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Utilising HealthPathways to understand the availability of public abortion in Australia

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ABSTRACT

Background. Access to publicly funded abortion in Australia is limited, with a considerable proportion carried out by private providers. There are no nationally reported data on public abortion services, and referral pathways are poorly coordinated between hospital and primary care sectors. HealthPathways is an online system for use in primary care that provides information on referral pathways to local services. The aim of this study was to describe abortion referral pathways for each HealthPathways portal in Australia. **Methods.** A review of Australian HealthPathways content on abortion was undertaken between January and June 2022. For each HealthPathways portal, data were extracted on referral options to abortion services. **Results.** Overall, 17 out of 34 Australian HealthPathways consented to be included. Nearly half (47%) had no public services listed for surgical abortion, and 35% had no public services for medical abortion. The majority (64% for surgical abortion, 67% for medical abortion) emphasised that public services should be considered only as a last resort. There was variation in information regarding gestation-specific options, the time-critical nature of referrals, and the importance of women's own preference when deciding between medical or surgical abortion. **Conclusion.** Despite few remaining legal restrictions to abortion, many regions across Australia either do not have public abortion services or do not provide information about them. There is an urgent need for transparency around public abortion service availability, clear guidelines to support referral pathways, and commitment from State and Federal governments to expand the availability of accessible, no-cost abortion in Australia.

Keywords: Australia, availability, health service access, HealthPathways, induced abortion, primary care, public services, referral, reproductive services.

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Introduction

Equitable access to abortion is a fundamental reproductive right and a key objective of the National Women's Health Strategy 2020–30 (Department of Health 2018). Although historically surgical abortion (surgical termination of pregnancy; STOP) has been the main approach to abortion care in Australia, medical abortion (medical termination of pregnancy; MTOP), using oral mifepristone and misoprostol, was made available on the Pharmaceutical Benefits Scheme in 2012 for use up to 9 weeks' gestation (Pharmaceutical Benefits Scheme 2022). However, access to these services remains highly inequitable in Australia; both limited availability and inconsistent access disproportionately impact young women, women living rurally, women on a low income and/or Aboriginal or Torres Strait Islander women (Nickson *et al.* 2006; Doran and Hornibrook 2014; Shankar *et al.* 2017).

General practitioners (GPs) are the first point of healthcare contact for most Australians (Australian Institute of Health and Welfare 2020). Primary care services provided by GPs are reimbursed through Medicare, Australia's federally funded public health insurance system. In order to access specialist services at public hospitals, patients must first receive a referral from their GP. Given that only about 10% of GPs in Australia are currently registered prescribers of medical abortion medications (MS Health 2021), the

majority will refer a patient to seek abortion services outside of their primary care practice. As such, GPs require up-to-date and comprehensive information to support a patient's decision-making and chosen care pathway for their pregnancy. Despite this need, there is currently no transparent, coordinated referral system comparable to those found in the United Kingdom (Glasier and Thong 1991; Rowlands 2006), and there is no nationally reported data on the number and location of publicly funded abortion services (Grayson *et al.* 2005). Furthermore, there is no prior literature around methods used by healthcare providers to consult or refer for abortion care in Australia.

HealthPathways is one of the few resources available to GPs and other primary care providers to assist with making appropriate referrals to local services in alignment with evidence-based practice. HealthPathways is an online health information system that outlines recommended management of common conditions and local referral options, usually to hospital services (Canterbury District Health Board 2022) (Box 1). For example, in the context of unintended pregnancy, a GP may access a HealthPathways page to review which pathology tests are recommended at the time of presentation, and to which services they may refer their patient for pregnancy options, counselling or surgical abortion. There are currently 34 HealthPathways portals in Australia, and most correspond with a Primary Health Network region (Canterbury District Health Board 2022). Australian studies show that practitioner utilisation and engagement with HealthPathways is increasing, particularly with early career practitioners and trainees who report using HealthPathways to improve their knowledge of local services (Gill *et al.* 2019; Lind *et al.* 2020). Furthermore, HealthPathways has been shown to play an important role in supporting GPs to access rapidly changing guidelines in times of natural disaster or global pandemic (Schluter *et al.* 2016; Nankervis *et al.* 2020). Despite its increasing relevance in primary care, HealthPathways has not previously been evaluated to understand abortion referral pathways and service availability. Therefore, in order to understand public availability of abortion services across Australia, the aim of this study was to describe referral pathways for abortion services available on each HealthPathway in Australia.

Methods

A review of Australian HealthPathways content regarding abortion was undertaken between January and June 2022. This timeframe was selected to capture recent data over a 6-month period. Permission was sought from all HealthPathways teams to access their online portal for the purpose of conducting this study. Each consenting HealthPathways portal was deidentified and coded to maintain anonymity (e.g. HP1, HP2). A member of the research team accessed each HealthPathways portal to populate a data collection spreadsheet. Search terms including 'abortion', 'termination of pregnancy' and 'unplanned pregnancy' were used to access relevant pages. For each HealthPathway, data were extracted regarding recommended assessment, management and referral options for abortion care.

The following information was recorded on the data collection spreadsheet from each HealthPathway: public, private or GP services for medical and surgical abortion; gestation-specific information; the role of women's own preference when deciding between medical or surgical abortion; the urgency of referral; presence of inclusion or exclusion criteria; and additional restrictions or warnings around access to public services. Public services were defined as public hospitals or local health network services such as government-funded community clinics. Private options were defined as private hospitals, private clinics or non-governmental organisations such as Marie Stopes International and the Tabbot Foundation. GP provider options were defined as named GPs who accepted referrals from other GPs for medical abortion.

Ethics approval

No formal ethics approval was required for this study as no personal, primary, or confidential data were collected.

Results

Of the 34 HealthPathways, 17 consented to be included, representing all states and territories except for South

Box 1. Overview of HealthPathways

HealthPathways was developed in Canterbury, New Zealand, and has been available in Australia since 2012. Each HealthPathway is linked to a Primary Health Network, and outlines a course of clinical assessment, management and referral to secondary or tertiary care based on local resources and services (Lind *et al.* 2020). Content for HealthPathways is created through collaboration between regional hospital specialists and primary care practitioners (Robinson *et al.* 2014), and many hospital websites publish links directly to HealthPathways so that GPs can view referral guidelines to access hospital services. Therefore, HealthPathways can be considered a recommended approach determined by local hospitals and a de facto roadmap for which services are available and where they are located.

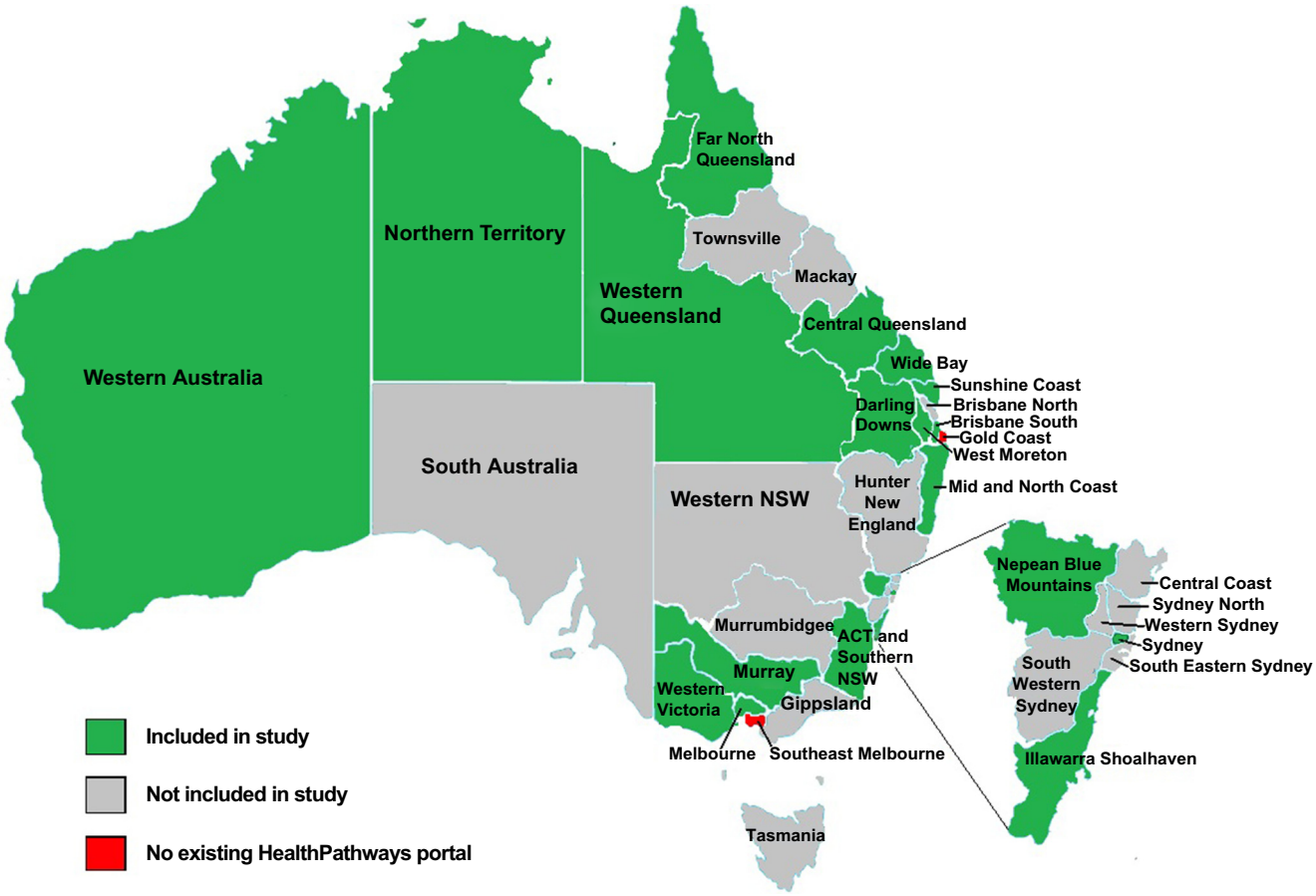

Fig. 1. Geographical distribution of HealthPathways portals included in this study.

Australia and Tasmania (Fig. 1). The majority (16 of 17) of HealthPathways had a dedicated page titled 'Termination of Pregnancy', and one (HP6) had a page titled 'Unplanned Pregnancy', with information about background, assessment, management and referral for abortion included on the portal. 'Medical termination of pregnancy (MTOP)' and 'Surgical termination of pregnancy (STOP)' were the terms used on all HealthPathways pages.

Assessment and management

All (17/17) HealthPathways included information about medical and surgical options. All (17/17) HealthPathways indicated that medical abortion was available up to 9 weeks or 63 days gestation. No HealthPathways portal had separate pages for particular gestations (e.g. termination of pregnancy <9 weeks). Only two HealthPathways (HP1, HP2) had tables indicating the appropriateness of method (medical or surgical) depending on the gestational age of the pregnancy, and 4/17 HealthPathways (HP7, HP10, HP11, HP16) referred to service-specific gestational limits for surgical abortion. Four HealthPathways (HP1, HP14, HP16, HP17) specifically referenced the importance of women's own preference when deciding between medical or surgical abortion, and 10/17 HealthPathways emphasised the urgency of the referral or made reference to the 'time-critical' nature of the assessment, management and referral.

Referral pathways for medical abortion

Most (65%; 11/17)) of HealthPathways listed public referral options for medical abortion such as public hospitals and publicly funded community clinics with no or minimal out-of-pocket cost associated with the service. Of these, three (27%; 3/11) public service pathways displayed inclusion and/or exclusion criteria for referrals, such as 'medical or obstetrically complex patients only', or exclusions for 'patients permanently residing out of the local area' (Table 1). Seven (64%; 7/11) indicated that the public services were likely to be very difficult to access, including warnings such as 'does not provide routine TOP service'; 'limited TOP service, consider private providers before contacting public service' (Table 2). Two (12%; 2/17)) had no public, private or GP provider options listed for referral at all. In contrast, three-quarters (76%; 13/17) of HealthPathways listed private referral options for medical abortion. Private options

Table 1. Referral options for medical abortion.

	Public			Private	GP
	Any listed	Inclusion/Exclusion criteria	Difficult access warning		
HP1	Y	–	–	Y	N
HP2	Y	–	'Does not provide routine TOP service'	Y	Y
HP3	N	–	–	Y	Y
HP4	Y	–	–	Y	N
HP5	N	–	–	Y	N
HP6	N	–	–	Y	N
HP7	Y	Inclusion: medical or obstetrically complex patients only.	'Limited number of appointments available on case-by-case basis'	Y	Y
HP8	Y	Exclusion: patients permanently residing outside of local area.	'Limited TOP service. Consider private providers before contacting public service'	Y	Y
HP9	Y	Exclusion: patients permanently residing outside of local area.	–	Y	Y
HP10	Y	–	'Limited appointments . . . for women with complex health needs and no ability to have a termination in the private sector.'	Y	N
HP11	Y	–	–	Y	Y
HP12	N	–	–	N	N
HP13	Y	–	'Limited appointments . . . for women with complex health needs and no ability to have a termination in the private sector.'	N	N
HP14	N	–	–	Y	Y
HP15	Y	–	'Referrals should be made to suitable community-based services. A referral to a health service may be required if there is no suitable community-based service available.'	Y	Y
HP16	Y	–	'Referrals should be made to suitable community-based services. A referral to a health service may be required if there is no suitable community-based service available.'	N	Y
HP17	N	–	–	N	N
Total (yes, included)	11/17	3/11	7/11	13/17	9/17
% (yes, included)	65%	27%	64%	76%	53%

Y, yes; N, no.

included non-governmental organisations and local private gynaecologists. Half (53%; 9/17) of HealthPathways had GP provider referral options listed for medical abortion. Throughout HealthPathways, GP providers were variably listed in both private and public options. There was no reference made to particular GP providers who offer a no-cost service.

Referral pathways for surgical abortion

Half (53%; 9/17) of HealthPathways had public referral options for surgical abortion. Of these, four (44%; 4/9) displayed restrictive inclusion and/or exclusion criteria for referrals, such as 'fetal abnormality or FDIU [fetal death *in utero*] only'. Two-thirds (67%, 6/9) contained additional warnings around difficult access to public services, such as 'limited appointments for women with complex health needs and no ability to have a termination in the private sector'; 'referral to a health service may be required if there is no suitable community-based service available' (Table 2). Just over half (59%; 10/17) listed private options, which included non-governmental organisations and private gynaecologists. Three (18%; 3/17)) did not have any private or public options listed.

Discussion

Our study found that nearly half of the included HealthPathways had no publicly funded services for surgical abortion, and one-third had no public medical abortion services. Approximately two-thirds of available public

Table 2. Referral options for surgical abortion.

	Public			Private
	Any listed	Inclusion/Exclusion criteria	Difficult access warning	
HP1	Y	–	–	N
HP2	Y	Inclusion: fetal abnormality or FDIU (fetal death *in utero*) only	'Does not provide routine TOP service'	Y
HP3	N	–	–	Y
HP4	N	–	–	Y
HP5	N	–	–	Y
HP6	N	–	–	Y
HP7	Y	Inclusion: medical or obstetrically complex patients only.	'Limited number of appointments available on case-by-case basis'	N
HP8	Y	Exclusion: patients permanently residing outside of local area.	'Limited TOP service. Consider private providers before contacting public service'	Y
HP9	N	–	–	N
HP10	N	–		N
HP11	Y	–	–	Y
HP12	N	–	–	N
HP13	Y	–	'Limited appointments... for women with complex health needs and no ability to have a termination in the private sector.'	N
HP14	N	–	–	Y
HP15	Y	–	'Referrals should be made to suitable community-based services. A referral to a health service may be required if there is no suitable community-based service available.'	Y
HP16	Y	Exclusion: STOP <13 weeks 6 days gestation only.	'Referrals should be made to suitable community-based services. A referral to a health service may be required if there is no suitable community-based service available.'	N
HP17	Y	–	–	Y
Total (yes, included)	9/17	4/9	6/9	10/17
% (yes, included)	53%	44%	67%	59%

Y, yes; N, no.

services listed additional warnings around accessibility, suggesting that public services should be considered only as a last resort. Our study also highlighted considerable variation between HealthPathways regarding the way information was presented in terms of gestation-specific options, the time-critical nature of referrals and the importance of women's preference in choosing between medical and surgical abortion. This suggests a lack of consistency in recommendations for referral across different regions of Australia. These findings emphasise the stark reality of public abortion access for GPs and their patients in practice, and are aligned with previous studies demonstrating large regions lacking in abortion services across Australia (Dawson *et al.* 2016; Shankar *et al.* 2017; Subasinghe *et al.* 2021*a*). Despite GPs being the first point of healthcare contact for most Australian women (Australian Institute of Health and Welfare 2020) and the target-users of HealthPathways, our study suggests that there is currently inadequate information to support GPs in referring women to abortion services when they need them. A range of factors likely contribute to the current situation in Australia, as we discuss below.

Although certain States and Territories in Australia have published evidence-based guidelines around abortion care (Women's Health Strategy 2019; Queensland Clinical Guidelines 2020), currently no national guidelines exist. A systematic review of quality abortion care indicators has highlighted the importance of national guidelines to support healthcare facilities in delivering services in accordance with the World Health Organization technical guidance document (Dennis *et al.* 2017). In the UK, the National Institute for Health and Care Excellence (NICE) provides guidance to the National Health Service (NHS) with the aim of

improving service organisation and accessibility for women (National Institute for Health and Care Excellence 2019). Key recommendations include making information about the number and location of abortion services widely available, providing abortion services across a range of settings to meet local population needs, and maximising workforce capability for healthcare providers across all stages of professional training. The current lack of nationally endorsed guidelines around quality abortion service provision in Australia is likely to be a significant barrier to accessible abortion.

Inadequate funding is another possible explanation for the limited public abortion services in Australia. Although cost is a known barrier to women's access to abortion in Australia (Nickson *et al.* 2006; Doran and Hornibrook 2014; Shankar *et al.* 2017), most public services in this study had messaging to direct referrers away from their services and towards private providers. This is in contrast to the United Kingdom, where 99% of abortions are funded by the NHS across both hospital and independent sectors (Office for Health Improvement and Disparities 2022). In Ireland, approximately 50% of public hospitals provide surgical abortions just 2 years after legislative reforms have made way for free, safe and legal abortion on request of the woman, despite the lack of public health insurance system (National Women's Council of Ireland 2021). In order to expand access to abortion beyond what hospitals currently provide, the Medicare system should adequately reimburse the cost of abortion to all Australian women who require the service.

Finally, there is limited transparency as to whether abortion services will be provided by a health service and under what circumstances they will be accessible to women who request them. Clear referral pathways for abortion services are particularly crucial in rural and regional areas of Australia. It is well known that women in rural and regional areas face greater barriers to access (Nickson *et al.* 2006; Shankar *et al.* 2017), and experience significant distress when they are unable to get adequate information about abortion from their GP (Doran and Hornibrook 2014). Clear referral pathways are essential in the case of conscientious objection; in some Australian jurisdictions, GPs who hold religious or moral personal objections to abortion are required by law to refer to another practitioner (Victoria 2008; Northern Territory 2017). Medical workforce shortages (Swami and Scott 2021) and high proportions of overseas-trained doctors in rural areas (Mason 2013) may result in a primary care workforce with limited background knowledge of management of pregnancy options in the Australian context (Keogh *et al.* 2019). In order to achieve equity in access across Australia, standardised national referral pathways for public abortion are essential to ensure best-practice abortion care in the primary care sector.

In this study, only half of HealthPathways portals had GP provider referral options listed for medical abortion. There is potential for primary care provision of medical abortion to enhance abortion access in Australia through GP-to-GP referrals, thus avoiding hospital services altogether. Primary care provision of medical abortion by GPs has been shown to be acceptable to women in international studies (Summit *et al.* 2016). Medical abortion medication has been approved for use in Australia by the Therapeutic Goods Administration since 2012, and theoretically, GP provision of medical abortion should widely expand availability and accessibility for women by allowing local access. However, in practice, only approximately 10% of GPs in Australia are currently registered medical abortion prescribers (MS Health 2021). Current barriers to GP provision include viewing medical abortion as beyond their scope of practice, religious or moral objections, and logistical or practical challenges (Dawson *et al.* 2017; Subasinghe *et al.* 2021*b*). Increasing primary care workforce support, capacity and training in the provision of medical abortion should be a focus of future policy change and ongoing research.

There are several limitations to this study. Only 17 of 34 HealthPathways consented to participate in the study, with no representation from South Australia and Tasmania. These omissions may be particularly relevant given recent legislative and policy changes in both states resulting in the development of new referral pathways for abortion services (Department of Health, Tasmanian Government 2022; Government of South Australia, South Australia Health 2022). In light of these changes, the data in this study may under-represent abortion services and referral pathways that may be currently in development. Additionally, the contents included on HealthPathways are continually updated; therefore, the data presented in this study are only accurate for the timeframe of the search. Finally, it is unclear how closely services listed on HealthPathways reflect actual service availability on the ground. In some regions, there may be additional public and private referral options available that are not listed on HealthPathways.

Conclusion

Despite few remaining legal restrictions to abortion services in Australia and a universal public healthcare system, many regions across Australia either do not have public abortion services or do not have information available to GPs about how to access these services. Limited public provision means that women will continue to experience barriers to abortion access. A truly equitable and accessible abortion service in Australia will require regional-level planning with commitment from State and Federal governments towards their funding and implementation. The time-sensitive nature of abortions necessitates clear referral pathways to support the care of women seeking this service. National collection and reporting on abortion data is also essential for maintaining transparency and accountability within health systems, and

nationally endorsed guidelines are required to support the expansion of abortion services across the public sector. Finally, increasing primary care workforce capacity and training in the provision of medical abortion should be a focus of future research and policy efforts.

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