THE NEW ZEALAND MEDICAL JOURNAL
Journal of the New Zealand Medical Association

Improving termination of pregnancy services in New Zealand

Martha Silva, Toni Ashton, Rob McNeill

Abstract

The aim of this article is to review evidence of the access and timeliness of termination of pregnancy (TOP) services to date in New Zealand and to provide clinic level and policy recommendations for service improvement. Compared to other countries, New Zealand successfully provides access to TOP services regardless of ability to pay, yet still lags behind other OECD countries in timeliness of services. There are clear differences in the organisational structure of clinics around the country, the most striking difference being between the private and public sectors. Streamlining referral pathways, expanding the availability of medical TOPs, and improving the organisational structure of clinics would all contribute to improving the timeliness of services and therefore the quality of care received by women. Improvements in the timeliness of TOP services in New Zealand are needed and achievable, even without legislative changes.

Termination of pregnancy (TOP) is a common surgical procedure and is one of the safest when conducted by trained professionals. The rate of complications for this procedure is extremely low when conducted under optimal conditions, but increases with gestational age.

Pregnancy terminations conducted during the first trimester, particularly before the 10th week, have a greatly reduced risk of complications compared to the second trimester.[1–4] In addition, medical practitioners and nursing staff are usually more willing to participate in pregnancy termination services the earlier in gestation they are conducted.[5] For these reasons, it is important to ensure that pregnancy termination services are provided in a timely manner. For women, lengthy delays or complicated referral pathways can add stress to an already emotionally difficult situation,[6] and this in turn can have an impact on emotional outcomes.

Despite the recognised importance of ensuring that pregnancy terminations are conducted in early gestation, New Zealand lags behind countries such as the United Kingdom, Australia and the United States in providing early terminations. In 2008, 73% of pregnancy termination procedures in the UK were conducted under 10 weeks gestation.[7] In Western Australia in 2004, 71% of procedures had taken place before the ninth week of gestation and 86.6% had occurred by the tenth week.[8]

In the US in 2006, 68.1% of women had their termination before the ninth week of pregnancy, and 78.5% had terminated by the tenth week.[9] In contrast, New Zealand statistics indicate that in 2007 only 40.5% of terminations had been conducted by the ninth week of pregnancy, and 60.5% had been conducted by the tenth week of pregnancy.[10] This unfavourable comparison spurred on a series of studies on TOP services in New Zealand to assess timeliness as an indicator of quality of services.

In 2009, a study found that on average women waited 25 days from the time of first contact with a health provider to the time of pregnancy termination.[6] Furthermore, this same study showed that 53% of women participating in the study thought the time they waited for a pregnancy termination was too long.

Further analysis of the data collected in this study revealed that women who attended a publicly funded clinic faced longer delays than women who attended a private clinic, and those who had multiple visits with a primary care physicians before being referred to a pregnancy termination clinic had lengthier delays than women with a single referral visit. Lastly, clinics offering medical termination of pregnancy and single day services experienced shorter delays to procedure.[11]

The aim of this paper is to consider how these findings, together with the experiences of other countries, might inform the development of TOP services and policies in New Zealand.

Policy and processes in New Zealand

The terms for pregnancy termination service provision in New Zealand are delineated by the Crimes Act (1961) and the Contraception, Sterilisation and Abortion Act (1977).[12,13]

Pregnancies that present a serious danger to the life of a woman or a serious danger to the physical or mental health of a woman, pregnancies resulting from incest or sexual relations with a guardian, pregnancies in women of mental sub normality, and pregnancies presenting fetal abnormality may all be legally terminated.

All District Health Boards (DHBs) in New Zealand are required to provide publicly funded TOP services, but some choose to subcontract these services to other DHBs. Previous research has shown that this subcontracting leads to some women having to travel large distances to obtain services.[14]

In order to access TOP services women must first go to a primary care provider such as a General Practitioner (GP) or a Family Planning clinic. The primary health provider can provide an initial assessment, including confirmation of the pregnancy.

If the woman requests TOP services, the primary care provider then orders diagnostic tests which usually include antenatal blood screening for blood type and several illnesses, a uterine scan to date the pregnancy and vaginal swabs to assess for sexually transmitted infections.

A referral from a primary care provider is considered a legal requirement for lawful service provision, given that this process is outlined in the Contraception, Sterilisation and Abortion Act. Once a referral has been received by the TOP service two certifying consultants must separately agree that the woman's circumstances fit the legal criteria. Usually the second certifying consultant is also the operating doctor.

The Abortion Supervisory Committee (ASC) appoints certifying consultants on yearly appointments. Most certifications are conducted in TOP services, but in some regions many primary care providers are also certifying consultants and can provide that service. In 2010 there were 193 certifying consultants around the country.[15]

All women seeking a pregnancy termination must be offered counselling, but legally are not required to actually see a counsellor. However, most of the clinics have

incorporated counselling as part of their services, and therefore all women are seen by a counsellor or social worker regardless of whether they wish to see one or not.

Northland is unique in that they do not have the counsellor incorporated with other clinical visits. Therefore women in Northland must travel to different sites to receive counselling, be certified, and finally to have the procedure.

Over ninety percent of TOPs around the country are conducted in public clinics. The remainder are carried out in the only private clinic in New Zealand, located in Auckland. Women who are willing and able to pay out of pocket are able to access TOP services from this private clinic, as do women who are not residents and are not entitled to publicly funded services. Non-resident women living in other regions of the country are required to pay out of pocket for services in local public clinics.

While the law still requires private patients to have a referral from a GP, these women can effectively self-refer because the private clinic employs its own GPs who can provide the referral. The three largest urban centres—Auckland, Wellington and Christchurch—have the largest patient flow and have a specialised clinic operating full time, regularly receiving referrals from other DHBs where services are not locally available. The remaining TOP services are conducted in weekly or fortnightly clinics offered at day surgery units which also provide other outpatient surgery services.

Currently statistics on the types of TOP procedures conducted are not published, but a clinical audit of nine clinics around New Zealand in 2009 showed that only 2.2% of all patients seen in a 3-month period underwent a medical TOP.[6]

To date, six out of the thirteen clinics that provide the great majority of TOPs during the first trimester offer the possibility of a medical TOP (medical termination of pregnancy is conducted using a combination of two drugs: misoprostol and mifepristone which stimulate the uterus to expel the products of conception similarly to a miscarriage), but most clinics have a limited number of openings for this service per week or per fortnight. Medical TOPs in New Zealand are only conducted in pregnancies under 9 weeks gestation. Therefore, based on official statistics, only around 40% of women would be able to choose between procedures if the clinic they are referred to provides the choice.

In 2009, the Abortion Supervisory Committee commissioned a working group to develop national standards of care for women requesting induced abortion in New Zealand.[16] This document delineates standards addressing service structure, waiting times, counselling and assessments. However this document does not specify recommendations for timely referral from primary care.

International comparisons

In the process of critically reviewing a health service it is often useful to understand how similar services in other countries function. Given the difference in timeliness of services between New Zealand and other OECD countries, the question arises of what could possibly account for more timely services in other countries.

The United Kingdom (UK) offers perhaps the closest comparison of health service structure to New Zealand. TOPs sought through the National Health Service (NHS) are free of charge but require women to visit a primary care provider such as a GP

first in order to be referred to specialised TOP services. However unlike New Zealand, women who are willing to pay for a private service may access a private TOP clinic without a GP referral. In 2006 99.3% of TOPs in Scotland took place in NHS hospitals.

In contrast England and Wales rely heavily on independent clinics under contract by the NHS (53% of TOPs), and only 38% of TOPs took place in NHS hospitals, with the remaining 9% being privately funded.[7]

In the UK, in order for a woman to access a TOP, two physicians must agree in good faith and sign a document stating that the woman fulfils one or more of five grounds outlined by the law, including risk to the physical or mental health of the pregnant woman or any other living children.[17] As in New Zealand, the majority of terminations are done due to risk to the mental health of the pregnant woman. Clinical guidelines were developed in the UK in 2000 to guide service provision with the objective of ensuring high quality services.[18]

These guidelines suggest that in order to expedite the process of referral to TOP services, the primary care provider should provide the first signature. If the primary care provider does not provide the signature, the TOP clinic provides both signatures. Unlike New Zealand, medical practitioners do not need to be certified to sign the legal agreement for the TOP.[19]

In contrast, Canada is one of only a few countries in the world with no legal restrictions on TOP. Despite the lack of restrictions on TOP, service provision varies significantly between provinces. Although TOPs are publicly funded, some provinces have established limitations on reimbursements for TOPs carried out in clinics rather than hospitals. Furthermore, accessibility of services outside the main urban centres is limited. Policies surrounding referral pathways and TOP service care pathways are institutionally based and not legally outlined.[20]

As is the case in Canada, Australia also lacks a single national structure for TOP services. Each state or territory has its own legislation, the most restrictive of which is Queensland, where pregnancy termination is a crime under the Queensland Act. Despite this, pregnancy termination is generally regarded as lawful if performed to prevent serious danger to the woman's physical or mental health.

As recently as 2009 criminal charges have been brought to women who had undergone pregnancy terminations, which has lead to physicians restricting their TOP practices for fear of further prosecutions.[21] With the exception of Southern Australia, most TOP services in Australia are offered in private clinics. A Medicare (federal government universal health insurance scheme) rebate is available to all women accessing TOP services, whether they be publicly or privately provided, but the rebate is insufficient to cover the full cost of the service. In Queensland, for example, the out-of-pocket costs for the first trimester TOP are between $350–$830 depending on location.[22]

The United States has a federal law legalising TOP, but state level restrictions and regulations exist including mandatory waiting period and parental notification.[9] Thirty-four states currently enforce parental consent or notification laws for minors seeking a TOP. The Supreme Court ruled that minors must have an alternative to

parental involvement, such as the ability to seek a court order authorising the procedure.[9]

Public funding is the exception; most TOPs are paid for with private money. Four out of seventeen states that use public funds to pay for TOPs for low income women do so voluntarily. The rest use public funds under a court order.[23] About 20% of TOP patients report using Medicaid to pay for TOPs.[9] As is common in most health services in the USA, self referral is the norm.

All countries presented here have different structures for delivering TOP services. The UK, like New Zealand, funds all TOP services for eligible women while access to services in Canada and Australia is more dependent on geographic location. Australia and the US rely on private clinics with partial public funding. All countries face some barriers to access, but little is known of the organisation of services.

How can services be improved in New Zealand?

A strength of the New Zealand arrangements for TOP services is that the same legal structure applies to the whole country. This contributes positively to increasing equity, as, in contrast to countries such as Australia and the USA, whether or not a woman can access a legal pregnancy termination does not depend upon in which region of the country she lives. It also does not depend upon her willingness and ability to pay, as TOP is regarded as a core or essential procedure which is publicly funded. However, the extent to which women who must travel for services have their expenses reimbursed is unclear.

The recent introduction of national standards in New Zealand should also improve equity by ironing out some of the differences in the modes of service across providers.[16] Having said this, TOP services in the first trimester are provided later on average in New Zealand than in other countries. The timeliness of services also varies depending upon the referral pathway, the type of procedure, and the organisational structure of each clinic. If differences in timeliness can be addressed, this would improve equity of access to the service.

Referral pathway—Nowadays, modern pregnancy tests are widely available over the counter from pharmacies and supermarkets. Therefore unlike many health conditions, it is relatively easy for women to self-diagnose their own pregnancy. Although medical practitioners will rightly argue that they have an ongoing relationship with their patients and a referral from primary care for TOP services is not only a legal requirement but is also entirely appropriate in terms of patient care, we question just how clinically necessary it is to have women enter the care pathway through primary care.

For women who reach a decision to terminate soon after they confirm they are pregnant, if they were able to self refer, the entry point to the care pathway could be the TOP clinic itself. Given that many clinics require two appointments within their service structure, diagnostic tests could be obtained between the first and the second appointments. Restructuring services to allow self-referral to TOP clinics would require legislative change. Yet, if the current legislation were to remain, further efforts are necessary to ensure that primary care physicians can reduce the time between when women first enter their practice for an unplanned pregnancy and the

time they are able to book an appointment with a termination clinic (currently averaging 10 days).

Type of procedure—Medical TOPs are less invasive and can be conducted much earlier than surgical TOPs. If access to medical TOPs could be expanded, women in the early stages of pregnancy would not have to wait for surgical timeframes. Family Planning has already applied to the Abortion Supervisory Committee for a licence to provide medical terminations in Waikato as a pilot programme. If this programme was expanded and medical terminations were available in Family Planning clinics throughout the country, women would be able to access services in an additional nine towns and cities around the country than is currently available.

Organisational structure of clinics—As mentioned previously, research conducted in New Zealand found that women attending clinics that offer medical TOPs and those who provide complete TOP services in a single day, eliminating the need for multiple visits to the TOP clinic, experience significantly less delay. As an example, the single private TOP clinic in New Zealand provides services at significantly earlier gestational dates than the public clinics.

There are a number of aspects of their organisational arrangements that contribute to providing a more timely service. Timeliness would be improved significantly if some, or all, of these features could be built into the public clinics.

First, women can effectively self refer to the clinic, and if they are unable or unwilling to go to their own GP for a referral, a primary care provider is available on site to provide this service. Second, this clinic has a standing agreement with a radiographer in close proximity and so women can get a scan appointment relatively quickly.

For women having a surgical termination, they offer a single day service including counselling, clinical assessment and certification. Except for those accessing medical termination, multiple visits to the clinic are not required. Finally, this clinic has a specific policy stating that women should not wait for more than 5 working days for an appointment, and in times of high demand they will schedule additional clinics to support patient flow. This written policy is monitored and booking times are used as a quality indicator.

In contrast, research has shown that women must wait an average of 10 days between the day that their appointment was booked and their first appointment with the TOP clinic. The process of certification, normally carried out within the TOP clinics for the great majority of women, does not seem to be the greatest factor affecting delays in the service.[6]

Conclusions

New Zealand has succeeded in providing safe, high quality TOP services to women who fulfil the legal criteria for terminating a pregnancy. Unlike Australia and the USA the service is provided free of charge for citizens and residents, plus the same regulations apply across the whole country. However, these important gains in equity of access to services—as compared with other countries—should not involve a trade off in the quality of services. Timeliness of services is an important aspect of the patients' experience of the service, and evidence points to concerning gaps in this area. Therefore improvements in the timeliness of service provision are still needed.

Legislative change allowing women to self refer to services would eliminate GPs as gatekeepers of the service and would therefore reduce the number of steps required to access TOPs. Yet, even without legislative reform, the timeliness of TOP services could be greatly improved by changing the way in which these services are organised, including extending access to medical TOPs.

Competing interests: None.

Author information: Martha Silva, Senior Research Fellow, National Institute for Health Innovation, University of Auckland; Toni Ashton, Associate Professor, School of Population Health, University of Auckland; Rob McNeill, Lecturer, School of Population Health, University of Auckland

Correspondence: Martha Silva, National Institute for Health Innovation, School of Population Health, Private Bag 92019, Auckland 1142, New Zealand. Fax: +64 (0)9 3737503; Email: m.silva@auckland.ac.nz

References:

1. Bartlett LA, Berg CJ, Shulman HB, et al. Risk factors for legal induced abortion-related mortality in the United States. Obstetrics and Gynecology. 2004;103:729-37.
2. Buehler JW, Schulz KF, Grimes DA, Hogue CJ. The risk of serious complications from induced abortions: do personal characteristics make a difference? American Journal of Obstetrics and Gynecology. 1985;153(1): 14-20.
3. Ferris LE, McMain-Klein M, Colodny N, et al. Factors associated with immediate abortion complications. Canadian Medical Association Journal. 1996;154(11):1677-85.
4. Zhou W, Nielsen GL, Moller M, Olsen J. Short-term complications after surgically induced abortions: a register based study of 56117 abortions. ActaObstetrica et Gynecologica Scandinavica. 2002;81:331-336.
5. Rosenblatt RA, Robinson KB, Larson EH, Dobie SA. Medical students' attitudes towards abortion and other reproductive health services. Fam Med. 1999;31(3):195-9.
6. Silva M, McNeill R, Ashton T. Ladies in Waiting: the timeliness of first trimester pregnancy termination services in New Zealand. Reproductive Health. 2010;7:19.
7. Department of Health. Statistical Bulletin, Abortion Statistics, England and Wales: 2008. Retrieved April 26, 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_099285
8. Department of Health – Government of Western Australia (2005). "Induced Abortion in Western Australia 1999-2004: Report of the WA Abortion Notification System".
9. Guttmacher Institute. Facts on Induced Abortion in the United States. New York: AGI. 2010. Retrieved May 26 2010. http://www.guttmacher.org/pubs/fb_induced_abortion.html#15
10. Ministry of Justice. 2007. Report of the Abortion Supervisory Committee: 2007. Wellington: Ministry of Justice.
11. Silva M, McNeill R, Ashton T. Factors affecting delays in first trimester pregnancy termination services in New Zealand. A NZ Journal Pub Health (In Press).
12. The Crimes Act 1961. Parliamentary Counsel Office. Accessed on December 11, 2009 from : http://www.legislation.govt.nz/act/public/1961/0043/34.../096be8ed803f6e27.pdf
13. Contraception, Sterilisation and Abortion Act 1977. Parliamentary Counsel Office. Accessed on December 11, 2009 from : http://www.legislation.govt.nz/act/public/1977/0112/latest/viewpdf.aspx
14. Silva M, McNeill R. Geographic access to termination of pregnancy services in New Zealand. Australia New Zealand Journal of Public Health. 2008; 32(6): 519-521.
15. Abortion Services in New Zealand. Retrieved July 26 2010, http://www.abortion.gen.nz/

16. Standards of Care For Women Requesting Induced Abortion in New Zealand. Unpublished Report of a Standards Committee to the Abortion Supervisory Committee. October 2009.
17. UK Abortion Law. Marie Stopes International. Retreived July 26, 2010. http://www.mariestopes.org.uk/Womens_services/Abortion/UK_abortion_law.aspx
18. Royal College of Obstetricians and Gynaecologists. (2004). The Care of Women Requesting Induced Abortion. London: RCOG Press.
19. Julie Douglas, Head of Marketing – Marie Stopes International, personal communication 2010.
20. Eggertson L. (2001). Abortion services in Canada: a patchwork quilt with many holes. CMAJ. 164(6):847-9.
21. Children By Choice. Australian abortion law and practice. Retrieved April 26, 2010.http://www.childrenbychoice.org.au/nwww/auslawprac.htm
22. Kate Marsh, Public Liaison Officer - Children by Choice, personal communication,2010
23. Guttmacher Institute, State funding of abortion under Medicaid, State Policies in Brief, 2010. Retrieved May 26, 2010. http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf