Out-of-pocket costs in Australian healthcare

Children by Choice Submission to the Community Affairs References committee

May 2014

CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

40 Years • 200,000 Women • Still Supporting Choice

About Children by Choice

Children by Choice provides counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting. We provide a Queensland-wide counselling, information and referral service to women experiencing unplanned pregnancy, deliver sexual and reproductive health education sessions in schools, and offer training for GPs and other health and community professionals on unplanned pregnancy options. We also advocate for improvements to law and policy that would increase women's access to reproductive health services.

Children by Choice supports women's access to all options with an unplanned pregnancy, including abortion, and have been involved in helping women access these options since the service began operation in 1972. Children by Choice is the only stand-alone pro-choice women's service dedicated to unplanned pregnancy in Australia. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to access to reproductive health services with regard to unplanned pregnancy.

In 2012-13 we received a total of 2937 client contacts, ranging in age from under 14 to over 50.

About this submission

This submission will examine issues relating to the out-of-pocket healthcare costs relating to sexual and reproductive health in Australia, with particular reference to contraceptive and pregnancy termination services.

The provision of all options unplanned pregnancy counselling and support services is the core business of Children by Choice. Since 2000, an ever-increasing part of this service delivery has been the provision of financial assistance to help disadvantaged women in Queensland access abortion. This part of our service delivery is the subject of this submission.

The high costs of accessing these services in some parts of Australia creates an inequitable system considerably impacting on some consumers' ability to access these services easily, and in some cases at all. The results of this include high flow on costs to other parts of the health system as well as other sectors of government services and spending.

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Why out-of-pocket healthcare costs impact significantly on reproductive health services

Despite the estimate that one in three Australian women will choose to terminate a pregnancy at least once during their lifetime, abortion remains the subject of criminal law in most states and territories:

> **Queensland & New South Wales:** Abortion a crime for women and doctors. Legal when doctor believes a woman's physical and/or mental health is in serious danger. In NSW social, economic and medical factors may be taken into account.
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> **Australian Capital Territory:** Legal, must be provided by medical doctor.
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> **Victoria:** Legal to 24 weeks. Legal post-24 weeks with two doctors' approval.
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> **South Australia:** Legal if two doctors agree that a woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Unlawful abortion a crime.
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> **Tasmania:** Legal to 16 weeks on request, and after that point with the approval of two doctors.
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> **Western Australia:** Legal up to 20 weeks, some restrictions particularly for under 16s. Very restricted after 20 weeks.
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> **Northern Territory:** Legal to 14 weeks if 2 doctors agree that woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Up to 23 weeks in an emergency.

This disparity in state based law causes large inequities in access to termination services. In South Australia, over 95% of terminations are provided through public hospitals (http://www.sahealth.sa.gov.au/wps/wcm/connect/71a4600041ffdcb9957dbdf8b1e08c6d/13103.1-Pregnancy+Outcomes+Report-FINAL.pdf?MOD=AJPERES&CACHEID=71a4600041ffdcb9957dbdf8b1e08c6d) , while in 2010 Queensland Health estimated that only around one percent of all terminations were performed in public hospitals. Other states have varying levels of public access, and availability of services is also affected by whether women live in metropolitan or regional areas. In addition, some public hospitals across Australia are run by Catholic Health Australia, with government funding. Although these hospitals are part of the public system, they are subject to Catholic Health Australia's Code of Ethics, which stipulates that:

- Patients are not to be provided with abortion services in any circumstance, nor a referral to another service that may provide them with abortion services;
- Patients are not to be provided with contraceptive advice or prescription, even in cases of sexual assault. Women presenting after sexual assault are not only denied immediate access to emergency contraception; the Guidelines explicitly forbid the provision of information about emergency contraception or a referral to a service

which may provide the patient with emergency contraception outside the hospital premises, until 'the likelihood of pregnancy has been excluded'.

Termination access through the public system is therefore somewhat of a postcode lottery, making private termination providers the only option for many women. Procedures offered through private clinics or day surgeries have out-of-pocket costs attached, and these costs have risen sharply over recent years.

The current and future trends of out-of-pocket expenditure in relation to reproductive health services

The cost of surgical termination procedures has more than quadrupled in Queensland since 2000. Then, a termination prior to 11 weeks gestation, provided in Brisbane, had an out-of-pocket cost of $120. Now, costs for the same procedure start at around $500. Prices rise after 11 weeks gestation, and are higher again in regional clinics, and can reach as high as $3800 out-of-pocket for women with access to Medicare, depending on gestation and location. Increasing numbers of women experience financial difficulties in raising the fee for a pregnancy termination.

The Children by Choice Women's Access Fund was started in 2000 in response to growing client demand for financial assistance regarding abortion access, and provided $2970 over a 12 month period for facilitating access to termination. Since the Fund was set up the amount of assistance we provide has skyrocketed as clinic prices have increased, the public system remains largely unresponsive, and the rising cost of living impacts significantly on women's financial stability.

This resulted in the provision of $49,823 in 2011-12 in direct financial assistance for access to abortion for women in Queensland. In the six months from July to December 2012, we provided another $21,857. These funds came from specific purpose grants and small individual donations. This grant funding has been expended and an application for its renewal was unsuccessful. Any funds we are now able to give to assist women to access terminations are donated by a small group of committed individual supporters; however, the demand continues to increase.

In August 2013, it was announced that mifepristone (also known as RU486) would be listed on the pharmaceutical benefits scheme for use in early medical abortion. It was hoped that this listing, combined the with Therapeutic Goods Administration's decision to licence the drug for prescription by GPs, would increase the availability and affordability of early medication abortion. However, the PBS listing has had little to no impact on the cost of medication abortion provided through private clinics, which has a higher out-of-pocket cost than early surgical termination through the same providers; and no public list of GPs prescribing mifepristone is available.

Almost half of contacts to the Children by Choice counselling and information service in 2012-13 identified the cost of abortion as a barrier, and around 39 per cent related to financial assistance to pay for a termination.

Women requesting financial assistance report three main issues impacting on their ability to access an abortion:

- The extreme difficulty in accessing a termination through the Queensland public health system;
- The high out-of-pocket costs of abortion procedures in private clinics and the inflexibility of providers in negotiating payments;
- High costs associated with travelling to access a procedure for women in rural and regional areas of the state.

These three issues are the same top three as reported by clients requesting financial assistance when the Fund began in 2000.

The impact of out-of-pocket costs on women's ability to access reproductive healthcare

Some populations experience higher risk of poor reproductive health outcomes, including Indigenous women, women from non-English speaking backgrounds, regional and remote women, younger women, and women experiencing violence. The risks are exacerbated for these groups by the high out-of-pocket costs of reproductive health services in Queensland.

Compared to our broader client base, women who received financial assistance from us in 2012 were:

- More likely to report domestic and/or sexual violence;
- More likely to identify as Aboriginal or Torres Strait Islander;
- More likely to report mental health issues;
- More likely to be parents; and
- Less likely to receive any support from the man involved in their pregnancy.

Women experiencing domestic or sexual violence

Children by Choice speak regularly to pregnant women who report sexual and/or domestic violence who are unable to afford a privately provided abortion but have been turned away from public hospitals.

> *Case study 1:*
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> *N was a refugee who was diagnosed with a pregnancy at a Catholic public hospital. She disclosed to the hospital social worker that she had been sexually assaulted by a friend of her family; she was 13 at the time of the assault and had turned 14 only a week before her presentation at the hospital. N had been a virgin before the assault and the social worker was concerned she was suffering from post-traumatic stress from her refugee experiences, now compounded by the sexual assault. The hospital had refused to offer a termination or refer her to any facility that may have provided one for her. The social worker was extremely distressed at the hospital's treatment of her patient and called us to help facilitate access to*

a privately provided termination. Funds were provided to the patient from Children by Choice and other community organisations in order to pay for this procedure.

Case study 2:

V, 31, suffers from Multiple Sclerosis and cataracts in both eyes, and was steadily losing her sight as these worsened. When we were contacted by a social worker on her behalf in late 2010, she was six weeks pregnant after being sexually assaulted by her carer. She was booked in for cataract surgery in two weeks time at her local public hospital to restore some of her sight, which was steadily deteriorating, when they informed her the surgery could not proceed if she was pregnant. The same hospital where she was receiving treatment for both her MS (which was worsening due to the pregnancy) and her cataracts, refused to provide a termination, despite a strong referral from V's GP and the fact she was a sexual assault victim, had a disability, and was at risk of losing her sight if she had to postpone her cataract surgery. Children by Choice helped V negotiate a significant price reduction with her closest clinic and paid for the remainder of the procedure cost through the Women's Access Fund.

The failure of the health system to provide adequate and appropriate care in terms of abortion provision is reflected in the system's lack of comprehensive preventative care for women presenting at emergency after confirmed or suspected cases of sexual assault.

Case study 3:

B presented to Children by Choice seeking financial assistance to terminate an eight week pregnancy. She had no recollection of the sex which led to the pregnancy: she had been at a friend's house one night and had woken up in hospital with no memory of how she got there. Hospital staff told her she had been dropped off there the night before, and appeared to have been drugged. B started vomiting after she woke up, and they advised her to stay in hospital a few more hours. In that time nobody came to see her or to speak with her. When she stopped vomiting she left the hospital. When she called us B said that she had not spoken to anyone about this before, and didn't know if she had been screened for STIs at the hospital. They had not advised her to get checked or suggested she seek support of any kind.

For women experiencing domestic violence, further hurdles may be encountered by the failure of some DV support services to provide assistance around abortion access.

Case study 4:

G, aged 31, lived in a regional centre and was into her second trimester when she discovered the pregnancy. Her decision to end the pregnancy hinged on the extreme violence she had experienced the hands of the man involved and a desire to cut all ties with him for the sake of her safety and that of her other children. The out of pocket costs for the procedure and associated travel amounted to approximately $3000. Although she was already accessing a domestic violence support service in her local town, and that service had brokerage funds available for client support, the service decided to ask their funding body, the Queensland Department of Communities, for permission to use this brokerage to assist their client to access a pregnancy termination. The Department denied permission as the procedure was 'illegal'. Children by Choice counsellors provided both a donation and a no interest loan from

our service as well as significant staff time in advocacy to other services and clinics, in order to assist this woman access a termination and cut ties with her perpetrator.

Women in rural, regional or remote areas

There are only ten private clinics in Queensland providing termination services, with seven of these being in the southeast corner and the remaining three situated along the east coast. No public list of GPs providing medication abortion is available, and publicly provided terminations are virtually non-existent in regional and rural hospitals. Consequently, many women face significant additional travel, accommodation and childcare costs on top of out-of-pocket procedural costs in order to access termination services.

Case study 5:

C was 42 with four adult children and using injectible contraceptive when she fell pregnant. Living in Longreach, she learned her closest abortion providers were in Townsville and Rockhampton, a drive of at least seven hours and around 700km each way. On top of travel costs, the procedure itself would cost over $550. C had no money available to her, being dependent on Centrelink payments and also supporting some members of her family. In addition to the financial stress, there was a time restriction – the clinic closest to her was only operating one day per fortnight, flying a doctor in from Brisbane to perform these procedures. The next operating day was four days from when C contacted us. If she couldn't raise the money in time, she would have to wait another fortnight – and pay a further $100, as the pregnancy would be further advanced. A local health service managed to arrange her transport from Longreach to the clinic and her accommodation while there, at no cost to C. Even with this covered, the concerted efforts by Children by Choice and several other services to provide financial assistance with the termination itself still were not sufficient to raise the necessary funds, and C was faced with a gap of $170 and a day to find it. In desperation we contacted some individual donors who had previously provided money for abortion access. Thankfully, the $170 was forthcoming – with C and the workers involved intensely relieved but also aware that but for the generosity of one supportive person, she would have been faced with the prospect of continuing with the pregnancy.

Case study 6:

S was in her early twenties, using two forms of contraception, and in a long-term relationship with a very supportive partner when she found she was pregnant. She had contacted her nearest clinic 4 ½ hours away and found out the cost of accessing a surgical termination. With the support of her partner she was able to cover the cost of the procedure as he was going to cover the cost of their bills for the week. However, the couple could not cover the cost of the petrol to drive to the clinic and back which they believed would be around $150. She explained that they were having to do the journey and back in one day as they could only afford for him to miss one day of work. We provided her with the cost of the travel through our Women's Access Fund.

Women with high-risk pregnancies

Women with serious health risks, often already facing financial instability due to ongoing healthcare costs relating to existing conditions, can experience further financial hardship due to the lack of publicly provided procedures.

Case study 7:

R, aged 26, sought our assistance to terminate her fourth pregnancy in late 2012. Along with financial pressures and the struggle to parent three quite young children on her own, she had also been diagnosed with pulmonary embolism – blood clots in her lung – as a result of the pregnancy. She'd experienced this in her previous pregnancy and it required careful medical management including travel to a specialist hospital prior to the birth of her child. R obtained a letter of referral from her GP recommending termination on the grounds that the embolism posed a significant threat to her health and was potentially life-threatening, her local hospital dismissed her request for a termination without considered clinical assessment or referral. Only through a small grant from us and withholding a week's rent could she find the required $400 dollars for a private clinic procedure, worsening her already precarious financial situation.

Women with no access to Medicare

Women studying or holidaying in Australia, or those living in the community on Temporary Protection Visas or awaiting a decision on their visa status, often have no access to Medicare and therefore face very high out-of-pocket costs for reproductive healthcare. Terminations provided through private clinics have out-of-pocket costs of $850 - $4500 for non-Medicare Card holders, depending on gestation and location, and public hospitals charge a fee even if they deem a woman eligible for a service.

Case study 8:

K is a 13 year old whose family is in Australia temporarily. She was raped by her older sister's boyfriend and is now 8 weeks pregnant. Queensland Health licencing restrictions on private abortion clinics prevent them operating on under 14s without a pediatric licence, which only one clinic in Queensland holds. She is severely underweight and therefore needs to be operated on in a hospital environment. Her nearest public hospital have assessed her and decided that although she fits the criteria for a lawfully provided procedure, as her family has no access to Medicare there will be an upfront, out-of-pocket cost of $2400. A sexual assault support service has agreed to provide some financial support for K to help her access this service but are not able to contribute the entire cost of the procedure. An urgent appeal to Children by Choice donors is the only way K will be able to access a termination.

The inadequacy of Medicare coverage of medication termination of pregnancy

Despite the fact that mifepristone is listed on the PBS for use in early medication termination of pregnancy, significant out-of-pocket costs remain a barrier for women wishing to access this service. As well as the subsided cost of the medication itself (if a GP can be found to provide it), are the costs associated with GP visits, including followup to ensure the termination was complete and there is no risk of infection, and ultrasounds and other diagnostic tests. With no Medicare item number covering the provision of medication abortion, most women accessing this option in Queensland still face upfront costs of over $350, not including the cost of the medication itself. Although a Medicare rebate for the consultation is available, some women choose not to access this due to privacy concerns and fear of judgement.

What happens when women are unable to access termination procedures?

International evidence is conclusive: when women can't access safe and legal abortion services they seek out unsafe or untried abortion methods, or attempt to induce a miscarriage themselves [source].

In the first quarter of 2014, Children by Choice has had contacts from or in relation to seven self-abortion attempts. We remain extremely concerned that women are putting their lives and health at risk due to the inaccessibility of abortion procedures in Queensland.

> *Case study 9:*
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> *T, aged 30, was supporting her unemployed partner on her Centrelink benefit, as well as her three existing children, when she found she was pregnant. T told us she was already struggling financially and had been relying on food vouchers from the Salvation Army to get by, making the required $450 seem an impossible target. She said the stress of trying to find the money for an abortion had her punching herself repeatedly in the stomach in the hope of giving herself a miscarriage, and that the stress was also causing more arguments and violence in her relationship. We gave her a donation from our Women's Access Fund as well as a No Interest Loan which together covered half the cost of the procedure.*
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> *Case study 10:*
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> *H is a married mother of two young children, the youngest just a year old, who called us for help with her unplanned pregnancy. H estimated her gestation to be at 5-6 weeks. Her husband was raised a strict Catholic and against using any form of contraception; he also refused to discuss the option of abortion with her despite being aware of H's reluctance to parent again so soon. He also worked out of town, and was not actively involved in*

parenting. In attempts to induce a miscarriage H had starved herself and consumed very high levels of caffeine and alcoholic spirits. This had been unsuccessful, although had made her very ill. H had tried home methods of abortion as she was unaware of the private clinics providing abortion in Queensland until her phone call to us, and the availability (albeit limited) of medication abortion – which seemed to her "more natural" and something she could pass off to her anti-abortion husband as a miscarriage.