Reproductive Healthcare Inquiry Submission

Australian Longitudinal Study on Women's Health

This submission is made on behalf of the management committee of the Australian Longitudinal Study on Women's Health (ALSWH) that includes both Directors of the study, Professor Gita Mishra (University of Queensland) and Professor Deborah Loxton (University of Newcastle).

ALSWH is a long-established national study that takes a comprehensive view of health, and the factors that affect health, across a woman's lifespan. Since 1996, ALSWH has collected data on over 57,000 women in four age cohorts using regular surveys and individual record linkage to administrative health databases, including Medicare (MBS, PBS), hospitals, and perinatal data. ALSWH provides evidence for the Department of Health and Aged Care to inform policy development and the provision of health services, and to support new and revised clinical guidelines for health professionals. In this submission we present findings from women in the two youngest ALSWH cohorts (spanning ages from 18 to 48) which are highly relevant to this inquiry.

Submission summary

This submission outlines findings from the Australian Longitudinal Study on Women's Health in relation to cost and accessibility of:

- health services;
- contraception; and
- reproductive healthcare.

Recommendations to improve cost and accessibility of health services, contraception and reproductive healthcare are also presented.

Cost and accessibility of health services

- GPs are often the first point of contact and a common source of contraception advice and reproductive healthcare for women. Up to 28% of women in their late twenties (aged 24-30 in 2019-20) and up to 33% of women in their mid forties (aged 40-45 in 2018-19) rated aspects of their experience of visiting their GP as fair or poor [1, 2].

Table 1 Percentage of women rating various aspects of the experience of visiting their GP as fair or poor

Aspect of the experience of visiting their GP	1989-95 Cohort (aged 24-30 in 2019-20)	1973-78 Cohort (aged 40-45 in 2018-19)
Fair or poor access wait time to get an appointment with their GP	14%	32%
Doctor's interest in how they felt about tests, treatment or advice given was fair or poor	21%	12%
Opportunity to ask all the questions they wanted at their most recent GP visit was fair or poor	15%	9%
The cost of their most recent GP visit was fair or poor	20%	28%
Fair or poor access to a GP who bulk bills	24%	33%
Ease of seeing the GP of their choice was fair or poor	28%	33%

- Some women reported inadequate access to other health services that also provide access to contraception and other reproductive health services, including medical specialists, hospitals, and Women's Health Centres or Family Planning Centres [1, 2].

Table 2 Percentage of women rating their access to various health services as fair or poor

Access to health services	1989-95 Cohort (aged 24-30 in 2019-20)	1973-78 Cohort (aged 40-45 in 2018-19)
Fair or poor access to a medical specialist if they need it	18%	14%
Fair or poor access to a hospital if they need it	7%	6%
Fair or poor access to a Women's Health Centre/Family Planning Centre	17%	9%

Cost and accessibility of contraception

- Cost, concern about side effects, poor access to contraception or health services, and not being able to find a suitable method are barriers to accessing contraception. Women in the 1989-95 cohort (aged 24-30 in 2019-20) who did not use contraception reported the reason behind this decision [1, 2]:
  - 13% of women indicated that they were concerned about health or side effects.
  - 6% of women indicated that they could not find a method of contraception that suited them.
  - Less than 2% of women indicated that it was because contraception cost too much.
  - Less than 1% of women indicated it was because they could not get contraception or access a health care service for contraception.
- Side effects affecting physical and mental health, lack of information about contraception, negative experiences with health services, contraceptive failure, and difficulty accessing contraception have all been reported by women as barriers to contraception use [3].
- Higher personal financial resources may improve access to a wider variety of contraception [4].
  - The oral contraceptive pill is one of the most commonly used contraceptive methods in Australia, and therefore one of the most accessible options for women. However, in 2021, we estimated

upwards of 30% of women who reported using an oral contraceptive pill did not have their prescription supplied through the Pharmaceutical Benefits Scheme (PBS).
    - For women born 1989-95 and 1973-78, those women who were supplied an oral contraceptive pill through the PBS were more likely to report difficulty managing on their income when compared to women who were not supplied their oral contraceptive pill through the PBS.
    - This points to women who have higher financial resources having a wider access to a variety of contraception, as they are not reliant on government-subsidised contraception.
- Need for access to contraception changes over time [4].
    - For women born 1973-78, use of contraception changed over time and peaked at age 22-27, with 82% of women (in 2000) using contraception, compared to 70% at age 18-23 (in 1996) and 74% at age 40-45 (in 2018).
    - Contraception use for women born 1989-95 decreased over time from 91% in 2012-13 (aged 18-24) to 79% in 2019-20 (aged 24-30).
- Women are accessing some long-acting reversible contraceptive methods more now than they were in the past, however, the proportion of women using these methods is still relatively low [4]:
    - For women born 1989-95, use of hormonal intrauterine devices increased from 2% in 2012-2013 (aged 18-24) to 13% in 2019-20 (aged 24-30). Implant use remained stable between 2012-13 (aged 18-24) and 2019-20 (aged 24-30), with 10% of women using this method.
    - For women born 1973-78, use of long-acting reversible contraceptive methods increased from 11% in 2009 (aged 31-36) to 25% in 2018 (aged 40-45).
- There are differences in contraception use between women living in major cities and remote areas [4]:
    - In 2019-20, women aged 24-30 living in major cities were more likely to use contraception than women living in remote areas (81% versus 71%).
    - In 2018-19, women aged 40-45 living in major cities were less likely to use contraception than women living in remote areas (73% versus 88%).
- Contraception use, needs and choices need to be supported through culturally appropriate service delivery [4].
    - Women's use of contraception differed depending on the country they were born in, and also the language women spoke at home.

Cost and accessibility of reproductive healthcare

- Some women indicated that they did not have adequate access to cervical screening or maternal and child health services [1, 2]:
    - 10% of women aged 24-30 rated their ease of obtaining cervical screening as fair or poor, and 13% of women did not know about their access to cervical screening.
    - 7% of women aged 40-45 reported that their ease of obtaining cervical screening was fair or poor.
    - 5% of women aged 40-45 reported that their access to maternal and child health services was fair or poor.
- Domestic violence in the form of pregnancy termination coercion and control is a barrier to access to reproductive healthcare for some women.
    - 3% of women born 1973-78 reported that a current or past partner had pressured, threatened or forced them to terminate a pregnancy (preliminary data).
- The prevalence of experiences of violence demonstrates the need for trauma-informed care for all women.
    - We know that over half of women born 1989-95 have already experienced sexual violence [5].
    - Trauma-informed care is essential to ensure women who have had these experiences access health services. Trauma-informed care is needed for all women, as experiences of violence are so common, all women should be treated under a trauma-informed model.

Recommendations

- ALSWH data indicate that workforce development is needed to:
  - Increase GP knowledge of long-acting reversible contraceptive methods.
  - Develop a decision-making guide for GPs to use to support women through the contraception decision-making process to ensure their needs are met.
  - Train health care workers on culturally appropriate service delivery. Any decision making / education needs to be adapted for each culture, not just one approach for all women.
  - Train GPs on the impacts of experiences of violence and how to offer trauma-informed care.
- ALSWH data show a number of issues accessing services and particularly contraception. Improving access to contraception is recommended:
  - Contraception could be fully covered under PBS, rather than just subsidised.
  - Appointments to get scripts for contraception could automatically be bulk billed, with online and telehealth consultations covered (without a need to attend in person).
  - A wider range of contraceptive methods could be covered under PBS.
- Health literacy and education for women:
  - Accessibility of particular contraceptive methods, such as long-acting reversible contraceptives, would be increased with improved awareness and understanding of the variety of methods of contraception.
  - Education on how to access to Women's Health Centres and Family Planning Centres could increase access to contraception and reproductive health services.
- Evidence is needed to identify the best practice approaches for women's healthcare, inclusive of sexual and reproductive healthcare. ALSWH data clearly show that contraception needs and use change over time, underscoring the need for continued data capture of these changes.
- Changes in service and contraception uptake in relation to policy changes can be monitored using ALSWH data linked with MBS and health services data. Use of data at the individual level, rather than the service level can facilitate a deeper understanding of the drivers of service and contraception use.

References

1. Australian Longitudinal Study on Women's Health. *Data book for the 1989-95 cohort* https://alswh.org.au/for-data-users/data-documentation/data-books/

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3. Suzanne C. Dixon, Danielle L. Herbert, Deborah Loxton & Jayne C. Lucke (2014) *'As many options as there are, there are just not enough for me': Contraceptive use and barriers to access among Australian women*, The European Journal of Contraception & Reproductive Health Care, 19:5, 340-351, DOI: 10.3109/13625187.2014.919380

4. Loxton D, Byles J, Tooth L, Barnes I, Byrnes E, Cavenagh D, Chung H-F, Egan N, Forder P, Harris M, Hockey R, Moss K, Townsend N & Mishra GD. *Reproductive health: Contraception, conception, and change of life – Findings from the Australian Longitudinal Study on Women's Health*. Report prepared for the Australian Government Department of Health, May 2021.

5. Townsend, N., Loxton, D., Egan, N., Barnes, I., Byrnes, E., & Forder, P. (2022). *A life course approach to determining the prevalence and impact of sexual violence in Australia: Findings from the Australian Longitudinal Study on Women's Health* (Research report 14/2022). ANROWS.