 – 450	0 - 450	0 – 202[2]
Surgical abortion			
Up to 12 Weeks	0 – 495	0 - 475	30 - 490
12 - 13 weeks	0 – 1,000	0 – 1,000	30 - 495
13 - 14 weeks	515 – 1,150	495 – 1,150	30 - 450
14 - 15 weeks	615 – 1,300	595 – 1,300	30 - 450
15 - 16 weeks	715 – 1,350	695 – 1,350	30 - 450
16 - 17 weeks	1,115 – 1,500	1095 – 1,500	30 - 714
17 - 18 weeks	1,245 – 1,700	1225 – 1,700	30 - 714
18 - 19 weeks	1,900	1,900	714
19 - 20 weeks	2,500	2,500	714
20 - 20.6 weeks	3,995	3,995	707

[1] out-of-pocket costs are exclusive of any Medicare rebate
[2] includes COVID-19 telehealth MBS items

There are significant additional costs to support women's access to medical and surgical terminations when they reside in rural and remote areas and there are no local services. ACCHOs, AMSs Women's Health Centres and other organisations can incur significant costs in providing transport and staff to attend abortion services with the woman.

Women with financial difficulties and / or marginalised groups either proceed with the pregnancy or may more commonly access services at a later gestation, due to access barriers, and abortion becomes progressively more expensive with increasing gestation. A 2015 Australian study found that beyond 12 weeks, the costs to women rose considerably.(13)

During the 2018-2019 financial year Penrith Women's Health Centre spent $40,000 in brokerage aiding women to access abortion services (they were managing referrals from across NSW) and will provide a similar amount in 2019-2020. The source of funds is private donation and agreed brokerage from funding grants in cases of domestic and family violence and or other crucial circumstances.

Women's Health Centres fundraise to help women financially access abortion services. Marie Stopes Australia often refer financially disadvantaged women who cannot afford MSA rates to Women's

Health Centres and Family Planning NSW with the expectation Women's Health Centres and Family Planning NSW will either provide brokerage or fund the services.

The availability of telehealth medical abortion services has significantly changed with the introduction of the COVID-19 MBS items for telehealth, however, these items were time-limited to 30 September 2020. Telemedicine services potentially provide access to medical abortion across the state. Typically, the service involves an online consultation, provision of a prescription for the required medications, access to a local health service for an ultrasound in some cases a baseline blood test, and a follow-up consultation. Prior to the introduction of the COVID-19 MBS items for telehealth, access to MBS rebates for telehealth was only available for medical specialists. Given that most telehealth abortions are provided by GPs, this meant these services attracted full private fees. The COVID-19 MBS items for telehealth had additional criteria where services are required to be bulk-billed, which includes services provided to pregnant women. In compliance with these requirements, all telehealth medical abortion services being provided under the COVID-19 MBS items for telehealth were bulk-billed by GP providers. However, from 30 September 2020 patients must have an existing relationship with a GP to access abortion services via telehealth, limiting access to abortion services.

Although some abortion providers promote reduced costs for those who cannot afford to pay out-of-pocket fees, this is limited and involves advocacy and overheads for other organisations facilitating such access (such as through the Family Planning NSW social work service or through Women's Health Centres).

Access to services in rural and remote areas

There are currently no comprehensive medical and/or surgical services within a publicly funded model for regional, rural and remote women, and this exacerbates inequity of access. Access to abortion in rural areas is extremely limited and is difficult. Furthermore, perceived local confidentiality is an issue resulting in women travelling to other areas, at significantly higher cost. In these circumstances, there may be a higher likelihood of inadequate post-abortion care. Women in all geographical locations should have equal access to affordable, appropriately located and safe abortions. Women also need access to unbiased information to enable them to make a choice that is right for them.

Having abortion services available closer to home may help reduce inequities in access to healthcare experienced by rural women. In 2016, a NSW-based study found rural women travelled 1–9 hours one way to access an abortion.(1) Another Australian study of 2,326 women aged 16 and over found women who travelled more than 4 hours were more likely to have difficulty paying, were more likely to be Aboriginal and Torres Strait Islander and more likely to present later.(13)

Access to medical abortion via telemedicine is limited in rural areas due to the referral criteria, out-of-pocket costs and the availability of registered dispensers in rural pharmacies.

Access to services delivered by GPs is variable. A study in 2017 found that most GPs thought abortion should occur in for-purpose clinic settings rather than general practice. GPs suggested access to abortion could be strengthened by formalised referral pathways to those clinics. However, some GPs are willing to provide a medical abortion.(14) Table 5 describes the availability of General Practitioners by Primary Health Networks in NSW in 2017.

Table 5 Number of Medical Practitioners by Primary Health Network

Primary Health Network[1]	n (%)
Central and Eastern Sydney	1671 (23.1)
Northern Sydney	972 (13.5)
Western Sydney	882 (12.2)
Nepean Blue Mountains	303 (4.2)
South Western Sydney	768 (10.6)
South Eastern NSW	552 (7.6)
Western NSW	235 (3.3)
Hunter New England and Central Coast	1139 (15.8)
North Coast	532 (7.4)
Murrumbidgee	166 (2.3)
Total	7220

[1] Data source: 2017, Health Workforce Data, https://hwd.health.gov.au/

Training and support

Training for GPs, nurses and specialists is needed to increase access to medical and surgical abortion.

Medical abortion
Mifepristone, the drug used to initiate the medical abortion process, is currently listed by the Therapeutic Goods Administration as a special drug. To prescribe it, doctors must register with MS Health (the company that sponsors the drug in Australia) and either

- complete the MS-2--Step 2–3 hour online education program OR
- be a Fellow of the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) OR
- have an advanced diploma from RANZCOG.

For medical abortion, MS-2Step can only be dispensed by a pharmacist registered with MSHealth. To become a dispenser, pharmacists do not need to attend training.

Nurses do not have access to the MS-2Step online training as they do not prescribe medications for abortion.

General Practitioners and any other registered primary care medical practitioners can provide medical abortion up to 9 weeks gestation, after completing MS-2Step online training. There is no published data available on uptake by GPs. Anecdotally to date the uptake of this training among GPs is very low. This proportion is lower in rural areas.(15) It is unknown how many GPs who have completed the MS-2Step online training are currently providing services. Training alone may not increase uptake given stigma may also play a significant role, particularly in regional, rural and remote areas. For example, in 2019, Murrumbidgee Primary Health Network organised face-to-face training in medical abortion for GPs in Wagga Wagga. However current service availability is unclear.

Nurses have a crucial role in providing clinically-sound, professional and accurate information to women and their partners about abortion services.(16) Currently nursing roles exist in Family Planning NSW and Women's Health Centres. Nurses and midwives play a key role in private and public abortion service provision. Mental health nurses can also have an important role in abortion care for some women.

To meet the training needs of GPs and nurses, Family Planning NSW has recently developed a comprehensive training course for medical abortion that goes beyond the MS-2Step training requirements. The training was developed to provide practical support to assist GPs in establishing and delivering medical abortion services, including prescribing through to follow up, and with a focus on clinical scenarios and complications.

FRANZCOG and DRANZCOG members must upload evidence of their qualifications when registering with MS Health, but are not required to complete the online MS-2Step online training.

The RANZCOG has developed educational programs in abortion. There is an online learning module (the 'CLIMATE Abortion Module') that (since December 2019) basic trainees are required to complete. For trainees in the final years of the RANZCOG fellowship there is an Advanced Training Module on *Contraception, Abortion and Sexual Health* that provides an opportunity to develop advanced skills in medical and surgical abortion.

Surgical abortion
For surgical abortion the primary issue is that there is currently no recognised training program in surgical abortion with the exception of the advanced training module for trainees in the RANZCOG program. Training in community clinics has generally been provided by experienced medical practitioners but there is, as yet, no formal credentialing process. The lack of training impacts on clinical capabilities and access to later gestation abortions.

Research, data and evaluation

Routine data collection, research and evaluation, are vital to assess current health promotion strategies and service provision, inform service delivery and education planning and identify gaps (such as barriers to access).(17)

Currently, there is no single authoritative or complete data source on induced abortion in Australia. The most accurate estimate of the number and rates of induced abortions in Australia are over 15

years old.(18) Since this time, there have been changes in legislation, health policy and service delivery across Australian states and territories. However, it is unknown whether these changes have affected the number and rates of abortions without a comprehensive and current estimate of abortion service delivery.

As with all health services, ensuring high-quality abortion care depends upon effective processes for monitoring, evaluation, quality assurance and improvement. Accurate collection of service statistics and routine monitoring and evaluation at the healthcare facility level are key components of programme management, and these data provide necessary information for improving access and maintaining and improving the quality of services delivered.(19)

Part 2 - Proposed model for abortion access

Part 2 proposes a model for expanding access to abortion services in NSW. Key areas for action are identified.

Health and service information

Having accessible credible information online is highly likely to assist in both the redistribution of abortion services from surgical to medical and to abortions occurring at earlier stages of gestation when interventions may be less complex. Educational resources, such as decision trees to communicate service options, would be of benefit to women. There should be complete and unbiased information accessible online for women to make informed decisions about their options, including information about risks and benefits, and about service availability. Access to unbiased counselling should also be highlighted. Access to information for women in rural areas must be improved, including through social and other media, and resources targeting these populations is needed.

Published models of care should be readily available online. These would assist health professionals to navigate health pathways. They would also assist women themselves to navigate these pathways.

Research with young people in NSW found they would prefer to find information about health services online.(20, 21) Having unbiased web-based information may be of particular benefit to young women, as well as to women of all ages so that they can understand their service options and access services as early as possible. The scope should include information in low English literacy formats for women from culturally and linguistically diverse backgrounds and women with intellectual disability.

Women accessing abortion services should be aware that there are legislated safe access zones in NSW to protect their privacy, dignity and safety from anti-abortion/anti-choice individuals and groups. The *Public Health Act* specifies 150-metre safe access zones around abortion clinics in NSW, making it illegal to obstruct and harass people accessing clinics or record them without their consent.

Clinical approach

Clinical services should be provided close to home and in clinical contexts relevant to their complexity. While most abortions could be provided in community contexts, public hospitals have a key role in service provision. Furthermore, to ensure that Australia maintains the highest standards of abortion practice, an essential health service, abortion care must be routine, and embedded, in our public hospital system. This commitment is essential for training of future specialists and primary care doctors in the best practice management of abortion procedures and complications.

Community-based services must be expanded. Delivering early abortion services through primary healthcare rather than via hospitals means that patient journeys may be simplified and more accessible. Medical abortion up to 9 weeks can be managed in primary care unless there are medical risk factors (complex cases or complications post-abortion). As some women are not clinically suitable for a medical abortion, there will always be a need for surgical abortion options and healthcare professionals to be skilled in this area.

To support the implementation of the *Framework for Termination of Pregnancy in New South Wales (PD2019_048),* there is a need to develop clinical guidelines for abortion in NSW across all gestational stages. Guidelines should be designed with a multidisciplinary representative group under the auspices of the Ministry of Health, with appropriate involvement from the range of organisations and professional providers involved in providing abortion services. Clinical guidelines could include flowchart summaries of the process with decision-making points, clinical standards for medical abortion and surgical abortion and care pathways and complications management.

A care pathway is a complex intervention for the mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period.[1] Formal care pathways should be developed so abortion providers can appropriately and seamlessly refer complex cases or complications requiring hospital management. Care pathways would also identify options for women who are financially and/or geographically disadvantaged or have complex psychosocial issues.
Care pathways should include access to post-abortion reproductive and sexual healthcare, especially contraceptive options.

Access to healthcare

There is a need for women across the state to be able to equitably access timely, affordable medical or surgical abortion services. To ensure every woman, regardless of her financial or geographical status, has access to abortion close to home, it is essential to adopt a woman-centred rather than a provider-centred approach. Access to abortion services in rural and remote locations, in particular, must be expanded. Projected volumes estimate that one-quarter of all abortion services are needed in rural areas (see Table 6).

Affordable services should be available for eligible women seeking abortion at any gestation including availability of subsidised, or free care. There is currently very limited access to abortion services through public sector funded services, except in cases of severe maternal health conditions, or fetal anomaly. As the majority of existing services funded outside the public sector charge a fee, this results in an inequity of access to abortion services for women at lower socio-economic levels. On the whole, abortion is primarily available for people who can afford to pay a fee.

Public hospitals have the potential to provide some of these much needed services by being embedded within public gynaecology and maternity services. These services should work in collaboration with primary care providers offering abortion services with clear, agreed referral pathways to local hospitals so that in the event women require further medical assistance post-abortion, this can be delivered in a seamless manner.

Development of centres of excellence which provide specialist care and expertise to manage complex cases or late-term abortions is a key issue. This would provide specialty support for rural LHDs in particular, where numbers are lower than in urban LHDs. Linkages between LHDs for referral pathways could be developed. Identifying key hospitals with expertise in maternal-foetal medicine and management of complex cases and later gestation presentations is pivotal.

Women should have the right to choose medical or surgical abortion, related to their priorities and circumstances. While an increase in medical abortion for early abortion would reduce service delivery costs overall, some women will prefer surgical abortion. Other women may not have a suitable home environment, support or the available time needed for a medical abortion.

Abortion services do not always, or even usually, need to be provided in higher-cost public hospital or outpatient facilities. Public funding can support public access to community-based clinics. All service types, including GP, NGO, private and public services, are important options so that women can make a choice based on their circumstances. This is in line with other healthcare access, where women currently choose private or public options. Women in lower socio-economic brackets should have access to the same options as women who currently access services in the private and not-for-profit sector.

Access to appropriate services, with appropriate models of care, for all women is needed, including for Aboriginal and Torres Strait Islander people, women of culturally diverse backgrounds, young women and women with physical and intellectual disability.

Projected need for abortion services
Table 6 provides relevant indicators (including socio-economic status and teenage fertility rate), along with projected data about the volume of medical abortions and projected demand for surgical abortions by Local Health District (LHD) in NSW based on current practice. Rural and regional NSW LHDs have a higher average percentage of low socio-economic status population (51.0%) compared

[1] The aim of a care pathway is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimizing the use of resources. Care pathways include: an explicit statement of the goals and key elements of care based on evidence; best practice, and patients' expectations and their characteristics; the facilitation of communication among the team members and with patients; the coordination of the care process; the documentation, monitoring, and evaluation of variances and outcomes, and the identification of the appropriate resources.

to the average for Metropolitan LHDs (45.3%). The teenage fertility rate is higher in rural and regional NSW LHDs (12.7 per 1,000 teenagers) compared to metropolitan LHDs (6.2 per 1,000 teenagers).

It is estimated that the projected volume for NSW for medical abortions is 2,500 per annum and for surgical abortions is 20,000 per annum (see Table 6 and Appendix A for sources). Approximately a quarter of projected abortion services are for women living in rural and regional NSW LHDs.

While based on available evidence, it is likely the data in Table 6 is an underestimated projection for medical abortion demand. PBS data is an unreliable indicator of where medical abortion services are delivered. For example, all MS-2Step combination packs supplied to Marie Stopes Australia clinics are dispensed from Brisbane.

In addition, the projections based on current data about existing rates of uptake of medical to surgical abortion are likely to change. Access to medical abortion may increase, as has occurred in other countries. For example, in Sweden in 2017, 75% of all early abortions were carried out at home, compared to 62% in 2014.(22) It is anticipated that abortions may be performed earlier as a result of increased access to information about abortion services and increased provision of medical abortion at the community level. A rural hospital in the Northern Territory found that the mean wait-time for surgical abortion ranged from 20-22 days in 2012–2016 and dropped to 15 days in 2017 following the law reform, due to an increase in community-based early medical abortions and fewer hospital-based surgical abortions.(23)

Estimated cost of abortion services

The projected numbers of required services indicate a need for increased staffing capacity to meet service demand. Provision also needs to be made for women who are financially and / or geographically disadvantaged or have complex psychosocial issues. Public sector support for medical and surgical abortion for clients who otherwise will not have equitable access to services is required. Applying public health funding to non-inpatient services to manage the care of women wanting access to abortions is critical. It is proposed that subsidies are provided so that women who cannot afford to pay can access abortion services at no- or low-cost.

The current out-of-pocket gap fees to clients are summarised in Table 3. With a Medicare card and healthcare card, medical abortion out-of-pocket cost ranges from $0 to $535 for face-to-face care ($0 to $555 without a healthcare card) and from $0 to $450 for tele-abortion ($0 to $450 without a healthcare card). Surgical abortion out-of-pocket costs ranges from $0 for early abortion to $3,995 for late abortion (with or without a healthcare card). Abortion costs for Family Planning NSW are described in Appendix B.

The cost of providing abortion services depends on the overall numbers of women seeking access to abortion, the proportion of women who can pay and the proportion who choose medical versus surgical abortion.

The estimated cost of surgical abortion provision in NSW Health facilities is outlined below, based on the National Efficient Price (NEP) Determination for 2020-21. The NEP for 2020-21 is $5,320 per National Weighted Activity Unit (NWAU):

- O05Z – Abortion W GIs: 0.5042 NWAU or $2,682.34
- O63A – Abortion W/O GIs, Major complexity: 0.5972 NWAU or $3,177.10
- O63B - Abortion W/O GIs, Minor complexity: 0.2136 NWAU or $1,136.35

Comparing the NEP costs for surgical abortion in NSW Health facilities (O05Z) with the fees currently charged at external providers (Table 3), abortion appears more cost-effective if provided outside public hospital facilities up until approximately 19 weeks gestation. It is noted that tertiary facilities are high cost due to their structural orientation towards complex surgical procedures. Day Procedure Units are relatively lower cost and are preferred for less complicated surgical abortions.

A direct comparison of costs for medical abortion (<9 weeks gestation) is less straightforward. Assuming this would be provided in a Specialist outpatient clinic if provided in a NSW Health facility and that a minimum of two consultations are required (assessment / provision and follow up) the comparative cost would be $414 in a NSW Health outpatient clinic (20.40 Obstetrics – Management of pregnancy without complications) compared with $182 - 500 in the non-government sector (includes MBS rebates +/- out-of-pocket fees). Hence, depending on the out-of-pocket fees charged by the non-government provider, uncomplicated early medical abortion appears more cost-effective outside public hospital facilities.

Table 6: Relevant indicators and projected needs for abortion service access for women living in Local Health District (LHD)[8,9]

LHD	Low SES[1] (%, 2016)	Teenage fertility rate[2] (per 1,000 teenagers, 2018)	Women of childbearing age(2020)[3]	Projected volume of medical abortion (2020)[4]	Projected volume of medical abortion per annum by gestation week[5] 1-9 weeks gestation	10-13 weeks gestation	14-19 weeks gestation	20weeks+ gestation	Projected volume of surgical abortion (2020)[6]	Projected volume of surgical abortion per annum by gestation week[7] 1-9 weeks gestation	10-13 weeks gestation	14-19 weeks gestation	20weeks+ gestation
Central Coast	48.3	10.0	60,988	**117**	108	0	5	4	**637**	488	112	37	1
Illawarra Shoalhaven	50.3	8.8	74,534	**142**	132	1	6	5	**778**	596	137	45	1
Nepean Blue Mountains	43.8	11.7	75,309	**144**	133	1	6	5	**786**	602	138	45	1
Northern Sydney	37.6	0.5	192,178	**367**	339	1	14	12	**2,006**	1,537	352	115	2
South Eastern Sydney	41.3	1.7	213,674	**408**	377	1	16	13	**2,231**	1,709	392	128	2
South Western Sydney	51.1	7.9	210,897	**403**	372	1	16	13	**2,202**	1,686	387	127	2
Sydney	43.8	2.1	169,024	**323**	298	1	13	11	**1,765**	1,351	310	102	2
Western Sydney	46.4	6.7	22,215	**434**	401	2	17	14	**2,372**	1,817	417	137	2
Total Metropolitan LHDs	**45.3**	**5.5**	**1,223,819**	**2,338**	**2,160**	**9**	**92**	**77**	**12,777**	**9786**	**2244**	**735**	**12**
Far West	54.8	9.1	4,794	**9**	8	0	0	0	**50**	38	9	3	0
Hunter New England	49.5	14.3	169,138	**323**	299	1	13	11	**1,766**	1,352	310	102	2
Mid North Coast	53.7	13.9	33,514	**64**	59	0	3	2	**350**	268	61	20	0
Murrumbidgee	49.1	14.3	41,211	**79**	73	0	3	3	**430**	330	76	25	0
Northern NSW	53.3	8.9	48,381	**92**	85	0	4	3	**505**	387	89	29	0
Southern NSW	46.1	8.9	34,900	**67**	62	0	3	2	**364**	279	64	21	0
Western NSW	50.4	19.7	49,713	**95**	88	0	4	3	**519**	397	91	30	0
Total rural and regional NSW LHDs	**51.0**	**13.7**	**381,651**	**729**	**674**	**3**	**29**	**24**	**3,984**	**3,052**	**700**	**229**	**4**
NSW*	**46.4**	**7.8**	**1,614,855**	**3,085**	2851	11	121	102	**16,860**	12,912	2,961	970	16

[1-9] See Appendix A for notes about Table 6 data sources.

Proposed service structures for abortion access

Table 7 sets out proposed service structures and referral pathways for abortion access in NSW for each gestational period, service type, by setting and includes services that may incur a cost, have low- or no-out-of pocket-costs and the management of complications and complex cases.

Table 7: Proposed service structures and referral pathways for medical and surgical abortion in NSW

Gestational period	Medical/ surgical abortion	Service settings for usual care including for those who can pay	Low- or no-out-of-pocket- cost services	Referral pathways for the management of complex cases	Referral pathways for complications management
Early					
Up to 63 days (9 weeks)	Medical abortion	Outpatient settings: • GPs and registered medical practitioners • Private clinics • NGOs (both not-for-profit and profit for purpose) • Gynaecologists and other specialists	GPs and registered medical practitioners NGOs which operate as not-for-profits Aboriginal Medical Services Women's Health Centres Public hospitals	Private clinics Public (via specialist clinics, ED, EPAS) or private hospital [1]	Private clinics, NGO clinics Public or private hospital
Up to 63 days (9 weeks)	Surgical abortion	Day surgeries: • Private clinics • NGOs • Gynaecologists and other specialists	NGOs which operate as not-for-profits Public hospitals	Private clinics Public (via specialist clinics, ED, EPAS) or private hospital [1]	Private clinics Public or private hospital
Middle					
9 to 22 weeks	Medical Abortion	Public or private hospital	Public hospitals	Public or private hospitals	Public or private hospitals
9 to 12 completed weeks	Surgical abortion	Procedural / day only settings: • Private clinics • NGOs (both not-for-profit and profit for purpose)	NGOs which operate as not-for-profits Public hospitals	Private clinics Public or private hospitals	Public or private hospitals
13 weeks to 20 weeks	Surgical abortion	Procedural / day only or inpatient settings: • Private clinics • NGOs (both not-for-profit and profit for purpose) • Public and private hospitals, either day-procedures or surgical theatre, depending on complexity.	Public hospitals NGOs which operate as not-for-profits	Public or private hospitals	Public or private hospitals
20 to 22 weeks	Surgical abortion	Procedural / day only or inpatient settings: • Private clinics • NGOs (both not-for-profit and profit for purpose) • Public and private hospitals, either day-procedures or surgical theatre, depending on complexity.	Public hospitals NGOs which operate as not-for-profits	Public or private hospitals	Public or private hospitals
Late					
22 weeks +	Surgical / medical abortion	Inpatient settings: • Public and private hospitals, surgical theatre	Public hospitals	Public or private hospitals	Public or private hospitals

[1] via referral to a named specialist with admitting rights

The gestational periods in Table 7 are indicative only and are not intended to preclude other service delivery settings appropriate to the needs of an individual client and their specific circumstances.

Training and support

There is a need to expand competency-based training for doctors and nurses in both medical and surgical abortion. In addition, there is a need for ongoing practice support.

Abortion values clarification workshops may also be conducted with abortion providers, trainers, policymakers and other stakeholders to mitigate the effects of abortion stigma and increase the provision of, and access to, abortion care.

Training in medical abortion
More GPs should be supported to become providers of medical abortion services**.** Although the numbers of GPs who provide abortion may remain small, it will be important to promote this opportunity among GPs and support their ongoing engagement through the development of Communities of Practice.

Family Planning NSW has developed an online training program to assist doctors and nurses to provide appropriate care for medical abortion services. It includes medical abortion assessment, informed consent, medication prescription, aftercare including the provision of contraception and management of any complications that might arise

For Obstetrician and Gynaecologist (O&G) trainees in the final years of the RANZCOG fellowship the advanced training module on Contraception, Abortion and Sexual Health provides an opportunity to develop advanced skills in medical abortion management of complications.

Training in surgical abortion
Family Planning NSW is developing training in surgical abortion for doctors working in community-based settings such as day surgeries. There needs to be a national process for accreditation.

Public hospitals are the training institutions for future primary and specialist providers of women's reproductive health services and it is important they have a role in normalising the provision of abortion care as a part of women's health and the provision of training in best practice models of care. RANZCOG has developed an online training module in abortion for O&G specialists and primary care practitioners, and O&G trainees. Basic trainees are required to complete this training. Trainees in the final years of the RANZCOG fellowship at the Royal Women's Hospital in Melbourne, Victoria have access to an advanced training module on Contraception, Abortion and Sexual Health that provides an opportunity to develop advanced skills in surgical abortion and medical abortion. This training module is not available in NSW as there is no LHD with a comprehensive abortion service. There is an urgent need to develop a centre of abortion care excellence and RANZCOG training pathways in public hospitals.

Practice support
A national *Community of Practice* for General Practitioners providing medical abortion was recently funded with Monash University as the leading organisation.(24) Family Planning NSW and RANZCOG are part of this initiative.

Local Health District groups could be formed that include gynaecologists, GPs, NGOs and private clinics providing services. These groups could meet for regular discussions, including about complex cases and management of complications. Primary Health Networks are important sources of information for GPs and pharmacies and should be involved. Like many other areas of healthcare, staff can benefit from a range of supportive mechanisms, from clinical support to employee assistance programs.

Primary care hubs, including nurse-led models, could be explored. A hub and spoke state-based model for abortion services where each hub assists in supporting services for medical abortion as well as a GP community of practice has been used by Victoria's Department of Health for integrated sexual health and reproductive health. The Royal Women's Hospital in Melbourne's Rural Sexual Health Resource Hub functions as a centre of excellence which assists in setting up medical abortion models of care. These are predominately nurse-led.(25)

Research, data and evaluation

The prevention of unsafe abortion and provision of safe abortion options, including medical and surgical, for women are internationally recognised components of optimal reproductive and sexual healthcare.(19) As with all health services, ensuring good-quality abortion care depends upon effective processes for monitoring, evaluation and quality assurance and improvement.

The accurate collection of service statistics and routine monitoring and evaluation at the healthcare facility level are a key component of programme management, and these data provide necessary information for improving access and maintaining and improving the quality of services delivered.(19) Improved data collection and service evaluation would provide a clearer picture of service access and acceptability to determine if policies to promote access for marginalised groups have been effective.

Routine data collection indicators and systems in relation to abortion service monitoring should be developed to capture data to estimate the abortion numbers and rates in NSW as well as the abortion method. Monitoring of abortion services and associated data collected should be reported to NSW Health periodically. De-identified data should be published so that it is accessible to those involved in abortion care.

Abortion service evaluations should be undertaken to better understand service access, to determine if policies and strategies to promote access for marginalised groups have been effective. Data on socio-economic background and geographic location would be beneficial in determining the effectiveness of programs in providing access to women from low socio-economic backgrounds and from rural / remote areas.

To date, there is no established monitoring or evaluation system for abortion services in NSW or Australia. Family Planning NSW is developing an evaluation framework of abortion services. This is based on the WHO safe abortion technical and policy guidance for health systems (19), Benson's conceptual framework for evaluating the outcomes of a safe abortion program (26), Dawson's framework for examining access to early abortion services(27), and a paper on the establishment of a minimum data set for abortion services.(28)

Minimum Data Set

An evaluation framework for abortion services in NSW could be based on the minimum data set developed by Assifi et al.(28) for adolescent services (but relevant for all ages), based on data from 11 high-income countries, including Australia. Table 7 proposes a minimum data set based on the one developed by Assifi et al.

Table 7 Minimum data set

Demographic data
Age of woman
Geographic location
Clinical Data
Method
Gestational age at time of procedure
Service location • Urban / Regional / Rural • Hospital / Clinic / GP • Public / Private
Previous delivery (number of previous pregnancies that resulted in a delivery)
Previous abortion (number of previous pregnancies that resulted in an abortion)
STI screening
Major complications (abortion-related morbidity) - Hospital- managed or managed outside hospital
Contraception used before abortion
Contraception prescribed / chosen as part of the abortion care

Part 3 - The impact of COVID-19 on Abortion Access

COVID-19 has impacted abortion access. There is a need to plan for the ongoing impact of COVID, future pandemics and climate crises, which highlight the absolute necessity for increased telehealth and geographical proximate services.

In a time of uncertainty in the midst of COVID-19, organisations have had to adapt quickly to continue delivering services safely. Reproductive and sexual healthcare are essential services that must continue to be provided in the face of pandemics and increasing environmental crises.

Women's Health Centres in NSW have anecdotally reported that that requests for access to abortion have increased during the COVID period.

The temporary COVID-19 Medicare Benefit Scheme (MBS) telehealth item numbers, introduced at the start of the pandemic made it possible for women to receive Medicare funded tele-abortion for the first time. This has been particularly beneficial for women who's travel is restricted due to fears about COVID-19, women in rural and remote areas and for those who cannot afford to pay.

However, recent changes to eligibility for these telehealth item numbers has meant women's access to tele-abortion has significantly reduced.

Recommendations

The Abortion Access in NSW stakeholder group (Appendix C) who have shaped this report, make a number of recommendations for increasing access to abortion in NSW.

To ensure every woman, regardless of her financial, geographical or psychosocial status, has access to an early medical or surgical abortion according to her preference and to later surgical abortions when needed, either through public, GP, private or not -for -profit NGO providers, the following is recommended:

1. **Statewide coordinated health and service information**
    - non-biased accessible service information available in verbal, written and on-line formats, for women to make timely informed choices and navigate the health system.
    - resources developed in consultation with relevant population groups and services, including those for Aboriginal and Torres Strait Islander women, culturally and linguistically diverse women, women with disability and youth, to assist women in their decision making and ensure culturally safe practices.
    - information available on 'safe access zones' to address client fears about privacy, dignity and safety from anti-abortion / anti-choice individuals and groups.
    - access to information about preventative strategies, including about long-acting reversible contraception (LARC) and about comprehensive sexuality education at age-appropriate stages, at school and community levels, to reduce the incidence of unplanned pregnancy
    - use of Health Pathways to offer clinicians locally agreed information to make decisions together with patients, at the point of care.

2. **Accessible, appropriate and affordable abortion services**
    - women centred care including choice of abortion type, equitable timely access, safe affordable medical or surgical abortion services, regardless of financial, geographical or psychosocial status
    - increased workforce planning and resourcing to facilitate expanded access to abortion across service types and options
    - clinical services in a range of settings provided close to home and, where feasible, in community contexts rather than hospital settings
    - well-defined and agreed referral pathways from community–based abortion services to the tertiary hospital sector for complicated cases, complications and later term abortions
    - access to unbiased counselling on request
    - expanded service availability in rural and remote locations

- expansion of accessible and affordable services that include both subsidised and free care when appropriate
- public hospitals meet a proportion of the need for service provision and training formation of a state-based group to review requests for those declined at the first site of review. If approved, then the woman able to access abortion at her local tertiary referral centre, closer to home and to her support network
- funding to increase access to abortion for women in financial need, where low and no-cost abortions are not available locally. This may include direct service funding and also funding for transport, accommodation and support for women, especially from rural and remote areas. Access to the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) funding for this should be considered
- adequate funding to support health professionals to provide required levels of aftercare for women who have had an abortion, especially for staff servicing rural and remote women
- increase in the provision of telehealth medical abortion services (including supportive local health services to enable access to ultrasound and baseline blood tests (if indicated) as well as information available about pharmacists registered to dispense the required medications
- access to appropriate services, with appropriate models of care, for all women, including for Aboriginal and Torres Strait Islander people, women of culturally diverse backgrounds, young women and women with physical and intellectual disability
- access to affordable post-abortion reproductive and sexual healthcare, including contraception

3. Improve quality of abortion services

- culturally safe abortion services available for all women, including for Aboriginal and Torres Strait Islander women, women of culturally diverse backgrounds, young women and women with disability
- documented evidence-based practice guidelines
- abortion services engagement in continuous quality improvement via local clinical governance activities and accreditation activities
- consumer input into the development of pathways of care for abortion services
- establishment of Centres of Excellence in abortion service provision, taking into account service volumes and areas of special interest and expertise

4. Training and support

- utilisation of reproductive and sexual health training institutions to embed abortion care provision within their service and training models
- ongoing competency-based training for doctors and nurses in abortion services provision
- support for more GPs to become providers of medical abortion services through the establishment of abortion services communities of practice in line with local health care requirements

5. Research, data and evaluation

- routine data collection indicators and service monitoring to capture data to estimate the abortion numbers and rates by method of abortion in NSW, ensuring compliance with national and state data privacy principles
- monitoring of abortion services and associated minimum data sets, reported to NSW Health periodically
- publication of indicators and service data by NSW Health
- evaluation of abortion services, follow-up and effectiveness of pathways of care in line with the National Safety and Quality Health Service (NSQHS) Standards
- commitment to a forward research program for abortion services in NSW, with consumer input

References

1. Doran FM, Hornibrook J. Barriers around access to abortion experienced by rural women in New South Wales, Australia. Rural and remote health. 2016;16(1):3538.
2. Rowe H, Holton S, Kirkman M, Bayly C, Jordan L, McNamee K, et al. Prevalence and distribution of unintended pregnancy: the Understanding Fertility Management in Australia National Survey. Australian and New Zealand Journal of Public Health. 2016;40(2):104-9.
3. Taft AJ, Shankar M, Black KI, Mazza D, Hussainy S, Lucke JC. Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes. Medical Journal of Australia. 2018;209(9):407-8.
4. Rowe H, Holton S, Kirkman M, Bayly C, Jordan L, McNamee K, et al. Abortion: findings from women and men participating in the national survey. Sexual Health. 2017;14(6):566-73.
5. Sharman LS, Douglas H, Price E, Sheeran N, Dingle GA. Associations Between Unintended Pregnancy, Domestic Violence, and Sexual Assault in a Population of Queensland Women. Psychiatry, Psychology and Law. 2019;26(4):541-52.
6. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia. Canberra: AIHW; 2018.
7. Campbell JC, Woods AB, Chouaf KL, Parker B. Reproductive Health Consequences of Intimate Partner Violence: A Nursing Research Review. Clinical Nursing Research. 2000;9(3):217-37.
8. Chibber KS, Biggs MA, Roberts SCM, Foster DG. The Role of Intimate Partners in Women's Reasons for Seeking Abortion. Women's Health Issues. 2014;24(1):e131-e8.
9. Foster DG, Kimport K. Who Seeks Abortions at or After 20 Weeks? Perspectives on Sexual and Reproductive Health. 2013;45(4):210-8.
10. NSW Health. Considering a termination of pregnancy (abortion) 2020 [updated 14 October 2019. Available from: https://www.health.nsw.gov.au/women/pregnancyoptions/Pages/abortion.aspx.
11. Lohr PA, Fjerstad M, Desilva U, Lyus R. Abortion. BMJ. 2014;348.
12. Goldstone P, Walker C, Hawtin K. Efficacy and safety of mifepristone–buccal misoprostol for early medical abortion in an Australian clinical setting. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2017;57(3):366-71.
13. Shankar M, Black KI, Goldstone P, Hussainy S, Mazza D, Petersen K, et al. Access, equity and costs of induced abortion services in Australia: a cross-sectional study. Australian and New Zealand Journal of Public Health. 2017;41(3):309-14.
14. Dawson AJ, Nicolls R, Bateson D, Doab A, Estoesta J, Brassil A, et al. Medical termination of pregnancy in general practice in Australia: a descriptive-interpretive qualitative study. Reproductive Health. 2017;14(1).
15. Black KI, Bateson D. Medical abortion is fundamental to women's health care. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2017;57(3):245-7.
16. Tomnay JE, Coelli L, Davidson A, Hulme-Chambers A, Orr C, Hocking JS. Providing accessible medical abortion services in a Victorian rural community: A description and audit of service delivery and contraception follow up. Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives. 2018;16:175-80.
17. The Royal Australian and New Zealand College of Obstetricins and Gynaecologists. Abortion. RANZCOG; March 2019.
18. Grayson N. Use of routinely collected national data sets for reporting on induced abortion in Australia. Sullivan EA, Hargreaves J, editors. Sydney: Australian Institute of Health and Welfare, National Perinatal Statistics Unit; 2005.
19. WHO. Safe abortion: technical and policy guidance for health systems – 2nd ed. Geneva; 2012.
20. Robards F, Kang M, Steinbeck K, Hawke C, Jan S, Sanci L, et al. Health care equity and access for marginalised young people: a longitudinal qualitative study exploring health system navigation in Australia. International Journal for Equity in Health. 2019;18(1).
21. Robards F, Kang M, Usherwood T, Sanci L. How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review. Journal of Adolescent Health. 2018;62(4):365-81.
22. The Local (Sweden). More and more abortions completed at home in Sweden: in stats. 22 May 2018.
23. Belton S, McQueen G, Ali E. Impact of legislative change on waiting time for women accessing surgical abortion services in a rural hospital in the Northern Territory. Aust N Z J Obstet Gynaecol. 2020:6.
24. Department of Health. $4.9 million for collaborative health and medical research for all Australians: Australian Government; 2020 [cited 2020 21 April]. Available from: https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/49-million-for-collaborative-health-and-medical-research-for-all-australians.
25. University of Melbourne CoEiRSH. Research, evaluation and knowledge sharing, [updated no date. Available from: https://www.cersh.com.au/resource-hub/.
26. Benson J. Evaluating Abortion-care Programs: Old Challenges, New Directions. Studies in family planning. 2005;36(3):189-202.
27. Dawson A, Bateson D, Estoesta J, Sullivan E. Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia. BMC health services research. 2016;16(1):612.
28. Assifi AR, Sullivan EA, Kang M, Dawson AJ. Adolescent abortion in 11 high-income countries including Australia: towards the establishment of a minimum data set. Aust N Z J Public Health. 2019.

Appendix A Explanatory notes for Table 6

The estimation of the number of medical and surgical abortions by LHD in NSW is as follows:

1. *Low SES* is defined as the percentage of individuals with a weekly income under $600, data source: http://www.healthstats.nsw.gov.au/Indicator/soc_income_age/soc_income_lhn (2016), accessed on 9/1/2020.

2. *Teenage fertility rate* is the number of live births to teenagers per 1,000 teenagers aged 15 to 19, data source: female population aged 15-19 by LHD (2018): http://www.healthstats.nsw.gov.au/Indicator/dem_pop_lhnmap/dem_pop_lhnmap?&topic=Population&topic1=topic_pop&code=dem_pop, live birth to teenagers by LHD (2018): https://www.health.nsw.gov.au/hsnsw/Publications/mothers-and-babies-2018.pdf, accessed on 9/1/2020.

3. *Population by Local Health District* (2020), data source: http://www.healthstats.nsw.gov.au/Indicator/dem_pop_lhnmap/dem_pop_lhnmap?&topic=Population&topic1=topic_pop&code=dem_pop, accessed on 12/3/2020.

4. The estimation of medical abortion number is 3,085 in NSW in 2020. The number of medical abortions was 3,069 in 2019, based on PBS services number (10211K, MS-2Step) statistics, among 1,606,465 women of childbearing age in NSW. The medical abortion rate of NSW in 2019 was then applied to 2020 NSW and LHD populations to get the projected number. Data source: http://medicarestatistics.humanservices.gov.au/statistics/pbs_item.jsp, accessed on 12/3/2020.

5. The estimation of medical abortion numbers by gestation is based on the report "Induced Abortions in Western Australia 2016-2018". The percentage of "Medication only" by gestation was calculated for medical abortions up to 9 weeks, between 10 and 13 weeks, between 14 and 19 weeks, and from 20 weeks gestation, respectively. The percentages were then applied to medical abortion numbers by LHD to project the medical abortion number by gestation in each LHD. Data source: https://ww2.health.wa.gov.au/Reports-and-publications/Reports-on-induced-abortions-in-Western-Australia, accessed on 7/2/2020.

6. It is estimated that 16,860 surgical abortions are performed in NSW in 2020. This estimation is based on the MBS item 35643 in 2018 in NSW/ACT and surgical induced abortion rates in Western Australia in 2018.
   - The Medicare item number 35643 was reported as 18,060 cases for NSW/ACT in 2018.
   - The number of abortion methods except for "Medication only" was reported as 5,239 in Western Australia in 2018 from the report "Induced Abortions in Western Australia 2016-2018", among 546,946 women of childbearing age in Western Australia. The surgical abortion rate was then applied to NSW 2018 women of childbearing age population to get an estimated surgical abortion number of 15,307.
   - An estimated surgical abortion rate of 10.4 per 1000 women of childbearing age was calculated via dividing 16,684 (an average of 18,060 and 15,307) by 1,598,075 NSW women of childbearing age in 2018, and this surgical abortion rate was applied to NSW women of childbearing age in 2020, to get the projected surgical abortion number of 16,860.

   This surgical abortion rate for NSW was then applied to 2020 LHD populations to get the projected number. Data source: https://www.sahealth.sa.gov.au/wps/wcm/connect/5a2705b2-1034-4c1b-8420-095d076a28bf/Pregnancy+Outcome+in+South+Australia+2017+V1+Feb.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-5a2705b2-1034-4c1b-8420-095d076a28bf-n08dPLn https://ww2.health.wa.gov.au/Reports-and-publications/Reports-on-induced-abortions-in-Western-Australia, accessed on 12/3/2020.

7. The estimation of surgical abortion numbers by gestation is based on the report "Induced Abortions in Western Australia 2016-2018". The percentage of all abortion methods except for "Medication only" by gestation was calculated for surgical abortion up to 9 weeks, between 10 and 13 weeks, between 14 and 19 weeks, and from 20 weeks gestation, respectively. The percentages were then applied to surgical abortion numbers by LHD to project the surgical abortion number by gestation in each LHD. Data source: https://ww2.health.wa.gov.au/Reports-and-publications/Reports-on-induced-abortions-in-Western-Australia, accessed on 9/1/2020.

8. Limits: the Medicare item numbers used to process abortions are not exclusively used for abortive procedures; they are also used with procedures used for the treatment of miscarriage and some other gynaecological procedures. Because there are no explanatory notes or subcategories assigned to these item numbers for data collection, there is no way of determining how many of these procedures are terminations.

9. Albury Wodonga Health Authority is included in the total population of NSW, but is not included in LHDs, so the sum of LHDs does not equal the total for NSW.

Appendix B Abortion out-of-pocket costs

Abortion costs at Family Planning NSW for fee-paying clients

Item	Total Fee	Medicare Rebate (if applicable)	Gap Fees
Medical abortion			
Abortion assessment appointment	$25.00	Not applicable	$25.00
Medical abortion appointment	$162.50	$117.50	$45.00
Medications (from local pharmacy) *			
MS-2Step (Medicare eligible)	$40.00		$40.00
Analgesic pack	$9.99		$9.99
Follow up appointment	$98.95	$73.95	$25.00
TOTAL FEES	**$336.44**	**$ 191.45**	**$144.99**
Surgical abortion			
Abortion assessment	$25.00	Not applicable	$25.00
Surgical abortion procedure (includes anaesthetic / sedation)	$730.34	$422.25	$350.00
TOTAL FEES	**$788.25**	**$422.25**	**$375.00**

* Approximate costs only – prices may vary between pharmacies.

Family Planning NSW bulk-billing provisions apply for the following clients accessing abortion services:

- Clients 18 years and under
- Health Care Concession Card holders
- Pensioner Concession Card holders
- Low Income Health Care Card holders
- Full-time students (Recipients of youth allowance; Holder of tertiary student concession card)

Appendix C Abortion Access in NSW Stakeholder Group

Name and position	Organisation
Stakeholder group members	
Adjunct Professor Ann Brassil, CEO Dr Fiona Robards, Senior Policy Officer Jodie Duggan, Director Clinical Operations Clinical Associate Professor Deborah Bateson, Medical Director	Family Planning NSW
Professor Kirsten Black	RANZCOG; The University of Sydney
Denele Crozier, CEO	Women's Health NSW
Jane Gold, Manager	Penrith Women's Health Centre
Faye Worner, CEO	Waminda
Christine Corby OAM, CEO	Walgett Aboriginal Medical Service
	Sydney Local Health District*
	Sydney Local Health District*
	South Eastern Sydney Local Health District*
	Western Sydney Local Health District*
	Western NSW Local Health District*
	Murrumbidgee Local Health District*
Dr Emma Bolton	Clinic 66
Dr Kevin Pedemont	Medical Practitioner
Dr Philip Goldstone, Medical Director	Marie Stopes Australia (NSW)
Dr Sue Brumby	Blue Water Medical
Dr Tuncer Cimenbicer	Contraceptive Services Macquarie St
Paul Nattrass	Private Clinic Devonshire Street
Dr Meaghan Heckenberg	Gynaecology Centres Australia
Dr Catherine Inslee	East Sydney Doctors
Karen Willis, Executive Officer	Rape & Domestic Violence Services Australia
Dr Danielle McMullen, AMA NSW President Ms Andrea Cornish, Senior Policy Advisor	Australian Medical Association
Julie Redway, Chief Operations Officer	Murrumbidgee Primary Health Network
Robyn Quinn, State Chair Kylie Ward, CEO	Australian College of Nursing
Marni Tuala, President of Board	The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
Dr Sama Balasubramanian	Royal Australian College of General Practitioners NSW & ACT
Dr Rod Martin, NSW representative College Council	Australian College of Rural and Remote Medicine
Charles Evill, President	Rural Doctors Association of NSW
Dr Laura Hardaker, Knowledge Mobilisation Manager	NSW Rural Doctors Network
Meeting observers	
Tish Bruce Bayne McKissock	NSW Ministry of Health

* LHD representatives listed in the stakeholder group in the document were not listed as endorsees, given their roles as employees of NSW.