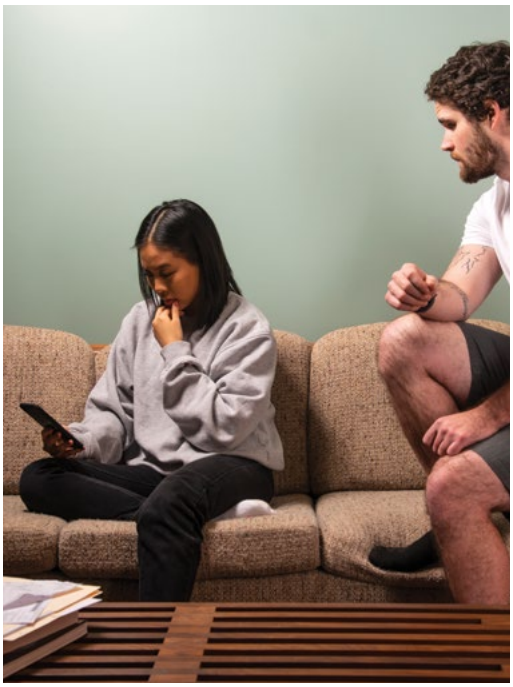

Early medical abortion provision via telehealth in Victoria: A qualitative descriptive study

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Background and objective
Little is known about the views of service providers currently working in telehealth early medical abortion (EMA) provision in Victoria, Australia. This study aims to contextualise the enablers and barriers to telehealth EMA provision, providing insight for healthcare policy and practice to improve the accessibility of this service.

Methods
This was a qualitative descriptive study involving semi-structured interviews with 14 Victorian stakeholders with expertise and knowledge on telehealth EMA provision. Data were analysed using conventional content analysis.

Results
This study presents perceived enablers and barriers across four different contexts of the Victorian abortion system: (1) perceived patient context; (2) perceived provider context; (3) health organisation-system context; and (4) sociopolitical context. The COVID-19 pandemic's disruption of healthcare services led to greater patient and provider acceptance of telehealth EMA. However, barriers within the patient context included the inability to ensure safety and confidentiality, digital access and literacy issues, language barriers, and the importance of trusting provider–patient relationships. Providers encountered challenges in delivering holistic care via telehealth, including time and workload issues and working with interpreters. Shortcomings within the organisational context encompassed structural barriers for culturally and linguistically diverse population groups, the absence of standard telehealth guidelines and varying interpretations of telehealth. Although temporary Medicare item number changes improved access, they presented financial challenges for mixed and private billing practices.

Discussion
The application of these findings by relevant health services and policymakers has the potential to improve the quality of, and increase accessibility to, telehealth EMA, better meeting the needs of individuals seeking this service.

EARLY MEDICAL ABORTION (EMA) involves the oral intake of medical abortifacients in the form of MS-2 Step: mifepristone and misoprostol.[1] EMA can be delivered through a face-to-face consultation or via telehealth up until nine weeks gestation.[1] In Australia, telehealth for EMA was first initiated in 2015 by the Tabbott Foundation and, subsequently, Marie Stopes International.[2] Telehealth services enabled Australians to access EMA in their homes without a visit to a medical practitioner and significantly increased access for people in rural and regional settings.[3]

The uptake and integration of telehealth EMA into mainstream Australian primary care has been slow and fragmented.[2] Telehealth EMA within general practice was previously inaccessible for most people until the COVID-19 pandemic. As a result of the pandemic, there was an increase in the uptake of telehealth in healthcare and the implementation of Medicare Benefits Schedule (MBS) telehealth item numbers that allowed general practitioners (GPs) to bulk bill telehealth EMA consultations.[4]

Since this policy change, little research has been undertaken to explore the benefits and challenges of telehealth EMA being provided through the primary healthcare system. Previous studies that have sought to evaluate the use of telehealth EMA in Australia have focused on the experiences of patients who have accessed this service.[3,5–7] As a result, little is known about the views and experiences of individuals working in telehealth EMA service provision in Australia.

As such, given the strong movement towards providing EMA within primary care settings, the aim of this study was to understand the barriers and enablers to providing telehealth EMA, as perceived by stakeholders working in this area in Victoria.

Methods

A qualitative descriptive approach with semi-structured interviews was used to obtain rich, detailed, contextual descriptions of a range of enablers and barriers surrounding telehealth EMA provision directly from study participants.[8]

Setting and sampling strategy

The population of interest was stakeholders (defined as individuals with expertise or knowledge on the topic of telehealth EMA) who were experts in EMA provision

within Victoria. These individuals were GPs, nurses, researchers, sexual health physicians, pharmacists and community advocates within relevant sexual and reproductive health (SRH) organisations. 'Providing' telehealth EMA was left broadly defined to ensure that any stakeholder who is integral to the delivery of telehealth EMA in any capacity was eligible to participate in the study. This research was limited to EMA provision in Victoria owing to non-legal barriers that disproportionately impact abortion access across Australian states.[9] Purposive sampling (ie the careful selection of knowledgeable participants who can provide rich information on the topic[10]) was used in combination with snowball sampling.

Data collection techniques

Semi-structured interviews occurred in August and September 2021. Interviews followed a semi-structured interview schedule and were conducted over telephone or using Zoom. The interviews were audio recorded and transcribed verbatim. Participant information was deidentified, and pseudonyms for names were used to protect confidentiality.

Analysis

Interviews were analysed using conventional content analysis.[11] Two participant transcripts were coded independently by three research team members (SS, CC, HW) to compare initial interpretations. An audit trail was used during data collection and the analysis process.[8] NVivo qualitative analysis software was used to organise and manage the data (www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home). The research team met weekly to discuss the progress of the analysis. When 14 interviews were completed, the research team agreed that sufficient data had been acquired to provide a thorough description of the topic, and therefore data collection was concluded.

Ethical considerations

Ethics approval was granted by the University of Melbourne Human Research Ethics Committee (ethics ID: 21451).

Results

Participant demographics

Fourteen stakeholders were interviewed (Table 1). Briefly, almost all participants identified as female, nearly half were GPs and most worked in metropolitan Victoria. Interviews ranged from 21 to 52 minutes.

All participants discussed a range of enablers and barriers to the provision of telehealth EMA from their perspective. Below we highlight these identified enablers and barriers across four different contexts of the abortion system: patient, provider, health organisation system and the sociopolitical context.

Patient factors impacting access to telehealth EMA

Only one enabler to accessing telehealth EMA was identified by our stakeholders within the patient context. Given the pandemic, and the rapid shift in healthcare services that occurred, stakeholders perceived that patients were far more accepting of receiving healthcare, including EMA, via telehealth:

> *... you know, we know that it's very safe and acceptable and that patients really like it.* (Obstetrician/Gynaecologist)

A few stakeholders noted that providers lacked control over the patient's home environment, resulting in an inability to guarantee patient confidentiality and safety within a telehealth consult. This was particularly concerning when providing care to patients who may be experiencing reproductive coercion and other types of violence, who would be unable to express themselves on telehealth out of fear of repercussions. In such cases, stakeholders expressed that providers may lack the confidence to screen for safety issues and, if they are uncertain, would decide to provide EMA in person as opposed to over telehealth:

> *So, the biggest concern for us is that we can't control the environment that that woman is in. So, we can't control who's going to walk in the door; we can't control who's got access to her while she's doing that telehealth appointment.* (Nurse practitioner)

Patient access to the digital tools required to access telehealth EMA, as well as general digital literacy, were also perceived as barriers to the provision of this service. Vulnerable groups, including people who were homeless or people who experienced socioeconomic disadvantage and were deprived of access to a phone, a phone with a camera or the money to access an unlimited data plan were perceived to potentially be unable to access EMA via telehealth. In addition, patients needed to be digitally literate to competently book appointments and adeptly use a computer:

> *So, people really need to have access to a computer and an email address to read that information, to be able to sign a consent form and send it back.* (GP)

Telehealth was considered as inaccessible for patients who do not speak English fluently or have low health literacy. In view of the considerable amount of information provided in an EMA consult, stakeholders expressed their uncertainty of acquiring informed consent and ensuring adequate patient understanding over telehealth:

> *So, women who don't speak English can't, you know, can't find out how it's available, can't find out where it's available.* (Obstetrician)

Table 1. Participant demographics (n=14)

Characteristic	No. participants
Sex	
Female	12
Male	2
Profession	
General practitioner	6
Nurse/midwife	2
Community advocate for SRH	2
Obstetrician/ gynaecologist	2
Sexual health physician	1
Pharmacist	1
Practice location	
Metropolitan	8
Regional	2
Rural	3
Statewide	3

SRH, sexual and reproductive health.

Stakeholders perceived that some patients placed importance on establishing trust and support in their provider before undergoing EMA, and therefore preferred to be physically present for emotional support and communication, meaning that these patients would not access telehealth EMA. In addition, stakeholders perceived that a pre-existing relationship between the provider and patient was a prerequisite for a patient to disclose any safety concerns to their provider:

> *It's a different relationship via telehealth, and so I think it takes trust with a healthcare provider for something like abortion.* (Community advocate)

Provision of telehealth EMA from the provider perspective

The stakeholders identified several perceived barriers to the delivery of telehealth EMA. Importantly, stakeholders noted that providers may feel unable to provide holistic sexual and reproductive healthcare via telehealth, including discussing postabortion contraception and taking the opportunity to undertake sexually transmissible infection (STI) testing and cervical screening, as appropriate. Although postabortion contraception could be discussed via telehealth, the stakeholders interviewed in our study suggested that providers might wish to provide abortion care face to face, rather than via telehealth, in order to be able to provide these additional services:

> *I find it easier to talk through things like contraception and teaching, you know, well firstly LARCs* (long-acting reversible contraception)*, but if they want to go on something like the pill, actually teaching them how to use the pill face to face is so much easier.* (GP)

In addition, stakeholders perceived that providers might have concerns about not being able to conduct a physical/visual examination of the patient during the telehealth consult, posing further barriers to its use for EMA. Stakeholders reflected that a physical examination of the patient is unnecessary to provide telehealth EMA, subsequently noting that additional support for providers in delivering telehealth EMA is required to overcome this barrier:

> *If you're doing it via phone, you don't see the patient. You can't examine the patient if you need to.* (GP)

Providing EMA via telehealth was perceived by stakeholders as time consuming due to substantial administrative work, including telephone triage, organising appropriate investigations and medication and considerable follow up. In addition, integrating telehealth services into a clinic requires establishment of new work and referral pathways, which can contribute to the low uptake of telehealth EMA among primary care providers:

> *It takes a lot of time. There's a lot of follow-up, and if they if they're not working with a nurse, it's a lot of follow-up from their behalf.* (Sexual health physician)

When providing care to linguistically diverse patients, navigating a three-way telephone call with the patient and the interpreter on the phone was perceived as inferior to working with the interpreter face to face by most participants. Furthermore, some discussed a perceived risk of losing important information when working with interpreters:

> *One of the barriers to telehealth for migrant and refugee population groups might be having to use interpreters. And those interpreters are often from community.* (Community advocate)

Before the pandemic, participants recognised provider resistance to adopting telehealth for EMA. The integration and sustained use of telehealth during the pandemic was identified to influence provider acceptance of this service modality:

> *... you know, if you'd asked doctors two years ago, were they prepared to do telehealth abortions? Well, most people would say – No, why, you know, that's too complicated.* (laughs) *And, you know, we're doing everything by telehealth now.* (GP)

Organisational issues in telehealth EMA provision

All stakeholders identified barriers and enablers at the organisation level to the provision of telehealth EMA. Informal relationships that developed organically between primary providers such as GPs and nurses, as well as pharmacists, sonographers, pathologists and doctors in emergency departments, were perceived as key enablers to the provision of a timely, non-judgmental service. Using a nurse-led model, wherein the primary care nurse conducted initial screening and organised appropriate investigations, was also identified to be timesaving for GPs. Stakeholders also noted that primary care nurses can play a key role in the provision of counselling to patients seeking telehealth EMA:

> *So, having a nurse-led clinic makes it much more feasible for our GPs to provide the service because it takes us a lot less time.* (GP)

The 1800 My Options website and telephone line, which is Victoria's information service for SRH services, was considered by stakeholders as an indispensable resource for patients and providers alike. However, participants expressed a need for a live central database system at a national level. A lack of visibility of pharmacists who dispense as well as stock the MS-2 Step medication was also identified, which was particularly challenging for provision in rural and remote areas:

> *It'd be great if there was sort of a central list that you could access as a practitioner and say I should send you here. So that you're not sending people off to a pharmacy that doesn't have the medication, just because it's a local one. And that you're not sending people to ultrasonographers that are going to say something yuck.* (Sexual health physician)

Most stakeholders stated that one of the barriers to the provision of telehealth EMA was the lack of established best practice clinical guidelines that would be beneficial for standardising delivery across clinics and ensuring service quality:

> *... when there is no documented standard, then there is nothing to compare with. And there is nothing to guide clinicians who want to do the right thing.* (Obstetrician)

The meaning of telehealth was perceived differently across the workforce. Most providers considered telephone instead

of videoconferencing as telehealth, and preferred using it because it was less complicated. However, stakeholders stressed the preference of using videoconferencing over telephone for rapport building and communication:

> *But in terms of improving it, one is obviously using I think, video over phone, is probably better for the patient and probably better for their provider.* (Metropolitan GP)

Participants also perceived several structural barriers within the abortion system that compounded access barriers for culturally and linguistically diverse population groups. This includes the absence of bilingual or multilingual doctors, the need for community/multicultural workers to help with system navigation, the absence of written and visual translated resources and a lack of trained interpreters familiar with EMA and SRH consults.

Sociopolitical context of telehealth EMA provision

Within the sociopolitical context, stakeholders noted the temporary MBS item numbers introduced at the start of the pandemic as a key factor that facilitated healthcare delivery via telehealth. This markedly increased accessibility to telehealth EMA for patients. Although the stakeholders noted the importance of this change for improving access to telehealth EMA, they also noted that the MBS telehealth item numbers mandated GPs to bulk bill for patients vulnerable to COVID-19, and therefore most patients needed to be bulk billed, resulting in a revenue loss for general practices that charged a gap fee or privately billed:

> *We have an item number, but that's not enough for private billing practices to be financially viable.* (GP)

The temporary telehealth MBS item numbers released during the pandemic have now been adapted as ongoing arrangements for telehealth services.

Discussion

This study provides insight into the factors that impede and enable telehealth EMA provision from the perspective of stakeholders in Victoria. Overall, the stakeholders in our study identified far more barriers to the provision of EMA via telehealth than enablers, spanning the patient, provider, organisational and sociopolitical contexts. For telehealth EMA to improve accessibility to people in Victoria, and indeed Australia more broadly, our findings demonstrate a range of barriers that still need to be addressed.

At the patient level, the perceived linguistic and structural barriers are key issues to accessing telehealth EMA. Language barriers, specifically the prerequisite skill for a high level of English to find this service, has also been noted in a study that explored Australian rural women's experiences of access to telehealth abortion.[4] That study also identified a perceived inferiority of using telephone interpreters compared with in-house face-to-face interpreters. Trained face-to-face interpreters have been found to increase continuity and trust among clinicians and patients in primary care settings.[12] However, the feasibility of this approach for SRH care would need to be determined. Further research on the impact of these barriers within diverse population groups is needed.

For providers, screening for reproductive coercion and domestic violence was identified as challenging when providing telehealth EMA. Reproductive coercion is commonly characterised as behaviours that interfere with an individual's reproductive health and decision making.[13] EMA providers are more likely to witness people experiencing reproductive coercion while delivering abortion care,[14] but express difficulty establishing patient safety through telehealth. This has been previously established by Wellington et al.[15] Our findings support current advocacy[16,17] for developing evidence-based guidelines to inform best practice reproductive coercion screening in Australian abortion settings. These guidelines must also consider the added challenges to screening via telehealth and should be implemented in conjunction with training and support for providers to increase confidence in their use.

The technical and interpersonal aspects of telehealth were identified to have a significant influence on the doctor–patient relationship. Most notably, although the 'existing physician–patient relationship' requirement to access the MBS telehealth item number was exempted due to COVID-19 restrictions,[7] participants expressed that the initial establishment of a doctor–patient relationship in person was beneficial, and that telehealth was inadequate to develop a new relationship with a patient. Considering some patients prefer face-to-face services over telehealth, telehealth EMA provision beyond the pandemic must highlight the importance of informing patients about their options and choosing a service modality that suits their needs and preferences. Our findings are consistent with previous research, that suggests that strong networks between providers create robust abortion referral pathways and thereby an effective service.[18,19] The formalisation of these networks might be advantageous to support future provision of telehealth EMA. Commensurate with the suggestion by Mazza et al,[20] the present study advocates for a central database at a national or state level (like 1800 My Options) that assists people in identifying local providers. Furthermore, encouraging providers to advertise the location of available services on this database might increase their visibility and enhance the approachability of telehealth EMA.

The MBS telehealth item numbers implemented as part of the pandemic response that have now been continued are vital to ensure that that providers can bulk bill telehealth EMA consultations. However, post-pandemic telehealth must consider its viability for private GP clinics. A recent report stated that private GP clinics were compelled to transition from privately billed face-to-face consultations to bulk-billed telehealth consultations to access the telehealth item numbers, resulting in a revenue loss for these clinics,[21] a finding also echoed by some GPs in the present study. There is a need to consider more blended forms of payment for GP clinics as telehealth demand increases.

The findings of this research should be considered within its limitations. Notably, this research was only conducted with a small number of stakeholders in the Victorian context; the experiences of those working in other Australian states and territories might differ. However, given the dearth of current literature exploring this topic, this research provides important insight into the barriers and enablers to the provision of EMA via telehealth, and serves as a platform for future, Australia-wide research examining this topic.

Conclusion

This qualitative study identified a range of enablers that need to be strengthened and various barriers that need to be mitigated at different levels of the abortion system to increase the accessibility of telehealth EMA in primary care. However, it must be recognised that telehealth for EMA might not be the answer for everybody. Patient choice of different healthcare options based on an individual's needs and preferences is critical for the future equitable delivery of EMA care; future research would be well placed to explore these needs and preferences.

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