Enabling Choice: Addressing Barriers to Abortion Services in Rural British Columbia

by

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Abstract

Induced abortion is an extremely common procedure in Canada; 1 in 3 Canadian women terminate at least one pregnancy in their life time. It is a medically necessary service, but women living in rural communities in British Columbia face extreme barriers when accessing abortion services. Women face extra-legal barriers related to distance, cost, a lack of rural health care professionals, and a lack of health care facility resources. This study seeks to examine existing interventions in BC and other jurisdictions, and synthesize existing research to compile a complete list of policy options. Following a full evaluation of these options to better understand effectiveness and tradeoffs, the study culminates with a list of priorities for action. The final recommendations first address flaws in existing policies for short term more immediate interventions, and secondly, introduce new initiatives for longer term success.

Keywords: abortion; equal access; health policy; British Columbia; rural; reproductive choice

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List of Acronyms

ARNBC	Association of Registered Nurses of British Columbia
BC	British Columbia
BCMA	British Columbia Medical Association (a.k.a. Doctors of BC)
CNM	Certified Nurse Midwife
CPBC	College of Pharmacists of BC
CPSBC	College of Physicians and Surgeons of British Columbia
CRNBC	College of Registered Nurses of British Columbia
GP	General Practitioner
IUD	Intrauterine Device
NAFC	National Abortion Federation Canada
NP	Nurse Practitioner
OR	Operating Room
PA	Physician's Assistant
RN	Registered Nurse
SOGC	Society of Obstetrics and Gynaecologists of Canada
WHO	World Health Organization

Glossary

Ambulatory Care	Medical or surgical treatment that does not require an overnight stay in a medical facility and from which the patient goes home; outpatient rather than inpatient care.
Aspiration Abortion	Also called a suction abortion or a vacuum aspiration abortion; the most common method used in a surgical abortion where the uterine contents are removed by suction (aspiration). If no electric pump is used, the abortion is a manual vacuum aspiration, or MVA.
Conscientious Objection	Objection formed on moral or religious grounds.
Ectopic Pregnancy	A pregnancy in which the fetus develops outside the uterus, typically in a Fallopian tube.
Induced Abortion	Also called a therapeutic abortion. An intentional termination of a pregnancy where the uterine contents are removed. An induced abortion is as opposed to a spontaneous abortion.
Medical Abortion	A type of non-surgical abortion in which abortifacient pharmaceutical drugs are used to induce abortion. An oral preparation for medical abortion is commonly referred to as an abortion pill. Common abortion medications include methotrexate, mifepristone, and misoprostol.
Methotrexate	A synthetic compound that interferes with cell growth. Used in many medical treatments. Its ability to interfere with cell growth means it can function as an abortifacient.
Mifegymiso	Brand name of the pharmaceutical drug which contains mifepristone and misoprostol.
Mifepristone	A synthetic steroid that inhibits the action of progesterone (a hormone that stimulates the uterus to prepare for pregnancy); given orally in early pregnancy to induce abortion.
Misoprostol	A medication which causes muscle contractions in the uterus, relaxes the opening of the cervix, and sheds the endometrium. Typically used to start labor, cause an abortion, prevent and treat stomach ulcers, and treat postpartum bleeding due to poor contraction of the uterus. For abortions it is often used with mifepristone or methotrexate.
Outpatient Clinic	An institution, building, or part of a building where ambulatory patients receive health care.

Spontaneous Abortion	A miscarriage; any pregnancy that is not viable (the fetus cannot survive) or in which the fetus is born before the 20th week of pregnancy. A spontaneous abortion is as opposed to an induced abortion.
Surgical Abortion	Procedure that empties the contents of the uterus. Two most common methods used in surgical abortion are vacuum aspiration (or manual vacuum aspiration) and dilation and extraction. The first is typically used during the first trimester, while the second typically during the second.
Telehealth	The provision of healthcare remotely by means of telecommunications technology.
Telemedicine	The remote diagnosis and treatment of patients by means of telecommunications technology.
Teratogenicity	The property or capability of producing congenital malformations. A teratogen is an agent that can disturb the development of the embryo or fetus. Teratogens halt the pregnancy or produce a congenital malformation (a birth defect). Classes of teratogens include radiation, maternal infections, chemicals, and drugs.
Therapeutic Abortion	An abortion induced following a diagnosis of medical necessity. An abortion induced because of the mother's physical or mental health, or to prevent the birth of a deformed child or of a child conceived as a result of rape or incest.

Chapter 1. Introduction

While abortions are legally protected in Canada, extra-legal barriers still hinder equal access. Rural areas are underserved across the country, and British Columbia is no exception. A staggering 91% of abortion providers in BC reside in the three largest urban areas. Over the past two decades, abortion clinics have steadily replaced hospitals as the primary site for abortion services. As of 2011 81% of abortions were provided in clinics located mostly in Vancouver and Victoria. However, hospitals are still the primary site of health care provision in rural BC, and most hospitals in rural communities do not offer abortions due to lacking physicians willing and able to perform the procedures. This situation has led to the policy problem where women living in rural communities in British Columbia face extreme barriers when accessing abortion services. This study seeks to better understand the causes of this policy problem, and offer policy interventions to address existing extra-legal (i.e., non-legal) barriers to abortion and equalize access across BC.

An in-depth literature review begins the study by exploring the primary extra-legal barriers to better understand their effects and interplay. A review and synthesis of existing research on abortion barriers finds that these obstacles are best understood when grouped into five categories: distance, cost, a lack of rural health care professionals, a lack of health care facility resources, and stigmatization. These barriers and their impacts are explored and explained in further detail in the following chapters.

Following the problem investigation, the study explores potential policy options through several research methodologies. A jurisdictional scan offers examples of policy interventions implemented by individual health care facilities and organizations across rural and urban British Columbia. These interventions have been successful on an individual basis, and larger scale policies seeking to target all of BC can use them as

models. Policy options were also gathered from existing, outside research. Lastly, expert interviews were used to form a deeper understanding of the problem background, to help formulate policy interventions, and to gain insight into the potential feasibility and impacts of proposed policy options.

These research endeavors produced a list of policy options each of which could improve access to abortion care in rural BC. Rather than being mutually exclusive, all or a combination of these options could be implemented. The options are grouped into two categories: smaller interventions which would address low-cost problems in existing policies and structures, and larger interventions that have the potential for greater long term impacts, but also have greater costs. The evaluation of the proposed polices presents the strengths and weaknesses of each option. The policy analysis culminates in a suggested list of priorities for action through a combination of both smaller and larger interventions.

Chapter 2. Access to Abortion in Canada and BC

2.1. Decline and Demand in Abortion Services

Health professionals and women's health advocates around the world agree that access to safe and legal abortion in a timely matter is critically important for women's reproductive health, and therefore their general health and wellbeing (Sethna, Palmer, Ackerman, & Janovicek, 2013). In the Canadian context, abortion is considered a "medically necessary" service, a phrase that the Canada Health Act considers to mean a service a patient needs "in order to avoid a negative health consequence" (Sethna & Doull, 2013). The Canada Health Act sets out five principles: Canadian health care must be accessible, portable, universal, comprehensive and publicly administered nationwide (*Canada Health Act, Revised Statutes of Canada*, 1985, c. C-6). These principles are meant to secure for Canadians equal and complete access to certain core health care services. Provincial and Territorial governments administer health care, and fund roughly 80% of their services through own-source taxation. The Federal government provides the remaining 20% under the condition that provinces and territories follow the Canada Health Act. Despite the Canada Health Act, Canadians living in rural areas tend to have less access to health care than their urban counterparts. Rural areas tend to be underserved by physicians; small hospitals struggle to stay open, and wait times can be abysmal. These concerns are widely known. However, the issue of unequal access to abortion services in rural areas remains at the periphery of public consciousness and of policy makers' agendas (Sethna & Doull, 2013; Sethna et al., 2013). Access to abortion is exceptionally unequal across Canada, and woefully absent in many parts of the country (Sethna & Doull, 2013). The designation of abortion as "medically necessary" would suggest that such services warrant equal government attention under the Canada Health Act.

Abortion services are a major concern in women's health care. As of 2011, 31% of women in Canada reported that they had terminated at least one pregnancy in their lifetime. Younger women ages 20 to 29 made up 52% of women who reported having an abortion from 1974 to 2005 (Norman, 2012). Women in their twenties with low incomes are the majority of women who visit abortion clinics (Sethna & Doull, 2013). The Canadian Institute for Health Information (CIHI) reported 81,897 abortions in 2014. The following table shows the breakdown of reported abortions by province or territory, and by hospital or clinic.

Table 1 Number of induced abortions reported in Canada in 2014, by province/territory of hospital or clinic

Province/territory	Number of induced abortions reported by hospitals	Number of induced abortions reported by clinics	Total
Newfoundland and Labrador	184	867	**1,051**
Prince Edward Island	0	0	**0**
Nova Scotia	2,061	0	**2,061**
New Brunswick	528	0	**528**
Quebec	9,192	15,891	**25,083**
Ontario	10,977	12,769	**23,746**
Manitoba	2,370	1,645	**4,015**
Saskatchewan	1,960	0	**1,960**
Alberta	2,093	11,722	**13,815**
British Columbia	4,124	5,072	**9,196**
Yukon	102	0	**102**
Northwest Territories	255	0	**255**
Nunavut	85	0	**85**
Total reported	**33,931**	**47,966**	**81,897**

Source: Canadian Institute for Health Information. (2014). Induced Abortions Reported in Canada in 2014. Retrieved from https://www.cihi.ca/sites/default/files/document/induced_abortion_can_2014_en_web.xlsx

Women who live in northern, rural, and maritime communities, who are more likely to be low income or unemployed, or indigenous women, experience the greatest hardships when trying to access abortion services. The provision of abortion services has steadily declined over the past 40 years. In 1977 only 20.1% of Canadian hospitals provided abortions; this number dropped to 17.8% by 2003. As of 2006 only 15.9% of Canadian hospitals offered abortion services (Sethna et al., 2013).

While British Columbia currently has one of the better infrastructures in Canada for providing access to abortions, the provision of abortion services is still drastically

unequal between rural and urban areas (Sethna & Doull, 2013). Over the past two decades abortion clinics have steadily replaced hospitals as the primary site for abortions services. In 1988 91% of abortions took place in hospitals, and by 2010 only 43% (Norman, Soon, Maughn, & Dressler, 2013). However, abortion clinics only exist in urban centres, meaning that in rural areas surgical abortions are only available in hospitals. Given that the overall number of abortions performed has been stable over this interval, the decline in the proportion of hospital abortions represents at least a 58% decline in the number of abortions performed in rural areas (Norman et al., 2013). Rather than indicating a drop in unintended pregnancies, this decline showcases the unequal access to abortion services in rural areas.

The number of abortion providers in BC has steadily declined as well. From 1996 to 2005 there was a 65% decrease in abortion providers, largely in rural areas (Norman, 2011). A staggering 91% of abortion providers reside in the three largest urban areas in BC, and as of 2011 81% of abortions were provided in clinics located mostly in Vancouver and Victoria (Contraception Access Research Team-Groupe de recherche sur l'accessibilité à la contraception (CART-GRAC), 2014; Sethna et al., 2013). This distribution of services is significantly unequal, given that only 57% of women of reproductive age currently live in large urban centres (CART-GRAC, 2014). Furthermore, providers in rural areas are severely limited in their resources, and cannot provide the full range of services offered in urban areas. For example, 98% of services for second trimester abortions are in BC's three largest urban centres (CART-GRAC, 2014). These developments have given rise to a serious policy problem facing BC public health promotion, namely that *women living in rural communities in BC face extreme barriers when accessing abortion services.*

2.2. Barriers to Abortion Services in Rural BC

Due to many factors, women in rural communities in BC currently face several barriers when attempting to access abortion services. Rural abortion providers face challenges due to insufficient resources in funding, personnel, equipment, facilities, and training. As a result, women contend with great distances and difficult travel circumstances, high monetary costs, increased stress and anxiety from delays, and sometimes serious

health consequences. The high costs to providers directly contribute to barriers. Providers face a shortage of health professionals such as replacement physicians, anesthetists, and allied health professionals who conduct counselling and preparation. They also face facility limitations, in that most hospitals lack ambulatory care facilities, and equipment and technology limitations. Compounding these barriers is the stigmatization of abortion, which is still widespread in many rural communities.

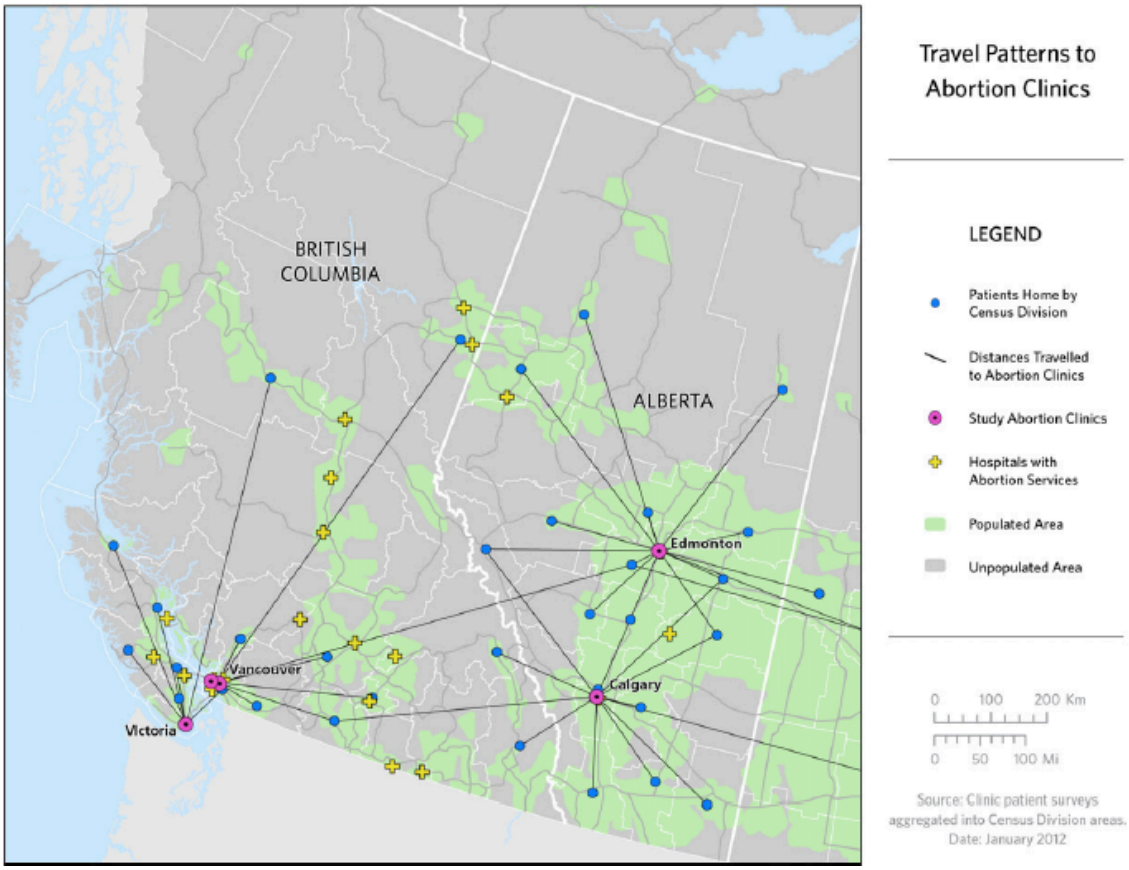
2.2.1. Distance

In many rural communities, hospitals are the primary point of access for health care, and many women must travel a considerable distance to reach the nearest hospital. This is particularly the case for First Nations women who live on-reserve. Additionally, many rural hospitals do not offer abortions, and thus women need to travel to other jurisdictions to reach a hospital that will provide abortions (Sethna & Doull, 2013). Many rural hospitals that do offer abortions are only equipped to offer first trimester abortions; only 25% of rural abortion providers offer abortion services after the first trimester (Norman et al., 2013). Thus, women whose pregnancies have progressed beyond the first trimester need to travel either to a different hospital or to a specialized abortion clinic in an urban area.

Many women prefer the services offered at abortion clinics rather than hospitals. Small hospitals in small communities can present confidentiality issues for women. Women may want to avoid general anesthesia and invasive procedures, or the multiple appointments and counselling sessions often required in hospital settings. There also may be longer waits for appointments at local hospitals due to the high demand and short supply, which characterize rural communities. In contrast, women in urban centres are more likely to procure a timely appointment due to their proximity to both abortion providing hospitals and numerous abortion clinics. Hospital staff at rural hospitals may harbour anti-abortion sentiments, which create unsupportive environments for women and they may even give women misinformation. There have been reports of physicians who misinform women about their eligibility for abortion or the timing of the procedure, in addition to using other stalling tactics, in order to prevent them from going through with an abortion (Kaposy, 2010). Specialized abortion clinics are more likely to be operated

by staff who support abortion services and may have sensitivity training (Doran & Nancarrow, 2015; Sethna & Doull, 2013). Given these considerations, many women living in rural areas will opt to visit a clinic in an urban setting, meaning extensive travel and inconvenience. On a national scale, of women who visited an abortion clinic nearly 82% lived within 100km and about 18.1% lived over 100km from said clinic. The distances traveled to clinics varied from 1km to as high as 3,558 km, where women had to travel outside their home province (Sethna & Doull, 2013). In British Columbia, women have reported needing to travel 8 to 10 hours each way to reach a clinic (CART-GRAC, 2014). The following figure demonstrates the travel patterns of women in rural British Columbia and Alberta who visited abortion clinics in urban centres.

Figure 1. Regional Map of Women's Travel Patterns to Abortion Clinics – BC and Alberta



Source: Sethna, C., & Doull, M. (2013). Spatial Disparities and Travel to Freestanding Abortion Clinics in Canada. Women's Studies International Forum, 38, 52-62. doi:10.1016/j.wsif.2013.02.001

For example, about a third of the women who visited Vancouver Island's one abortion clinic (in Victoria) traveled over 100km to do so. From the journeys depicted, with origins in BC, the average distance traveled was about 250km. The two longest distances traveled were 650km and 750km.

Ramifications due to distance and resulting travel disproportionately affect women who are underprivileged and from vulnerable groups. Women with lower incomes are more likely to face greater travel than their higher income counterparts; women under 30 are more likely to travel over 100km to reach an abortion clinic, and are more likely to report a difficult journey. First Nations and Métis women are almost three times more likely than non-indigenous women to travel over 100 km to an abortion clinic (Sethna & Doull, 2013). Travel can have serious consequences for women attempting to access abortion services. The further a woman lives from abortion services and the further she must travel, the less likely she is to be successful in procuring an abortion (Sethna & Doull, 2013).

Abortion providers in rural areas are also negatively affected by distance, as they typically live and practice far from other health care professionals or health care facilities. Rural hospitals are typically established in the few larger communities and are often far from typical rural women. Given that not all hospitals offer abortions, abortion providers tend to be few and far between, creating a feeling of professional isolation (CART-GRAC, 2014). Physicians report they are often the only provider in their community, often with a large catchment area, and are often unable to meet their community's needs. Their feeling of professional isolation causes providers to feel responsible for being available at all times (Dressler, Maughn, Soon, & Norman, 2013). Physicians also report a lack of professional education opportunities, which makes it difficult for them to stay up to date in their service provision. The lack of continuing education opportunities prevents physicians from discussing issues with fellow abortion providers, and from having a feeling of comraderie, which would help them feel more supported (Dressler et al., 2013). Additionally, providers often experience personal isolation because they live in small communities, and feel as though they need to hide their work. They feel concerned about the potential impact on their children or families if their practice was discovered by the community (Dressler et al., 2013).

2.2.2. Cost

The cost of abortion services is one of the primary barriers facing women (CART-GRAC, 2014). Surveys of women in Canada who procured abortions found that 20% of participants felt the fees were too high (Doran & Nancarrow, 2015). As a medically necessary service, provincial medical insurance should cover abortion services; however on a national level 22.1% of women who visited an abortion clinic reported that they paid for the abortion themselves (Sethna & Doull, 2013). While most women do not pay for the abortion procedure directly, supplementary costs can include administrative fees and the medication cost for medical abortions. For example, Willow Women's Clinic, one of the few clinics offering medical abortions in BC, charges $100 for the methotrexate–misoprostol regimen for abortion medication (Willow Women's Clinic, 2010b). The abortion pill mifepristone, which was recently approved for use in Canada, is taken with another pill misoprostol, and together the two-step medication regimen costs between $300 and $360 (Norman & Soon, 2016; Wiebe, 2017). Canada wide, administrative fees tend to range from $60 to $100. Some women report supplementary costs ranging from $50 to $100, but admit that even costs as low as $50 were more than they could afford (Sethna & Doull, 2013). For women without provincial medical coverage, total abortion procedure costs can range from $370 to $1,300. These costs vary depending on whether the woman is from out of the province or the country, and the advanced stage of the pregnancy. At Elizabeth Bagshaw Women's Clinic, a primary abortion clinic in Vancouver, BC, there are fees for women who do not have a valid BC Care Card (Elizabeth Bagshaw Women's Clinic, n.d.). An abortion up to a 12-week pregnancy costs $500; an abortion for a 12 to 14 week pregnancy costs $550, and an abortion from a 14 week pregnancy costs $650 (Elizabeth Bagshaw Women's Clinic, n.d.). The clinic does provides out-of-province reimbursement forms, but full payment is required upfront at the time of the appointment (Elizabeth Bagshaw Women's Clinic, n.d.). About twenty five percent of women who attended an abortion clinic in BC reported that they paid more than $300, indicating that they most likely paid for the procedure itself (Sethna & Doull, 2013). Some of these women may succeed in obtaining reimbursement from their provincial health plans; however for many women, affording the upfront cost is out of the question.

Travel costs are the most common abortion-related expense for women accessing abortion services (CART-GRAC, 2014). These costs can vary from nothing to over $100 (Sethna & Doull, 2013). Travel costs can encompass purchasing plane tickets, bus tickets, ferry tickets, and paying for gas or a taxi. Typically, women need to pay these costs for themselves and for a travel partner. Paying for these travel expenses can be extremely burdensome for many women; 23.8% of women who must travel to an abortion clinic have an annual income of less than $10,000, and 23.3% of women make between $10,000 and $19,000 a year (Sethna & Doull, 2013). In other words, nearly half of women who travel to abortion clinics make less that $20,000 a year.

Indigenous women who live on-reserve face unique barriers related to cost when attempting to access abortion services. They often have the greatest costs associated with travel, and are more likely to experience difficulties paying for abortion procedures or related fees. Additionally, women on reserve must go through an application process to obtain formal approval of funds for off-reserve travel, otherwise they themselves need to pay for their travel expenses. This process will typically create long delays, and confidentiality is by no means guaranteed (Sethna & Doull, 2013).

Women accessing abortion services also contend with a variety of miscellaneous costs. Examples encompass childcare costs, parking costs, food costs and car repairs before extensive travel. Typically, about 38% of women undertake these expenses, which can range from $10 to over $100. Additionally, women usually take time off work for travel to an abortion clinic, and suffer the associated loss of income. These miscellaneous costs are typically doubled because most women take along a companion for travelling and for support during the process. 73.1% of women reported traveling with someone, 42.3% reported travelling with a boyfriend or partner, 24% with a friend, and 15.2% with their husband (Sethna & Doull, 2013).

2.2.3. Lack of Rural Health Care Professionals

Several factors have led to the shortage of health care professionals willing to provide rural abortion services. First of all, in Canada the only health professionals licensed to perform abortions are physicians (Norman et al., 2013). There are only 46 licensed

surgical abortion providers in BC, and currently about one third are nearing retirement (CART-GRAC, 2014; Norman et al., 2013). Many physicians are never trained to perform abortions, or have no interest in obtaining such training. Rural providers have reported approaching other physicians and found that there was no interest in obtaining training (Dressler et al., 2013). Moreover, physicians who are properly trained rarely opt to practice in rural areas. Thus, licensed abortion providers in rural BC are few and far between.

Additionally, there is a serious lack of training available for physicians interested in performing abortions. Rural physicians are less likely to train other physicians than their urban counterparts, sometimes citing insecurity and feeling inadequate in their abilities to provide proper training. This feeling is compounded by the unavailability of specialists should a complication occur. One provider even reported closing his/her practice because s/he felt unable to provide an adequate service. This was due to the lack of continuing education and professional training opportunities in rural areas, which renders providers unable to obtain updated training and skills (Dressler et al., 2013). Not having enough replacements contributes to the high burn out rate of the providers (CART-GRAC, 2014).

There are also insufficient support staff and allied health care professionals. In rural areas, almost all abortions are performed in a hospital operating room and require an anesthetist to administer general anesthesia. As such, the shortage of anesthetists limits the number of abortions that can be performed. Additionally, there is a shortage of allied health care professionals who provide counselling and preparation (CART-GRAC, 2014). As a result, physicians who provide abortions have to take on those tasks as well. This involves providers arranging counseling sessions and pre-operative assessments in their schedules, which limits the number of women they can serve. In abortion clinics, the interdisciplinary professional health staff includes counselors, nurses, and even volunteers who take on those responsibilities (Dressler et al., 2013).

Women often must contact multiple providers before they can secure an appointment. Nearly 40% of women who attended an abortion clinic reported that the first provider they contacted had no appointments available. Women will often choose to travel to a

more distant clinic because of the long wait list for the first provider they contacted (Sethna & Doull, 2013). These wait lists are often up to 4 or 5 weeks (Dressler et al., 2013). In that time pregnancies may progress to the next trimester. Because many rural hospitals are unable to provide services beyond the first trimester, this forces women to travel farther. Beyond the greater travel, adverse consequences include higher costs for an advanced pregnancy abortion, and higher risk for complications. Such long wait periods have serious emotional and psychological effects (Sethna & Doull, 2013).

2.2.4. Lack of Health Care Facility Resources

In rural areas, hospitals are for the most part the only facilities to offer abortions. Most rural hospitals do not have ambulatory outpatient clinics, and as a result almost all abortions are performed in hospital operating rooms (CART-GRAC, 2014; Dressler et al., 2013). Thus, most abortions are surgical and require general anesthesia. Such procedures take a greater toll on women, and are not always required. Women who wish to avoid general anesthesia must travel farther to urban areas that have clinics with more options (Sethna & Doull, 2013). Abortions undergone in the OR are also costlier to the provincial health system than those conducted in outpatient clinics (CART-GRAC, 2014). Surgical abortions performed in the OR require an anesthetist, and as discussed earlier, the shortage of anesthetists contributes to the long wait lists. Providers also find they do not always have comfortable working relationships with OR staff. Sometimes members of the general OR staff do not approve of providing abortions, and this prevents providers from creating a supportive environment for women (CART-GRAC, 2014). There can often be difficulty in logistically scheduling staff in the OR to accommodate staff who do not wish to be a part of providing abortion care (Dressler et al., 2013). Abortions are usually given low priority in ORs, adding to wait times (CART-GRAC, 2014).

Other miscellaneous restrictions face providers in rural hospitals. Many rural hospitals have gestational limits. Women whose pregnancies are past the first trimester often must go to urban area clinics or hospitals where advanced pregnancies can be accommodated. As discussed earlier, this presents women with greater travel burdens, higher travel costs, and other associated travel costs such as childcare, missed work

and so on (CART-GRAC, 2014). Additionally, many rural facilities are unable to provide medical abortions, where an abortion is induced with medication rather than surgery. This is often a preferred method of abortion because no general anesthesia is required; fewer staff are needed; costs are lower; chances for complications are lower, and fewer appointment are needed. (Sethna & Doull, 2013). Rural hospitals also often have limited equipment and technology, meaning it can be difficult for women to have timely ultrasounds (CART-GRAC, 2014; Dressler et al., 2013).

2.2.5. Stigmatization

In many rural communities, the public perception of abortion continues to be predominantly negative and judgmental. In rural Canada the primary reason doctors and nurses stopped providing abortion care was harassment and public stigma (CART-GRAC, 2014; Doran & Nancarrow, 2015). Resignations only exacerbate the already serious shortage of abortion providers in rural areas of BC. The providers who remain often choose to hide the fact that they work in abortion care because of the public stigma. They report having to "fly under the radar," particularly in smaller communities (Doran & Nancarrow, 2015). The stigma and harassment that providers experience can be a significant deterrent to new licensed physicians. Public stigma also seriously affects women accessing abortion services.

Chapter 3. Methodology

In this study, I employ mixed methodologies including a literature review, a jurisdictional scan, and expert interviews.

3.1. Literature Review

Since the legal barriers to abortion have been minimized, there has been a growing interest among women's health advocates and academics in the extra-legal barriers to abortion. While the existing literature is not extensive, a fair amount of research has been conducted into such barriers and their consequences. This work provides the backbone for my synthesis of the problem background. Additionally, research into the difficulties of providing health care services of any kind in rural areas has helped to inform the exploration of problem drivers. I explore each major barrier and show the relationships between them. Through this overview I explain the resulting harms to both women and health care professionals, and touch on the effects to the health care system.

3.2. Jurisdictional Scan

Extra-legal barriers to abortion services are similar across rural jurisdictions. A jurisdictional scan of rural and urban communities in Canada identifies hospitals, clinics and organizations that have implemented or are in the process of implementing policy options to address one or more barriers to abortion services. Through the scan I identify and assess potential policy options.

3.3. Expert Interviews

I conducted interviews with experts in the fields of women's health and reproductive health services. Interviews targeted representatives from organizations such as Options for Sexual Health, Willow Women's Clinic, physician and nurse advocacy organizations, and government health organizations. Experts from these fields offered insight into the details of the policy problem, and which policy options would be well regarded. Interviews were used to gather information regarding the costs and benefits of options as well as their practicability and feasibility. Interviews were conducted in a semi-structured format.

Chapter 4. Jurisdictional Scan

This chapter presents policy interventions undertaken by different health care organizations in a variety of jurisdictions across BC. The successes and challenges of these interventions are delineated for future policy consideration. These individual examples provide insight into how policies could be formulated to address abortion barriers on a larger more systematic scale across all BC.

4.1. The Benefits of Ambulatory Care

Many hospitals have found advantages in performing abortions in outpatient clinics rather than in operating rooms. Many hospitals transitioned abortion care from operating rooms to outpatient clinics and found great success in areas such as cost, effectiveness, fewer complications, more flexibility and privacy.

4.1.1. Kelowna General Hospital: Women's Services Clinic

There are two notable examples of the success of ambulatory care for abortion procedures in BC. The first is the Women's Services Clinic in the Kelowna General Hospital. The clinic was instituted in 2000 and is in the acute care facility, although notably separate from patient wards to afford greater privacy. At its inception the clinic was intended, due to its funding, to provide 650 procedures per year and to provide care up to the 12th week of pregnancy (CART-GRAC, 2014). The clinic offers surgical abortions, related abortion care, and a number of other reproductive health services including pap tests, birth control counselling and prescriptions, contraceptive sales, IUD insertion and removal, RH factor typing, and sexually transmitted infection screening (CART-GRAC, 2014; Interior Health Authority, n.d.).

The staff model allows for great efficiency with specific staff for dedicated administrative and support care. A unit clerk takes care of booking appointments and clinic flow, and is present in the clinic three days a week. The clinic also features four registered nurses who provide patients with counseling, pre and post procedure care, and general support during procedures. In addition, there is one licensed practical nurse and one Sterile Processing Technician (CART-GRAC, 2014). This staffing model allows the physicians to dedicate all their time to patient procedures, greatly increasing efficiency and the number of patients to which the clinic can attend.

The clinic has exceeded its expected capabilities. Despite original funding for only 650 procedures, the clinic provided 750 procedures in 2013/2014, within its level of funding. Despite improvements in efficiency the clinic unfortunately still has a fairly long wait-list, which averages about four weeks. While a four-week waitlist is not as long as at other rural hospitals, such a long wait for abortion procedures is still a major barrier to quality abortion care. Additional funding would allow the clinic to provide additional procedures and address the long wait period (CART-GRAC, 2014).

The clinic features security accommodations such as access restrictions, and at its start had security personnel on site. Presently, the clinic no longer employs security staff and has not experienced a security incident in 14 years (CART-GRAC, 2014).

Kelowna General Hospital has seen significant cost savings since instituting the Women's Services Clinic. Moving abortion procedures from the operating room to an outpatient setting has saved between $300 and $350 per case; in the operating room, surgical abortions cost an average of $830 per case. Beginning in 2009 the hospital began to use clinic space rather than the operating room for gynecological procedures, and seen equivalent savings. Offering abortion services in the Women's Services Clinic has also helped to fight stigma by increasing privacy and offering all women's services in the same clinic (CART-GRAC, 2014).

4.1.2. Kootenay Boundary Regional Hospital

The Kootenay Boundary Regional Hospital is the other notable example of ambulatory care for abortion procedures in BC. Originally the abortion clinic was run out of Castlegar

Hospital in the 1990s. Then in 2002 the Kootenay Boundary Regional Hospital took on the program. It was only recently in 2012 that the hospital transitioned abortion procedures from the operating room to an outpatient setting. The clinic offers surgical abortions only and runs twice a week with a dedicated staff of three: one registered nurse, one licensed practical nurse, and one clerk. Although the clinic does not have its own dedicated space, it runs successfully out of the surgical day care centre. Most of the general hospital staff do not have objections to working in the clinic, but staff are permitted to opt out if they do (CART-GRAC, 2014). This is important to keeping the clinic a positive and supportive space for patients.

The clinic typically sees between six and ten patients each day, and the move to ambulatory care helped to make the setting more relaxed for patients. The hospital has also seen significant savings, with an almost identical reduction in costs per case as seen at Kelowna General Hospital. Like the Kelowna Women's Services Clinic, the Kootenay clinic has never had a security incident and does not presently employ security personnel onsite (CART-GRAC, 2014).

Hospital funding is only provided for staffing an infrastructure, not for abortion provision, so physician payment is fee-for-service. The clinic staff does not include counsellors or nurses to support patients, and as a result the one physician available is also responsible for these services. The clinic does not provide follow up, so patients must go to a GP, an Options for Sexual Health clinic or a walk-in clinic for follow up. However, some GPs will not provide care to abortion patients. With only one physician, there are still problems with burn out (CART-GRAC, 2014).

Other hospitals could emulate several successful features of these abortion outpatient clinics. A dedicated clinic for all women's reproductive related services provides anonymity and privacy. It also gives staff greater control and an easier time scheduling patients without having to go through OR staff. However, many hospitals in rural areas are limited in their space, funding, and staff. The Kootenay clinic shows that it is also possible to run an abortion outpatient clinic in an ambulatory care facility rather than the operating room. Some hospitals run abortion clinics in outpatient facilities used for colposcopy or colonoscopy clinics. All hospitals could adopt this practice relatively

easily, and thus benefit from the significant cost savings from avoiding general anesthesia and other operating room costs. It is also important to follow the Kootenay clinic's practice of allowing staff to opt out of working in the abortion clinic. Providing patients with a supportive environment is equally important in combatting stigma and harassment. Lastly, it is important to note that even if another outpatient clinic setting is unavailable, and the only space for abortion procedures is in the operating room, staff can still use ambulatory care procedures. OR staff can be trained to avoid general anesthesia in deference to local anesthesia or analgesia.

4.2. Distance Abortions

Distance abortions offer an opportunity to bring abortion care to women rather than requiring them to travel great distances. Surveys have found that women widely prefer medical abortions to surgical (Doran & Nancarrow, 2015). Using telehealth with medical abortions allows providers to offer distance abortions. Distance abortions allow for an earlier termination thereby lowering the risk of complications and emotional hardship. They can be done at home affording women greater privacy and the ability to involve partners or friends for support. A home abortion reduces the need to travel, saving women great financial costs and emotional stress.

4.2.1. Vancouver Willow Women's Clinic

Currently Willow Women's Clinic in Vancouver and Vancouver Island Women's Clinic are among the few clinics or hospitals in British Columbia that offer medical abortions. The clinic in Vancouver offers distance abortions as well as medical abortions on-site with a combined regimen of methotrexate and misoprostol (Willow Women's Clinic, 2010a). Since the approval of Mifepristone in Canada Willow Women's Clinic also uses Mifegymiso for medical abortions (Wiebe, 2017). Women who live more than a two hour drive from Willow Women's Clinic or Vancouver Island Women's Clinic have the option of procuring a distance abortion (Willow Women's Clinic, 2010a).

Willow Women's Clinic conducts its abortion consultations via Skype. Patients schedule an appointment with the clinic and speak with a doctor, through Skype, who reviews the

patient's history and determines the necessary tests. The clinic faxes a requisition to a local lab near the patient for the necessary tests. On occasion a patient may need to go to a local hospital or clinic for an ultrasound to determine the pregnancy gestation. All the test and ultrasound results are sent to Willow Women's Clinic after which patients have a second skype appointment with a doctor. At this appointment patients go over the tests and learn the process and steps they will need to take to self-induce the medical abortion. A counsellor goes over what to expect, any potential side effects, and answers any questions. Willow Women's Clinic then couriers the medication to the patient, and requires confirmation of medication receipt from the patient. Patients must go to a local lab for a blood test on the day they intend to take the medication. One week after taking the medication patients must either get another blood test or an ultrasound to ensure the abortion is complete.

Women can safely have medical abortions at home if they are given proper instruction, and have access to emergency medical care in case of complications. Surgical and medical abortions are extremely safe; the death rates for both are under one in 100,000. In fact, abortions are actually ten times safer than child birth: the maternal death rate for child birth is ten per 100,000 in Canada. The morbidity rate of severe bleeding from medical abortion is only one in 3,000 (Wiebe, 2017). Therefore, morbidity rates for distance abortions are not of extreme concern. In case of complications, such as severe bleeding, women can procure emergency medical care. The effects of a medical abortion appear the same as a miscarriage. Miscarriages are extremely common: one out of every six pregnancies results in a miscarriage. They are easily treated in every rural community (Wiebe, 2017). However, having an abortion can be a distressing ordeal, and many women do not have sufficient supports to help them through it, often due to societal stigma. Additionally, mifepristone does not interrupt an ectopic pregnancy the way methotrexate does. This is just one reason why blood tests are a necessary part of the medical abortion regimen (Palmqvist, 2017). Pre- and post-counselling are important not just for properly supporting the patient, but to ensure she is undergoing an abortion by choice, and is aware of the risks (Palmqvist, 2017).

The model used by Willow Women's Clinic offers an opportunity to offer medical abortions through additional clinics and hospitals. The availability of medical abortions is

extremely limited in BC. The key to Willow Women's Clinic distance abortion is the recognition that the aspects of abortion which require in-person care are blood tests and ultrasounds. These are both services available at any hospital or local lab. The only abortion-related aspects are the dispensing of methotrexate and misoprostol (or since its approval mifepristone and misoprostol), and the appointments for consultation and counselling.

4.3. Telemedicine Hotlines

Telehealth and telemedicine have been utilized more and more in health care over the last decade. Contraception and abortion hotlines present exciting opportunities to reach women in remote areas, and to make reproductive health information more readily accessible to all women. BC has two major reproductive health hotlines: BC Women's Hospital offers the Pregnancy Options Line, and Options for Sexual Health offers the Sex Sense Hotline. The Pregnancy Options Line offers counselling and referral services (Norman, Hestrin, & Dueck, 2014). The Pregnancy Options Line has answered over 2000 calls per year since 1999 (Norman et al., 2014). It has also collected data on Access barriers and improved understanding of obstacles (Norman et al., 2014). Both lines provide trustworthy information and help women to secure appointments with valid providers.

Chapter 5. Beyond BC: Research on Abortion by Mid-Level Providers

Current policy in BC restricts abortion provision to physicians only. However, research suggests that midlevel providers such as registered nurses (RNs), nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) can provide abortions with no increased risk to patients. Many studies have come to this conclusion, and these findings are reflected in the policies of many countries which allow midlevel providers to perform surgical and medical abortions (Berer, 2009). Sweden, France, Great Britain, and the US, for example, all have regulations allowing midlevel providers varying levels of involvement in providing surgical and medical abortions (Berer, 2009). For the purposes of this study, this chapter will provide an overview of one recent study conducted in California, USA, to demonstrate the success of allowing midlevel providers to perform abortions.

In the chosen study NPs, CNMs, and PAs were trained to perform aspiration abortions to assess the potential risk to patients. To qualify for the training providers had to have a valid licence to practice in California, be certified in basic life support, and have at least 12 months' experience in clinical work, including at least three months' experience with medical abortions. Training was provided to 28 NPs, five CNMs, and seven PAs, who conducted 5,675 aspiration abortions during the study period from August 2007 to August 2011. Their procedures were compared with a group of 96 physicians who performed 5,812 abortions during the study period. The average years' experience physicians had in abortion provision was 14, while the average years' experience for the midlevel providers was 1.5. There were very few complications overall from either physician or midlevel provider procedures. From physician performed procedures 0.9% resulted in complications, and from midlevel provider performed procedures 1.8% resulted in complications. Most complications were minor; there were only six major complications in total, with three in each provider group. There was no difference in the

risk of major complication between the two provider groups. The difference in risk for all complications between provider groups was 0.87%. Given that the 0.87% risk difference fell within the confidence interval of 2%, the complication rates of midlevel providers was not statistically worse than the rates of physicians. Moreover, the midlevel providers had far fewer years' experience in abortion provision, and performed similarly to newly trained physicians (Weitz et al., 2013). This study is only one of many that have found that the risk of complications during surgical abortions does not increase when procedures are completed by midlevel providers.

Chapter 6. Interview Findings

I conducted interviews with Helena Palmqvist, the clinical manager for Options for Sexual Health, and with Ellen Wiebe, the medical director of Willow Women's Clinic and clinical professor at the University of British Columbia. The two interviewees offered their expertise on a range of topics related to abortion care and potential policy interventions. I summarize the major findings of the interviews in the following sections, and group the information according to topic. I conducted additional interviews with anonymous representatives of government and advocacy organizations. Most insights from these interviews are not specified due to anonymity concerns, but were used in synthesizing research findings, developing policy options, and conducting policy analysis.

6.1.1. Major Barriers

The primary barrier to abortion provision in rural areas is the lack of providers willing and able to perform abortions (Palmqvist, 2017; Wiebe, 2017). Difficulty with issues around privacy and confidentiality are also a major concern. Stigma is still a big problem in many small, rural towns; it can be difficult for women to secure the privacy they would like (Wiebe, 2017). There is limited support for women who need to travel, and little accommodation for any of the financial needs which result from traveling. These needs include the cost of transport, dealing with time away from work, childcare requirements, and accommodation while traveling (Palmqvist, 2017). Allowing the conscientious objection of some medical staff to performing abortions is also a contributing factor to barriers. Allowing for conscientious objection dramatically limits the number of physicians who will perform abortions (Palmqvist, 2017). The movement for physician assisted suicide raises challenges to the conscientious objection policy. Gains made in that sector may open the door to challenges made on behalf of the pro-choice movement.

6.1.2. Distance Abortions

Distance abortions are a promising way to provide care in remote areas, but distance abortion provision still involves several challenges. For physicians to bill for the care they provide they must use a video connection with a patient. Conducting counselling over the phone is not sufficient (Palmqvist, 2017). This can be quite difficult in areas where there is no guarantee of a strong internet connection. There can also be privacy concerns with video consultations. It can also be challenging for women to access the auxiliary services required for distance abortions. Some providers who are not pro-choice may stand in the way of patients getting ultrasounds or blood work, and slow down the processes in an urgent situation. Abortion clinics have limited connections to pharmacists in rural areas so helping women access medication can also be very challenging (Palmqvist, 2017; Wiebe, 2017).

6.1.3. Dispensing Mifepristone

In 2016 Mifepristone was approved for use in Canada, but there are still many difficulties in dispensing the medication. Mifepristone is not yet widely available, but some physicians, clinics, and pharmacists have already begun to try and provide the medication to women. Dr. Wiebe described some of the challenges that Willow Women's Clinic has faced in attempting to provide the medication, and which many other providers are also encountering. In Canada mifepristone is packaged with misoprostol and sold under the name Mifegymiso. Mifepristone has long been considered the global gold standard for abortion medication, and is listed as an essential medicine by the World Health Organization (Norman & Soon, 2016). Mifepristone works faster, more completely, and more effectively than methotrexate. It has almost no teratogenicity and is the safest abortion medication available. It is significantly safer than the combined methotrexate–misoprostol regimen that providers have been using up until now (Wiebe, 2017). The dosage for mifepristone is also extremely simple; there is only one appropriate dose for all women. In contrast the proper dosage of methotrexate must be calculated for each individual woman according to height and weight. The risks of the wrong dose are much higher for methotrexate, for the wrong dose can damage bone

marrow. In the case of mifepristone, a dose three times too large still would have no negative effect (Wiebe, 2017).

Mifepristone is clearly extremely safe with next to no risks associated, especially in comparison with methotrexate, but the rules surrounding dispensing the medication are unnecessarily complex and onerous. The College of Pharmacists of BC has a set of rules, the College of Physicians and Surgeons of BC has a set of rules, the Society of Obstetrics and Gynaecologists of Canada has a set of rules, and Health Canada has a set of rules. Health Canada's guidelines do not allow pharmacists to dispense directly to patients, instead they must dispense to physicians. Physicians must only dispense the medication in office, and must witness taking the first medication (Wiebe, 2017). The CPSBC have their own set of guidelines which state that physicians cannot dispense medication that patients take at home, that is a pharmacist's responsibility. In order to dispense medication that patients take at home physicians need a special licence, which next to no one has (Wiebe, 2017). These rules create a situation where only doctors can dispense mifepristone, only in office, and patients can only take it in office. This means the medical abortions with mifepristone can only take place in office, making distance abortions extremely difficult to achieve. The nature of mifepristone and how effective, safe, and simple it is, makes it perfect for distance abortions, but the bureaucracy is preventative (Wiebe, 2017). Moreover, for pharmacists to dispense mifepristone they must take an additional course and pass an additional exam. The chances that a pharmacist in a small, rural town will undergo these additional steps are extremely small (Wiebe, 2017).

Beyond the complex dispensing guidelines, the cost of Mifegymiso is very prohibitive. A pharmacist who has completed the necessary course and exam will likely charge $360 for the medication (Wiebe, 2017). Willow Women's Clinic is one of the few providers that offers medical abortions and they are charging $325 for Mifegymiso. Additionally, because the clinic cannot depend on small town pharmacists to have completed the necessary course and exam, they must courier the medication to women having distance abortions. As a result, women must pay not only the cost of the medication but the courier costs as well (Wiebe, 2017).

6.1.4. Provincial Reciprocal Billing

Due to the portability guarantee of the Canada Health Act, medical providers are required to accept patients' health care cards from other provinces and territories. The Interprovincial Health Insurance Agreements Coordinating Committee oversees the agreement between provinces and territories for reciprocal billing for health services. This way when a patient presents a health care card outside of their home province, the provider bills the home province directly so that the patient does not have to pay point of service fees (Abortion Rights Coalition of Canada, 2005). There is a list of medical services which are exempted from the reciprocal billing agreements between provinces and territories. This list includes therapeutic abortion despite the fact that abortions are legal and an insured service in every province. The other services on this list are exceptions to the reciprocal billing agreements because they are either not time sensitive, they are insured under a federal institution, they are still in an experimental stage, or a more conventional and cheaper treatment is available.[1] Abortion does not fall under any of these categories and should not be exempted from reciprocal billing agreements (Abortion Rights Coalition of Canada, 2005). However, with the current system, abortion providers encounter patients every day who come from out of province, and who will have to pay for services up front (Wiebe, 2017). People who come to abortion clinics are less likely to be settled down, seeing as most women settle down before deciding to have a baby. Often these women are still in school and studying across provincial boundaries. Providers encounter women who have flown in and who have driven in from out of province. However, of the women who have crossed provincial boundaries, more often than not they are students who require abortion care (Wiebe, 2017).

6.1.5. Abortion by Midlevel Providers

Allowing nurse practitioners and certified nurse midwives to provide abortion care would make a huge difference for both patients and physicians (Palmqvist, 2017; Wiebe, 2017). Nurse practitioners already have the scope of care for diagnosing and prescribing

[1] For a full list of the services exempted from provincial reciprocal billing see Appendix B.

for the relevant health issues. They also are already certified for well-woman care. When it comes to skills and training, nurse practitioners could perform abortions now with minimal extra certification (Wiebe, 2017). Midwives provide abortion care in Sweden, in many other place around the world, and there is no reason why they could not do so in Canada as well (Palmqvist, 2017; Wiebe, 2017). The first step would be to expand the role of midwives to include well-woman care (Wiebe, 2017). Additional training could be easily developed to certify midwives for surgical and medical abortions (Palmqvist, 2017).

Registered nurses could also provide abortion care, but would require more training and supervision than nurse practitioners and certified nurse midwives (Palmqvist, 2017; Wiebe, 2017). With proper training and skill development nurses could perform abortions, however even after certification it is likely that they would require supervision when providing care (Wiebe, 2017). BC has previously expanded the scope of practice for nurses and seen great success. Certified practice for nurses expanded to include sexual health services including contraceptive management, STI management and contraceptive dispensing. Occasionally some cases in those areas are still referred to a physician, such as when complications arise. However, nurses now provide most of that care, and this has made a huge difference to issues of access. The success in sexual health services demonstrates that proper certification for nurses can be developed appropriately in other areas, and ensures that nurses will be adequately supported (Palmqvist, 2017).

The delays in expanding scope of practice for midlevel providers likely have to do with the various health care colleges. It is likely that this issue is not a top priority currently for the College of Registered Nurses of BC (Palmqvist, 2017; Wiebe, 2017). Issues around conscientious objection are also relevant. There may be some nurses and midwives who would prefer not to offer abortion care. As such if an expansion of scope occurred, provision would likely have to be optional (Palmqvist, 2017). The other major question with expansion of scope is that of finances. It is unclear who and what program would pay for nurses to provide abortion care. However, it is also important to remember that when abortion care is not provided, there is still a greater cost to the health care system elsewhere (Palmqvist, 2017). It is also possible that the CPSBC are not in favour of

expanding scope for nurse practitioners and midwives, seeing as some physicians are against it (Wiebe, 2017).

6.1.6. Utilizing Ambulatory Care

Providing surgical abortions in operating rooms is generally considered unnecessary. Surgical abortions are not typical surgeries (Palmqvist, 2017). They do not involve incisions or stitches, and do not require general anesthesia. Providing surgical abortions in operating rooms involves complying with all the certifications and costly requirements associated with typical operating room procedures (Palmqvist, 2017). Dealing with these high costs are completely unnecessary seeing as surgical abortions do not require operating room conditions, and can easily occur in ambulatory care with local anesthesia. Unfortunately, there is no relevant category for the specific type of care provided with surgical abortions. As a result non-profit abortion providers are considered surgical units and have to comply with all the same certification requirements imposed on surgical facilities (Palmqvist, 2017).

There are, however, some scenarios where it makes more sense to provide surgical abortions in the operating room. Many rural communities do not have free-standing clinics for surgery, so any surgery must be done in a hospital. Whether a surgical abortion should be done in the operating room or the ambulatory clinic has a lot to do with the number of surgical abortions usually provided. If a hospital is only providing one abortion per month, it may make more sense to do the procedure in the operating room. If that hospital is doing six abortions per week then it would be better to do so in an ambulatory clinic. An ambulatory clinic has dedicated staff, it can be made to feel less like a hospital, local anesthetic can be used, and providers and patients alike can all benefit from these advantages. But again, using an ambulatory clinic for those purposes only makes sense if the number of abortions provided is large enough to warrant doing so (Wiebe, 2017).

6.1.7. Telemedicine Hotlines

Telemedicine hotlines are important for providing women with accurate information and referral services. Many women needing abortion care do not know where to go or how to find trustworthy information. They do not necessarily have the digital literacy skills necessary to evaluate the information they find on the internet, and may fall prey to misinformation about abortions and available abortion services (Wiebe, 2017). As a result it is incredibly important to have correct information easily available. Information and referral hotlines play an important role in providing this service (Wiebe, 2017). The two major hotlines in BC are the Pregnancy Options Line run by BC Women's Hospital and the Sex Sense Line run by Options for Sexual Health. These lines could be improved to provide better and more consistent access. The Pregnancy Options Line has limited hours and the Sex Sense Line is short staffed (Palmqvist, 2017; Wiebe, 2017). The Sex Sense Line also does not have access to the same information as the Pregnancy Options Line, so it acts as a complimentary rather than an equivalent service (Palmqvist, 2017). It would be especially valuable to add a live chat option, as live chats are the preferred mode of communication for most people (BC government official, 2017). The aspects of abortion care which are the most important to women are getting accurate information and referrals, securing an appointment quickly, and having the appointment quickly (Wiebe, 2017). Bettering the telemedicine hotlines can help to provide those services.

Chapter 7. Policy Options

The following policy options are a list of priorities for reforming abortion care. The options are not mutually exclusive, and can be accomplished individually or in conjunction with others. Some policies will work best if implemented with one or two other options.

7.1. Improving Existing Structures and Programs

These policy options would introduce incremental changes to address problems in existing abortion care, and to improve existing programs.

7.1.1. Expanding Telemedicine Resources

The Pregnancy Options Line and the Sex Sense Line are successful telemedicine programs that provide information and referrals for women seeking abortion care. Improving these hotlines would help ensure that more women have access to accurate information, would ease the process of finding abortion care, and would increase the number of women who benefit from hotline services. This option includes increasing the number of hotline staff, the hours of operation, and adding communication options such as live chat and email. Additionally, the Pregnancy Options Line could achieve greater visibility through outreach and social media. The Sex Sense Line could work with the Pregnancy Options Line to improve its access to information and be an equivalent service.

7.1.2. Allowing Provincial Reciprocal Billing

Abortions are currently on the list of medical services exempted from provincial reciprocal billing agreements. As a result, women obtaining abortions outside their home

province must pay point of service fees, which can be extremely burdensome, and seek subsequent reimbursement from their home province. Abortions have no place on this list. They are an insured service in every province. Moreover, the other services on this list are exempted because they are either not time sensitive, are insured under a federal institution, are still in an experimental stage, or a more conventional and cheaper treatment is available (Abortion Rights Coalition of Canada, 2005). Abortion does not fall under any of these categories and should not be exempted from reciprocal billing agreements. This option would institute an agreement between BC and Alberta where the two provinces could bill each other for abortion services. This would avoid the necessity of a federal agreement which would be difficult to achieve between all provinces and territories. Moreover, BC experiences more interprovincial travel with Alberta than other provinces for abortion services.

7.1.3. Relaxing Regulations for Dispensing Mifepristone

The recent approval of mifepristone in Canada opens up opportunities for better access to medical and distance abortions. Mifepristone has long been considered the global gold standard for abortion medication, and is listed as an essential medicine by the World Health Organization (Norman & Soon, 2016). Like methotrexate it is taken in conjunction with misoprostol, but has a higher rate of effectiveness and lower rate of complications. Current regulations from Health Canada are unnecessarily restrictive and prevent its efficient distribution. Pharmacists are required to take an additional course and exam to dispense the medication, and can only dispense to physicians. Physicians can dispense to patients but only in office, and must witness the patient taking the medication. The CPSBC requires physicians to have a special licence to dispense medications in-office. (Medications are normally dispensed by a pharmacist and taken by the patient at home.) There is widespread agreement among reproductive health care experts that these regulations are unnecessarily restrictive. Pharmacists already have the regulatory requirements, the training, and the infrastructure in place to properly dispense prescription medications directly to patients (Norman & Soon, 2016). Physicians who provide abortions are already over-burdened, especially in rural areas, and mandating additional training and responsibilities will only hinder the availability of this essential medication. This option includes adjusting and coordinating the regulations

for mifepristone between Health Canada, the CPSBC, and the CPBC to allow for easy dispensing. Pharmacists would be allowed to dispense mifepristone directly to patients without any addition courses or exams. These changes would help to make distance abortions much easier to facilitate. They would also create additional opportunities for clinics and hospitals to provide medical and distance abortions.

7.1.4. Expanding Fair PharmaCare

While surgical abortions have no point of service fees, medical abortions can be quite costly due to the cost of the medications. The old regimen of methotrexate and misoprostol typically cost $100 (Willow Women's Clinic, 2010b). The new abortion medication Mifegymiso typically costs $360 from a pharmacy, $325 from a Willow Women's Clinic and $270 from Vancouver Island Women's Clinic (Vancouver Island Women's Clinic, 2016); (Wiebe, 2017)

PharmaCare, a provincial BC program, subsidizes the cost of formulary drugs, medical supplies and other pharmacy services for low income residents. There are several plans under PharmaCare, the largest of which is Fair PharmaCare. Individuals and families who have the BC Medical Services Plan (MSP) and who fall below a certain annual income qualify for Fair PharmaCare (British Columbia Ministry of Health, n.d.). Families who have a net income of $15,000 or less pay a $0 deductible, and PharmaCare covers 70% of their eligible costs (British Columbia Ministry of Health, 2009).[2]

Currently, Fair PharmaCare covers a very small portion of methotrexate and misoprostol separately, and Mifegymiso receives no PharmaCare coverage (British Columbia Ministry of Health, 2017);(British Columbia Ministry of Health, 2016). The federal and provincial Common Drug Review are still in the process of reviewing Mifegymiso. Once reviewed for effectiveness and safety it is likely that Mifegymiso will be covered by FairPharmaCare, and coverage will follow the standard Fair PharmaCare formulas (BC government official, 2017). To combat the dollar cost of medical abortions,

[2] For a full table of Fair PharmaCare Assistance Levels see Appendix A.

this option proposes that Fair PharmaCare extend its coverage to protect a greater range of incomes. This extension would cover specifically Mifegymiso, as it will soon become the standard in medical abortion care, and it would cover the maximum 70% of Mifegymiso for the qualifying incomes.

7.2. Major Initiatives and Policies

The following policy options introduce larger changes to existing policies and involve greater financial costs.

7.2.1. Abortion Care by Midlevel Providers

Many countries certify midlevel providers for abortion care. Extensive research has shown that midlevel health professionals can safely provide abortion care with no increase in risk to patients (Berer, 2009; Weitz et al., 2013). Nurse practitioners and midwives in BC already have most of the necessary knowledge and skills to provide abortions. Nurses have undergone training and certification in the past to provide sexual health care, and can now successfully conduct STI and contraception management. Additional training and certification could be developed for abortion care as well, and nurses could successfully provide those services with appropriate supervision. Developing abortion training and certification for nurses, nurse practitioners, and nurse midwives would dramatically increase the supply of health care professionals willing and able to provide abortions. This option proposes expanding the scope of practice of RNs, NPs, and CNMs to include medical and surgical abortions.

7.2.2. Creating New Women's Services Clinics

There are many benefits to providers and patients in conducting abortions in ambulatory care rather than operating rooms. There are several ways to harness the benefits of ambulatory care. The most direct and comprehensive option is to wholly transfer surgical abortions from the OR to outpatient settings in a separate women's services clinic. Providing abortions in the outpatient clinic would not only reduce costs, increase

flexibility, and decrease complications, but the grouping of all women's reproductive care services in a women's services clinic would increase privacy and decrease stigma.

7.2.3. Utilizing Existing Spaces for Ambulatory Care

In cases where hospitals are unable to provide a separate outpatient clinic for abortion care, providers can use existing outpatient settings. For example, when surgical day care centres or colposcopy and colonoscopy clinics are available, those settings could be used for abortions (as seen in the Kootenay Boundary Regional Hospital).

For hospitals without outpatient facilities, providers can use the operating room like an outpatient clinic. This would necessitate providing OR staff with some training to familiarize them with the necessities and practices of providing abortions in ambulatory care. In these cases, staff can use local anesthesia or analgesia rather than general anesthesia and still reap some of the benefits of providing abortions in outpatient clinics.

Chapter 8. Objectives, Criteria and Measures

These policy options are proposed with the intention of addressing barriers to abortion and meeting certain societal and governmental objectives. I evaluate each policy option using a set of criteria to assess how well it meets the societal and governmental objectives. Each policy option will meet these objectives with different degrees of success, and present different trade-offs. The evaluation criteria use a standardized set of measures to compare the policy alternatives and develop a clear understanding of these trade-offs in order to issue a policy recommendation.

8.1. Equity

Abortions are medically necessesary services and should be equitably available to all women in BC regardless of their income or geographic location. I evaluate the policy options with an eye to how well they decrease the costs of abortion care in order to increase equitable access. There are a number of costs related to abortion care including travel costs, missed work, arranging childcare, and abortion medication, among many others described in detail above. For the purposes of this analysis, I will evaluate the policy options using two measures: how well they lower the dollar amount paid out of pocket by the patient at the point of service, and if the policy decreases the necessity of patient travel. Travel causes many of the associated costs of abortion. By decreasing the likelihood that a patient will have to travel, the policy decreases the costs of missing work, losing wages, finding childcare, and travel expenses.

8.2. Efficiency

Some rural women experience extreme delays when attempting to access abortion care. These delays prevent the health system from efficiently providing abortion care. The

aspects of abortion care which are the most important to women are getting accurate information and referrals, securing an appointment quickly, and having the appointment quickly. The criteria for increasing efficiency are whether the policy option reduces delays to care at these two main points of interaction with the health care system. The first is where women look for information, referral, and secure an appointment. Obtaining accurate information and connecting with a provider can sometimes be difficult and time consuming. It is thus important to measure the time between when the patient discovers the pregnancy and manages to schedule an appointment. The second point is visiting a provider and procuring the procedure. It is important to measure the time between when the patient schedules the appointment and obtains the procedure. This measure aims to capture changes to wait times for abortion appointments.

8.3. Patient Privacy

Abortions tend to be stigmatized in many rural communities and this can make obtaining necessary services more difficult. Women may fear running into people they know at a hospital or pharmacy, and risking exposure in a community that is not supportive of their decision. Fear of judgment from family, friends and coworkers is a significant impediment to obtaining an abortion, therefore, I evaluate policy options on how well they increase patient privacy. I measure an increase in privacy by examining if the policy decreases the number of opportunities for recognition or judgment of the patient.

Table 2: Summary of Societal Objectives, Criteria & Measures			
Objective	**Criterion**	**Measure**	**Ranking**
Equity	Lowers cost to patient	Dollar amount paid out of pocket by patient at point of service	**Low (0):** No change to the cost to patient at point of service
			Medium (1): Some decrease in cost to patient at point of service
			High (2): Significant decrease in cost to patient at point of service
		Decreases the likelihood of necessity of patient travel	**Low (0):** No change to likelihood of need to travel
			Medium (1): Some decrease to likelihood of need to travel
			High (2): Significant decrease to likelihood of need to travel
Efficiency	Reduces delays to abortion care	Time between pregnancy verification and obtaining information/resources/scheduling appointment	**Low (0):** No change in time before interaction
			Medium (1): Some decrease in time before interaction
			High (2): Significant decrease in time before interaction
		Time between scheduling appointment and attending appointment/undergoing procedure	**Low (0):** No change to wait times for appointment
			Medium (1): Some decrease to wait times for appointment
			High (2): Significant decrease to wait times for appointment
Patient Privacy	Increases patient privacy	Fewer opportunities for recognition or judgement	**Low (0):** No change to number of opportunities
			Medium (1): Some decrease to number of opportunities
			High (2): Significant decrease to number of opportunities

By assigning two measures for the criteria to lower the cost to the patient and to reduce delays to abortion care I indirectly give those criteria twice the weight. This is intentional because equity and efficiency are the primary objectives of this policy intervention.

8.4. Budgetary Cost

I evaluate all options on this criterion by examining the incremental cost to the health system. The attention is on *incremental,* or net cost. Avoided costs arising from the

recommendation should be part of the consideration. If avoided costs are greater than the incremental costs of the recommendation, then net costs are negative and the policy option is financially appealing.

8.5. Stakeholder Acceptability

The political implications of policies are also important factors for evaluation. Securing buy in and avoiding censure from the relevant stakeholder groups are essential considerations for whether a policy will succeed. Therefore, I evaluate the policy options on how well they would be supported by relevant health care stakeholders. For these policies, I measure the degree of support they would receive from the Association of Registered Nurses of BC and from Doctors of BC, as they are the prominent health care provider advocacy organizations in BC. I estimate these measures from information and insight gathered during expert interviews.

Table 3: Summary of Governmental Objectives, Criteria & Measures

Objective	Criterion	Measure	Ranking
Budgetary Cost	Minimizes incremental cost to health system.	Net dollar change in overall health care spending	**Low (0):** Positive net cost to health system
			Medium (1): No change in cost to health system
			High (2): Negative net cost to health system
Stakeholder Acceptability	Would be supported by relevant health care stakeholders	Degree of support from Association of Registered Nurses of BC	**Low (0):** No support expected
			Medium (1): Some support expected
			High (2): Significant support expected
		Degree of support from Doctors of BC	**Low (0):** No support expected
			Medium (1): Some support expected
			High (2): Significant support expected

Chapter 9. Evaluation of Policy Options

9.1. Expanding Telemedicine Resources

The primary impact of Expanding Telemedicine Resources will be a significant decrease in the time it takes patients to find accurate information and connect with a provider and schedule an appointment. Patients will have better access to information and more streamlined, timely access to providers willing to perform abortions. It will be easier for patients to avoid interactions with providers unwilling to perform abortions, and this will help patients avoid being recognized or judged. As a result, the main benefits of this option are a reduction in delays to abortion care and an increase in patient privacy. It has the added benefits of likely being significantly supported by the ARNBC and Doctors of BC. Nurses and doctors tend to support expansion of community resources such as information hotlines (Physicians' advocate, 2017). However, expanding the resources will generate some incremental cost to the health system.

Table 4: Evaluation of Expanding Telemedicine Resources	
Measures	**Ranking of Expanding Telemedicine Resources**
Amount paid at point of service	Low (0): No change to cost to patient at POS
Decreases likelihood of need to travel	Low (0): No change to likelihood of travel
Time between pregnancy verification and first interaction	High (2): Significant decrease to time before interaction
Time between scheduling appointment and procedure	Low (0): No change to wait times for appointments
Increases patient privacy	Medium (1): Some decrease to number of opportunities for recognition
Net dollar change in overall spending	Low (0): Positive net cost to health system
Degree of support from ARNBC	High (2): Significant support expected from nurses
Degree of support from Doctors of BC	High (2): Significant support expected from doctors
Ranking	**7 out of 16**

9.2. Allowing Provincial Reciprocal Billing

Allowing Provincial Reciprocal Billing lowers the cost to patients at the point of service. Patients who come from Alberta will no longer have to pay for services out of pocket and patients from BC will not have to pay out of pocket if in Alberta. There will be a shift in timing of cost to the Ministry of Health but no incremental cost. The flow of patients between BC and Alberta is relatively equal in each direction, therefore the cost will even out (BC government official, 2017). This policy can expect significant support from doctors and nurses. The reduction in bureaucratic inefficiencies will motivate Doctors of BC and the ARNBC to support this policy.

Table 5: Evaluation of Provincial Reciprocal Billing	
Measures	**Ranking of Provincial Reciprocal Billing**
Amount paid at point of service	High (2): Significant decrease to cost to patient at POS
Decreases likelihood of need to travel	Low (0): No change to likelihood of travel
Time between pregnancy verification and first interaction	Low (0): No change to time before interaction
Time between scheduling appointment and procedure	Low (0): No change to wait times for appointments
Increases patient privacy	Low (0): No change to number of opportunities for recognition
Net dollar change in overall spending	Medium (1): No change in incremental cost to health system
Degree of support from ARNBC	High (2): Significant support expected from nurses
Degree of support from Doctors of BC	High (2): Significant support expected from doctors
Ranking	**7 out of 16**

9.3. Relaxing Regulations for Dispensing Mifepristone

This option will significantly ease the process of dispensing mifepristone by pharmacists and physicians. As a result, patients will have better access to the medication, and it will be much easier for clinics and physicians to offer distance abortions. The experiences of other countries show that when mifepristone is easily available, medical abortions are far more common. For example in France, Scotland, Sweden, and Switzerland, where mifepristone is easily available, medical abortions make up over half of all induced abortions (Doran & Nancarrow, 2015). In contrast, in Canada, medical abortions make up only 3.8% of induced abortions (Guilbert et al., 2016). Due to the expected increase in distance abortions this policy will decrease wait times for appointments, and significantly increase patient privacy. The increase in medical abortions will reduce overall costs to the health system, because surgical abortions cost the health system more than medical. However, there will be no change to the cost to patients at the point

of service, and no change to the time before patients' first interaction with the health system. This option will likely receive significant support from doctors and nurses, as health care professionals have long been petitioning for a change to the regulations around dispensing mifepristone.

Table 6: Evaluation of Dispensing Mifepristone	
Measures	**Ranking of Dispensing Mifepristone**
Amount paid at point of service	Low (0): No change to cost to patient at POS
Decreases likelihood of need to travel	High (2): Significant decrease to likelihood of travel
Time between pregnancy verification and first interaction	Low (0): No change to time before interaction
Time between scheduling appointment and procedure	High (2): Significant decrease to wait times for appointments
Increases patient privacy	High (2): Significant decrease to number of opportunities for recognition
Net dollar change in overall spending	High (2): Negative net cost to health system
Degree of support from ARNBC	High (2): Significant support expected from nurses
Degree of support from Doctors of BC	High (2): Significant support expected from doctors
Ranking	**12 out of 16**

9.4. Expanding Fair PharmaCare

If Fair PharmaCare covers the cost of abortion medication, this option will significantly decrease the cost to patients at the point of service. Currently, patients must pay for the cost of abortion medication out of pocket. Patients with extended benefits may be reimbursed if the medication is covered under their plan. However, this option will have no effect on delay in interactions with the health system, on wait times for appointments, or on patient privacy. This option will require additional health care spending. This option

can expect significant support from doctors and nurses because it makes care more affordable for their patients (Physicians' advocate, 2017).

Table 7: Evaluation of Fair PharmaCare	
Measures	**Ranking of Fair PharmaCare**
Amount paid at point of service	High (2): Significant decrease to cost to patient at POS
Decreases likelihood of need to travel	Low (0): No change to likelihood of travel
Time between pregnancy verification and first interaction	Low (0): No change to time before interaction
Time between scheduling appointment and procedure	Low (0): No change to wait times for appointments
Increases patient privacy	Low (0): No change to number of opportunities for recognition
Net dollar change in overall spending	Low (0): Positive net cost to health system
Degree of support from ARNBC	High (2): Significant support expected from nurses
Degree of support from Doctors of BC	High (2): Significant support expected from doctors
Ranking	**6 out of 16**

9.5. Abortion Care by Midlevel Providers

This policy option can significantly reduce wait times for appointments by increasing the supply of abortion providers. With the increase in provider supply, appointments will be more easily available. This option will have no impact on the cost to patients at the point of service, on the time before interacting with the health system, or on patient privacy. It will, however, decrease the incremental cost to the health system. Nurses and nurse practitioners cost the health system less than do physicians; therefore, procedures performed by RNs, NPs and CNMs will cost less than if the procedures had been performed by doctors. With appointments available more quickly, abortions will be performed at earlier gestational periods, which will be less costly. It is likely that this

option will receive significant support from nurses, and it may receive some support from doctors. Allowing nurses to perform abortions will alleviate the burden and work load on rural doctors, and as such they may support this option. However, doctors are often concerned with issues of liability and responsibility. With nurses performing abortions on patients, doctors will want to know who is ultimately responsible for the patient and whether the nurse is protected by insurance. Physicians will want to avoid situations where they may be held responsible for a procedure they were not present for and did not perform (Physicians' advocate, 2017). Issues of liability and insurance will have to be settled for this policy to be a success. Additionally, because RNs do not work independently there may be complications with billing and payment issues (BC government official, 2017). These are additional logistical questions which will need attention for implementation success.

Table 8: Evaluation of Abortion Care by Midlevel Providers

Measures	**Ranking of Abortion Care by Midlevel Providers**
Amount paid at point of service	Low (0): No change to cost to patient at POS
Decreases likelihood of need to travel	High (2): Significant decrease to likelihood of travel
Time between pregnancy verification and first interaction	Low (0): No change to time before interaction
Time between scheduling appointment and procedure	High (2): Significant decrease to wait times for appointments
Increases patient privacy	Low (0): No change to number of opportunities for recognition
Net dollar change in overall spending	High (2): Negative net cost to health system
Degree of support from ARNBC	High (2): Significant support expected from nurses
Degree of support from Doctors of BC	Medium (1): Some support expected from doctors
Ranking	**9 out of 16**

9.6. Creating New Women's Services Clinics

This policy option will have two primary impacts. Providing abortion care in an outpatient clinic rather than in an OR will save on hospital resources. As a result, more patients will be served and wait times for appointments will decrease. Additionally, a women's services clinic will dramatically increase patient privacy by allowing women to come in for abortions under the umbrella of general women's reproductive health. This policy will not affect the cost to patients at the point of service or the time before interacting with the health system. It will also cost the health system substantially to create new women's services clinic. In many cases this will require construction or renovations on existing hospitals in rural communities. At minimum, it will require a reorganization of hospital structure and flow which will increase the incremental cost to the health system. This policy can expect some support from nurses and doctors.

Table 9: Evaluation of Creating New Women's Services Clinics	
Measures	**Ranking of Creating New Women's Services Clinics**
Amount paid at point of service	Low (0): No change to cost to patient at POS
Decreases likelihood of need to travel	High (2): Some decrease to likelihood of travel
Time between pregnancy verification and first interaction	Low (0): No change to time before interaction
Time between scheduling appointment and procedure	High (2): Significant decrease to wait times for appointments
Increases patient privacy	High (2): Significant decrease to number of opportunities for recognition
Net dollar change in overall spending	Low (0): Positive net cost to health system
Degree of support from ARNBC	Medium (1): Some support expected from nurses
Degree of support from Doctors of BC	Medium (1): Some support expected from doctors
Ranking	**8 out of 16**

9.7. Utilizing Existing Spaces for Ambulatory Care

This policy option will primarily affect wait times for appointments. Like Creating New Women's Services Clinics, providing abortion care in existing outpatient clinics will save significant resources, time and staff, which will aid in decreasing wait times. Unlike the previous option, women will not benefit from any added privacy. The option will also have no impact on cost to patients on point of service or on time before interacting with the health system. However, providing abortion care in exisitng outpatient clinics will significantly decrease the incremental cost to the health system. Providing abortions in the OR is expensive and unecessary, and requires much more time and staff than in ambulatory care. This policy can expect some support from nurse and doctors.

Table 10: Evaluation of Utilizing Existing Spaces

Measures	**Ranking of Utilizing Existing Spaces**
Amount paid at point of service	Low (0): No change to cost to patient at POS
Decreases likelihood of need to travel	High (2): Significant decrease to likelihood of travel
Time between pregnancy verification and first interaction	Low (0): No change to time before interaction
Time between scheduling appointment and procedure	High (2): Significant decrease to wait times for appointments
Increases patient privacy	Low (0): No change to number of opportunities for recognition
Net dollar change in overall spending	High (2): Negative net cost to health system
Degree of support from ARNBC	Medium (1): Some support expected from nurses
Degree of support from Doctors of BC	Medium (1): Some support expected from doctors
Ranking	**8 out of 16**

Table 11: Summary of Evaluation of Policy Options								
	Improving Existing Structures and Programs					Major Initiatives and Policies		
Measures	**Dispensing Mifepristone**	**Expanding Telemedicine**	**Provincial Reciprocal Billing**	**Fair PharmaCare**		**Midlevel Providers**	**New Women's Services Clinics**	**Utilizing Existing Spaces**
Amount paid at point of service	Low (0)	Low (0)	High (2)	High (2)		Low (0)	Low (0)	Low (0)
Decreases likelihood of need to travel	High (2)	Low (0)	Low (0)	Low (0)		High (2)	High (2)	High (2)
Time between pregnancy verification and first interaction	Low (0)	High (2)	Low (0)	Low (0)		Low (0)	Low (0)	Low (0)
Time between scheduling appointment and procedure	High (2)	Low (0)	Low (0)	Low (0)		High (2)	High (2)	High (2)
Increases patient privacy	High (2)	Medium (1)	Low (0)	Low (0)		Low (0)	High (2)	Low (0)
Net dollar change in overall spending	High (2)	Low (0)	Medium (1)	Low (0)		High (2)	Low (0)	High (2)
Degree of support from ARNBC	High (2)	High (2)	High (2)	High (2)		High (2)	Medium (1)	Medium (1)
Degree of support from Doctors of BC	High (2)	High (2)	High (2)	High (2)		Medium (1)	Medium (1)	Medium (1)
Ranking	**12/16**	**7/16**	**7/16**	**6/16**		**9/16**	**8/16**	**8/16**

Chapter 10. Recommendations

Each of the policy options evaluated above could be individually implemented and would help to improve access to abortions services. However, as demonstrated, each option has different strengths and weaknesses. Based on my evaluation in the previous chapter, the two highest priority policies to pursue are improving protocols for dispensing mifepristone and enabling midlevel care providers to administer abortions. The other policy interventions are valuable but of lower priority.

10.1. Improving Existing Structures and Programs: Relaxing Regulations for Dispensing Mifepristone

The first priority for action should be Relaxing Regulations for Dispensing Mifepristone. This option will ease the dispensing of mifepristone by adjusting and coordinating the medication's regulations among Health Canada, the College of Physicians and Surgeons of BC, and the College of Pharmacists of BC. The policy would have the greatest impacts and presents the fewest trade-offs of all policy options suggested. By reducing the bureaucratic barriers to dispensing, pharmacists and physicians can more easily distribute the medication and more easily facilitate distance abortions. The increase in the availability of distance abortions will dramatically increase rural women's access to abortions and several beneficial impacts can be expected. Women will no longer have to travel far distances for abortions, and can instead easily have them in the privacy of their own home. The increase in medical distance abortions will offset the demand for surgical abortions, and hospitals should experience a decrease in wait-times as well as savings from diverted surgical abortions.

This option's effectiveness could be increased furthermore by pairing its adoption with the policy option Expanding Fair PharmaCare. Relaxing Regulations for Dispensing Mifepristone fails to address the direct cost of abortions to the patient, and Expanding

Fair PharmaCare policy mainly targets the cost of abortions at the point of service. Therefore, adopting both policies in combination would address nearly all criteria for success.

10.2. Major Initiatives and Policies: Abortion Care by Midlevel Providers

For long term success from new policies, expanding the scope of practice of midlevel providers to include abortion care would create the greatest impacts. With proper training nurses, nurse practitioners and nurse midwives can provide abortions with no increased risk to patients. This option address the shortage of abortion providers in rural communities, one of the root causes of barriers to abortion in rural BC. The addition of midlevel providers would greatly help to address this shortage, and several beneficial impacts would follow. Wait-times would decrease significantly, and as a result women could obtain a timely procedure in their own community thereby reducing the likelihood of travel and its associated costs. The health system would experience savings as well, as midlevel providers are less costly than physicians. Among the suggested policies that have greater costs and require greater mobilization efforts, this option would provide the most effective intervention.

Chapter 11. Final Thoughts

I considered several policy interventions for this analysis that I ultimately did not include as potential options. Due to the shortage of abortion training opportunities, I considered including an option for increasing abortion training in BC medical schools. However, the University of British Columbia introduced the Ryan Program[3] in Family Planning eight years ago, and extended the program in July 2016. UBC now features a Fellowship in Family Planning which is organized by the Fellowship in Family Planning National Office housed in the Bixby Center for Global Reproductive Health at the University of California San Francisco. The Fellowship offers training in research, teaching and clinical practice in abortion and contraception (Department of Obstetrics & Gynaecology, 2015). The recent addition of this Fellowship will help to increase abortion training opportunities, thus I concluded that an additional policy intervention would likely be redundant.

I also considered suggesting a policy intervention that would introduce a mentoring program for physicians willing to perform abortions. The opportunity for support through mentorship can encourage more physicians to provide abortion care in rural communities. However, the National Abortion Federation of Canada has a mentoring program where they match new physicians with more experienced abortion providers who are located relatively close by. The NAF answers physicians' questions and helps new physicians to navigate difficult situations. They also send mentors to facilities to support new physicians (CART-GRAC, 2014). Seeing as an established

[3] The Ryan Program in Family Planning is run out of the department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco. It provides resources and technical expertise to departments of obstetrics and gynecology to institute a dedicated, opt-out rotation in family planning (Ryan Residency Training Program, n.d.).

mentoring program already exists, I decided to focus on potential interventions that would address other areas with less attention.

The policies I have recommended will likely present several implementation challenges. Adjusting and coordinating the regulations for mifepristone between Health Canada, the CPSBC, and the CPBC to allow for easy dispensing will be administratively complex and time consuming. Each body has its own regulations, and its own procedures for how to change regulations. It will likely be a long, drawn out process for all bodies involved to reach consensus. Expanding the scope of practice of RNs, NPs, and CNMs to include medical and surgical abortions will be challenging because of political battles. Many physicians will likely object to such an increase in scope, because it has the potential to infringe upon physicians' practices. Some nurses may also object because if their scope of licence allows them to provide abortions, it will be more difficult for them to refuse provision. On the other hand, there are likely many doctors, both rural and urban, who would favour such an increase in scope because they recognize that many rural doctors are overburdened and could use the assistance in their communities. As a result, navigating the political battles between Doctors of BC and ARNBC will be difficult. Additionally, the necessary training programs for nurses will have to be created and instituted. A process for certification and verifying the completion of training will also have to be established.

The goal of this project is to develop a deep and well-rounded understanding of all non-legal barriers to abortion in rural BC, and provide a comprehensive analysis of policy options. Previous studies have identified distinct barriers to abortion in BC; this project aims to synthesize previous findings, providing an inclusive report of non-legal barriers, and provide insight into their interrelatedness. Studies have examined the effects that an individual program or policy has on addressing barriers to abortion. There have been examples of singular interventions implemented by individual health care facilities and organizations across rural and urban BC. This project intends to provide a more exhaustive collection of potential policy interventions, with a complex and comprehensive policy analysis of all options. This project adds a more wide-spread and inclusive report to the literature, with the intention of aiding BC in developing a more unified and systemic approach to combating barriers to abortion in rural BC.

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Appendix A. Fair PharmaCare Assistance Levels

Family Net Income Income Range		**Family Deductible**	**Portion PharmaCare pays** after deductible is met	**Family Maximum** PharmaCare covers 100% of costs for the rest of the year after the maximum is met
$ 0.00	$ 1,875.00	$ 0	70%	$ 25
$ 1,875.01	$ 3,125.00	$ 0	70%	$ 50
$ 3,125.01	$ 4,375.00	$ 0	70%	$ 75
$ 4,375.01	$ 6,250.00	$ 0	70%	$ 100
$ 6,250.01	$ 8,750.00	$ 0	70%	$ 150
$ 8,750.01	$ 11,250.00	$ 0	70%	$ 200
$ 11,250.01	$ 13,750.00	$ 0	70%	$ 250
$ 13,750.01	$ 15,000.00	$ 0	70%	$ 300
$ 15,000.01	$ 16,250.00	$ 300	70%	$ 450
$ 16,250.01	$ 18,750.00	$ 350	70%	$ 525
$ 18,750.01	$ 21,250.00	$ 400	70%	$ 600
$ 21,250.01	$ 23,750.00	$ 450	70%	$ 675
$ 23,750.01	$ 26,250.00	$ 500	70%	$ 750
$ 26,250.01	$ 28,750.00	$ 550	70%	$ 825
$ 28,750.01	$ 30,000.00	$ 600	70%	$ 900
$ 30,000.01	$ 31,667.00	$ 900	70%	$ 1,200
$ 31,667.01	$ 35,000.00	$ 1,000	70%	$ 1,350
$ 35,000.01	$ 38,333.00	$ 1,100	70%	$ 1,475
$ 38,333.01	$ 41,667.00	$ 1,200	70%	$ 1,600
$ 41,667.01	$ 45,000.00	$ 1,300	70%	$ 1,750
$ 45,000.01	$ 48,333.00	$ 1,400	70%	$ 1,875
$ 48,333.01	$ 51,667.00	$ 1,500	70%	$ 2,000
$ 51,667.01	$ 55,000.00	$ 1,600	70%	$ 2,150
$ 55,000.01	$ 58,333.00	$ 1,700	70%	$ 2,275
$ 58,333.01	$ 61,667.00	$ 1,800	70%	$ 2,400
$ 61,667.01	$ 65,000.00	$ 1,900	70%	$ 2,550
$ 65,000.01	$ 70,833.00	$ 2,000	70%	$ 2,675
$ 70,833.01	$ 79,167.00	$ 2,250	70%	$ 3,000
$ 79,167.01	$ 87,500.00	$ 2,500	70%	$ 3,350
$ 87,500.01	$ 95,833.00	$ 2,750	70%	$ 3,675
$ 95,833.01	$ 108,333.00	$ 3,000	70%	$ 4,000
$ 108,333.01	$ 125,000.00	$ 3,500	70%	$ 4,675
$ 125,000.01	$ 141,667.00	$ 4,000	70%	$ 5,350
$ 141,667.01	$ 158,333.00	$ 4,500	70%	$ 6,000
$ 158,333.01	$ 183,333.00	$ 5,000	70%	$ 6,675
$ 183,333.01	$ 216,667.00	$ 6,000	70%	$ 8,000
$ 216,667.01	$ 250,000.00	$ 7,000	70%	$ 9,350
$ 250,000.01	$ 283,333.00	$ 8,000	70%	$ 10,000
$ 283,333.01	$ 316,667.00	$ 9,000	70%	$ 10,000
$ 316,667.01	$ 999,999,999.00	$ 10,000	100%	$ 10,000
Deductible for a family registered for Fair PharmaCare whose income cannot be verified		$ 10,000	100%	
Deductible for a person actively enrolled in the Medical Services Plan but not registered for Fair PharmaCare		$ 10,000	100%	

Appendix B. Services Exempted from Provincial Reciprocal Billing

1. Cosmetic surgery to alter appearance.

2. Sex-reassignment.

3. Surgery for reversal of sterilization.

4. Routine periodic health examinations, including routine eye examinations.

5. Therapeutic abortion.

6. In-vitro fertilization; artificial insemination.

7. Lithotripsy for gall bladder stones.

8. Treatment of port-wine stains other than on the face or neck

9. Acupuncture, acupressure; transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy.

10. Services to persons covered by the RCMP, Canadian Armed Forces, Workers' Compensation Board, Veterans Affairs, Correctional Services (federal penitentiaries)

11. Services requested by a third party (i.e., your employer, insurance company)

12. Team conferences.

13. Genetic screening and other genetic investigations, including DNA probes.

14. Anaesthetic services and surgical assistant services associated with any of the above.