Women's Reproductive Rights in Saskatchewan: Advocating for Universal Coverage of Mifegymiso

SMSS Day of Action March 21st | March 26th, 2018 - Regina, SK

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Alisha Beler
Regan Brownbridge
McKayla Cozart
Jessica Froehlich
Kieran Johnson
Conley Kriegler
Shane Leyen
Cadence MacPherson
George Mutwiri
Lyall Pacey
Samuel Simonson
Sebastien Turcotte
Lara Witt

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With Appreciation,
Alan Chan, Government Affairs and Advocacy Committee Sr. Rep.
Sehjal Bhargava, Government Affairs and Advocacy Committee Jr. Rep

Executive Summary

Since its introduction in January 2017, Mifegymiso has been granted universal coverage by nearly every province and territory in Canada, establishing a national standard of care for medical termination of pregnancies. Regardless of population size and demographics, provinces and territories have recognized the necessity and feasibility of providing Mifegymiso without barriers. Saskatchewan and Manitoba remain the last provinces in Canada to not provide universal coverage of Mifegymiso, the designated Health Canada medical termination of pregnancy pill. Access to medical termination of pregnancies is a critical issue for women across Saskatchewan, with women in rural areas and women of lower socioeconomic status most severely affected. We commend the efforts put forth by the Government of Saskatchewan in creating access to medical abortion by adding Mifegymiso to the Saskatchewan Prescription Drug Plan in 2017, but contend that a considerable gap still exists. Without universal coverage for Mifegymiso, women in Saskatchewan are deprived of the equal access and care expected of the Canadian healthcare system, and put them at a disadvantage to the rest of the country. It is know that surgical termination of pregnancies carry a greater risk to patients, require more intensive care by healthcare practitioners, and impose more significant emotional toll on women. Additionally, surgical termination of pregnancies are often only performed in urban centers, creating further challenges in accessibility for women in rural and remote communities.

Currently, surgical termination of pregnancies are covered by the provincial healthcare system, while costing more than medical terminations. The costs terminations of pregnancies incurred by our healthcare system could be significantly alleviated by allowing women to choose medical options. Additionally, the ease-of-use of Mifegymiso would allow for alleviation of Operating Room availability as well as specialists services, creating more efficient usage of healthcare services.

To ensure that women in Saskatchewan are treated equally to the Canadian national standard of abortion care, and to protect and promote women's reproductive rights, the Student Medical Society of Saskatchewan calls on the Government of Saskatchewan the following:

i) Implement universal coverage of Mifegymiso for all women seeking medical termination of pregnancies, and

ii) Introduce a billing code for medical abortion counselling to ensure Saskatchewan physicians are not deterred by bureaucratic factors to provide care

Jane's Story

The following is a fictional scenario inspired by true accounts from patients:

Fifteen-year-old Jane Doe is a young high school student from rural Saskatchewan. Outside of school, she plays badminton, paints, and spends time with her boyfriend of 9 months. The topic of sex is broached, and after ample discussion and mutual consent, the couple decide it is time to take their relationship to the next level. Unfortunately, the condom they use for the sake of safe sex unexpectedly breaks. In the resulting panic, they rush to the nearest pharmacy, where the pharmacist denies them a levonorgestrel prescription due to conscientious objection. The desperate couple then make their way to Planned Parenthood in Regina, enlisting the help of a 17-year-old friend with a driver's license, where they receive a levonorgestrel prescription for $15.00. After Jane is finally able to take the levonorgestrel, the couple collectively breathes a sigh of relief – they've successfully averted unwanted pregnancy…or so they think. One and a half months go by, and Jane's previously regular-as-clockwork menstrual cycle is late by one week. Then two. Then three. Anxiety mounting, she purchases a $20.00 brand-name pregnancy test from the nearby pharmacy. During the excruciating wait for the test result, she prays for the test to be negative, choking back tears as she envisions a future where her parents find out she's pregnant at 15. Pale lines of ink slowly begin to form. The test is positive.

In most Canadian provinces, young women in Jane's situation can obtain a Mifegymiso prescription from their family physician or, in some provinces, their local pharmacist. These prescriptions are provided free-of-charge, and the prescribing provider is adequately compensated for the time required for this sensitive patient encounter. Saskatchewan, however, only provides partial coverage to residents in very specific circumstances and does not compensate providers for their time spent in consultation with these young women – the allegorical black sheep of the Canadian provinces. Jane Doe's circumstance mirrors that experienced by thousands of Saskatchewan women annually. An estimated one in three Canadian women will seek abortion of some kind within their lifetime, with abortion being the second most common reproductive procedure provided in Canada. One of the five founding principles of the Canada Health Act is accessibility for all citizens to healthcare services and adequate compensation for providers of said services. According to this standard, Saskatchewan is grievously under-serving its residents, and violating fundamental ethical principles of justice, autonomy, beneficence, and non-maleficence.

Jane's Story (continued):

Looking back to Jane's case, she is now 5 weeks pregnant and researching options for termination. She discovers that medical abortion with Mifegymiso is a viable option for women who are less than 7 weeks pregnant. Additionally, surgical abortion can be performed up to 18

weeks of pregnancy. Through her research, she finds that a Mifegymiso prescription costs approximately $400.00 - she is uninsured and not young enough to benefit from child coverage. Investigating the surgical route, she finds that it costs at least twice as much, and is reluctant to undergo an invasive procedure that entails multiple clinic visits and the potential to induce significant emotional trauma. Weighing her options, Jane feels medical abortion is the best option for her. Jane subsequently makes an appointment with her family physician.
During the visit, the physician believes Jane to be a 'mature minor' capable of making her own medical decisions. Jane clearly states her desire to obtain Mifegymiso. The physician recalls the recent billing code removal for this service, and mentally calculates the cost of giving Jane the prescription. Because reproductive health issues require lengthy initial consultations, follow-up appointments, and adequate counselling to ensure the patient is coping with their decision, the physician could be looking at substantial work for little pay. After all, the physician herself has a partner and four children to support at home, and she's barely making ends meet – thrust into managing the small business that is her clinic straight out of medical school with heavy overhead and a 6-figure student loan debt. Ultimately, she determines that providing a Mifegymiso prescription is currently beyond her financial capabilities and turns down Jane's request. Following this appointment, Jane quickly tries to find a physician who will cater to her needs. Without easy access to transportation, she is unable to make another trip to Planned Parenthood. After phoning around to multiple clinics, she discovers the family physicians of Saskatchewan are facing massive volumes of patients requiring urgent care. It will be impossible for her to schedule an appointment slot until the following week. At this point, she is past the 7-weeks pregnant threshold to be eligible for Mifegymiso – her only option now is surgical abortion.

This situation is commonplace for women seeking abortion in Saskatchewan. The astronomical costs of these procedures are an insurmountable barrier for many. Additionally, many family physicians are overburdened and do not have the means to support patients with extensive healthcare needs which are not billable. Saskatchewan is far behind the rest of Canada in regards to accessibility of medical abortion. Reform in this area is essential to create safe, equitable space for women to adequately access reproductive healthcare in Saskatchewan

Background

Medical background

Mifegymiso is a combination pill of Mifepristone and Misoprostol, and currently the best medical option available for induced abortion. It has been on the World Health Organisation's list of essential drugs since 2005, and is currently their recommended drug for terminations of early pregnancy (World Health Organization, 2012). Compared to older medications, Mifegymiso is more effective, faster, safer, and can be used successfully later in the pregnancy. Mifegymiso is 96.7% effective up to 63 days gestation, eliminating the need for surgery. Conversely, methotrexate is successful in 94% of induced abortions less than 49 days gestation. However, 20-30% of women experience delayed expulsion with methotrexate, causing considerable patient distress (Levine et al., 2019). Furthermore, abortions induced by Mifegymiso are completed faster than methotrexate abortions, resulting in a higher patient acceptance rate than methotrexate abortions. (Wiebe E, 2002)

Mifegymiso is easier for patients to use, as it is minimally invasive and readily accessible. Patients seeking medical abortion meet with their physician who determines if abortion is a safe option for them. Physicians will determine that the patient has access to medical care in the 14 days following administration. They will provide counselling about the risks and benefits of medical abortion, schedule a follow-up between 7 and 14 days post administration, determine gestational age by ultrasound, and obtain the patient's informed consent. Furthermore, physicians will ensure patients do not have any contraindicated conditions: confirmed or suspected ectopic pregnancy, IUD, chronic systemic corticosteroid use, chronic adrenal failure, coagulopathy or anticoagulant medication, uncontrolled hypertension or cardiovascular disease, or severe renal, liver, or respiratory disease (Wiebe E, 2002, Levine et al., 2019). This type of screening and counseling is common practice for family physicians and within their scope of practice

Following screening and counseling, Mifegymiso can be administered. In Saskatchewan, any physician can prescribe Mifegymiso and the medication can be dispensed to patients directly by pharmacists. Patients can take Mifegymiso in the comforts of their own homes, facilitating patient well-being. A mifepristone tablet is swallowed by the patient and 24-48 hours later they take a buccal (between the cheeks and gums) dose of misoprostol. Patients should plan to rest for 3 hours after taking misoprostol. (Wiebe E, 2019) Serious complications are unlikely, with hospital admissions occurring in less than 0.06% of patients. However, some women may experience bleeding, cramping, nausea, vomiting, diarrhea, or headache. Incomplete abortions, requiring surgical abortion occur in less than 4% of patients. (Levine et al., 2019)

Current Coverage

In 2015, Health Canada approved the use of Mifegymiso. (Health Canada, 2015) Mifegymiso is the only pharmaceutical agent approved by Health Canada for medical termination. To purchase Mifegymiso in Saskatchewan women must have third party insurance, qualify for coverage under a provincial assistance program, or pay out of pocket. In 2017, Saskatchewan added Mifegymiso to the provincial drug formulary making it eligible for partial financial coverage but only if the patient qualifies under one of the provincial assistance programs. Under the Saskatchewan drug formulary if you qualify as a beneficiary a varying percentage of a drug cost will be covered by the province. Categories of beneficiary that would apply to accessing Mifegymiso include the Children's drug plan, Emergency Assistance program and Family Health Benefits. Under the Children's drug plan, children fourteen and under are automatically eligible for coverage with a co-pay amount of $25 per prescription. (Saskatchewan Government Children's Drug Plan, 2019) Under the Emergency Assistance program residents who require immediate treatment with formulary prescription drugs and are unable to cover their share of the cost may access a one-time Emergency Assistance. The level of assistance provided is in accordance with the patient's ability to pay. (Saskatchewan Government Emergency Assistance for Prescription Drugs, 2019) The Family Health Benefits program operates for low-income working families who meet the standards of an income test or are receiving the Saskatchewan Employment Supplement. Drug coverage is offered with $100 semi-annual family deductible and 35 per cent consumer co-payment thereafter (Saskatchewan Government Family Health Benefits, 2019). If someone does not qualify under these categories coverage of the drug would be out of pocket or left to third party insurance.

Currently only Saskatchewan, Manitoba, Nunavut, and Northwest Territories are the only provinces and territories that do not provide universal coverage of Mifegymiso. (Mifegymiso, 2019) We contend that while the Saskatchewan government has undergone steps to create access to Mifegymiso to the most vulnerable persons of Saskatchewan, lack of universal coverage of Mifegymiso limits women's access to medical termination services and can cost upwards of $400 out of pocket, creating a discrepancy of access to care.

Economic Implications

It is estimated that one in three Canadian women will have an abortion, making abortion one of the most common medical procedures experienced by women of reproductive age. (Norman, 2012) From 2007-2017 there was an average of 1,952 induced abortions performed annually in Saskatchewan. (Abortion Rights Coalition of Canada, 2019) In 2017, across Canada, 94.6% of induced abortions included a surgical component. (Canadian Institute for Health Information, 2015) By increasing availability and accessibility to Mifegymiso, the Saskatchewan government will decrease the number of surgical abortion procedures that need to be performed.

Surgical termination procedures are much more costly to the province due to the infrastructure and resources required, a surgeon, operating room time, nursing staff etc. (Norman W et at., 2016) The average treatment costs per patient in Ontario for medical and surgical termination are $300 and $1187 respectively. (Rausch M et al., 2012) Providing women the choice of medical termination, irrespective of financial constraint will increase the number of patients accessing medical termination, providing access to less invasive care and would have significant healthcare expenditure savings for the province of Saskatchewan.

Currently in Saskatchewan the cost of surgical termination is covered by the province whereas Mifegymiso is not. If a woman cannot afford Mifegymiso, and does not have insurance or government coverage, they are forced to choose either surgical termination or keep the pregnancy. This significantly limits women's choice and accessibility to care when seeking termination services. Surgical termination is a much more invasive procedure, and more emotionally traumatic for the patient. With surgical termination, there may be damage to the uterus, there can be anesthetic side effects, and the woman has less control over the procedure, and who is with her during it. (Abortion Rights Coalition of Canada, 2019)

The following information was provided courtesy of the Women's Health Centre at Regina General Hospital and from a research study (pending publication) conducted by Dr. Megan Clark.

When women seek a medical termination at the Women's Health Center (WHC), they are provided information about their options for medication. We have found that women are wanting, and are requesting Mifegymiso by name. These patients have done their research and prefer the outcomes of the medication. It is more effective, it can be done to a higher gestational age, and takes less time to complete the process. Unfortunately the cost is often a barrier for women, and this is very unfortunate. We believe it is very important for the patients of Saskatchewan to be able to access this medication no differently than its competitor Methotrexate. This medication would significantly lessen the need and/or desire for surgical intervention.

The goal of WHC is to provide support and unbiased care to all. When Mifegymiso first became available in Saskatchewan it was not covered. In our National Abortion Federation conference calls, it was made very clear that although having fully covered access to the drug would take some time, it would eventually be fully covered in Saskatchewan. This has not yet happened and we are now one of the last provinces in Canada with limited access.

The Women's Health Centre started using Mifegymiso on June 27, 2017. Mifegymiso was only used by patients who could afford to pay for it. It was not offered free of charge in Women's Health Centre until March 26, 2018. That is nine months of patients who were affected

by having no coverage. 136 patients in that time completed medical termination of pregnancies (TOPs) with Mifegymiso. There was another 65 patients who used Methotrexate. We know that 57 of these could not afford Mifegymiso and that is why they chose Methotrexate. There are a high number of patients who also chose surgical termination because they could not afford Mifegymiso and did not want to use Methotrexate. This means that the initial bottom line number of 136 patients increases even more. It was these women we were trying to help by providing the drug free of charge in Women's Health Centre. At that time, Women's Health Centre made the choice to incur the cost of Mifegymiso for all patients.

Prior to the introduction of Mifegymiso, patients were routinely treated with Methotrexate. Failure rates at the WHC were 10-15%. The WHC did 93 medical termination of pregnancies in 6 months, from January to June 30, 2017, with Methotrexate. Eleven failed, equating to a 11.8% failure rate. All of these patients required a dilation and curettage (D&C), a surgical procedure, to complete the termination.

Once Mifegymiso was introduced we began to notice an increase in demand and success of the patients. Mifegymiso has an efficacy of 95-98% versus Methotrexate which is only 85-90%. Performing medical terminations has a decreased cost compared to surgical procedures as one does not require as many staff, procedure room, recovery time, and equipment to complete. Medical terminations can be done with a doctor, one nurse and the medication. Medical terminations with Mifegymiso can be done at up to 10 weeks gestational age, versus Methotrexate which can be administered at up to 7 weeks gestational age. The visit for a medical termination of pregnancy takes approximately 1 hour, whereas an entire day is required for the surgery.

We know that there are risks with both the surgical and medical termination of pregnancy. Most commonly are hemorrhage, infection and possibility of ongoing pregnancy with both methods of termination. However, with medical terminations, there is no risk of perforation of the uterus, patients can be done at earlier gestations and suffer less from pregnancy symptoms. They also do not require conscious sedation for a medical which does not alter their medical state putting them at risk for airway complications and difficult resuscitation. On the more emotional side of safety, patients would opt for medical termination at an earlier gestation and suffer less feelings of guilt than they would at 10-17 weeks. Patients would also be able to take the medication in the privacy of their own homes.

Our priority is that our patients are given all the information and are able to make a decision that is best for them, regardless of the cost. The Women's Health Centre strongly believes in providing this medication to all patients. A medication that has such a high success rate should be accessible to everyone across the province.

Women's Health Center Timeline:

January-June 2017: 93 medical TOPs with Methotrexate/Misoprostol

- Failure Rates: 11/93 = 11.8%

July-December 2017 :108 medical TOPs

- 58 with Mifegymiso
- 50 with Methotrexate
- At this time, methotrexate was free of charge and Mifegymiso cost approximately $300.00
- Failure Rates:

    Mifegymiso: 1/58 (1.7%)

    Methotrexate: 11/50 (22%)

January-June 2018 : 191 medical TOPs

- 173 Mifegymiso
- 19 Methotrexate
- At this time, the WHC began offering Mifegymiso at no cost
- Failure Rates:

    Mifegymiso: 7/173 (4%)

    Methotrexate: 3/19 (15.8%)

July-December 2018: 199 medicals

- 199 Mifegymiso
- 0 Methotrexate
- Failure Rates:

    Mifegymiso: 7/199 (3%)

Cost-Benefit analysis conducted and provided by the Women's Health Centre:

At the Women's Health Centre, the total, comprehensive cost (including staff, OR booking time, physician billing, supplies, laboratory tests, medications) of medical and surgical termination of pregnancies was calculated. It was calculated that the average cost of a medical abortion at the WHC was $298.45, compared to the average cost of a surgical abortion which was $483.89. In terms of potential cost savings, electing to have a medical termination of pregnancy instead of a surgical termination of pregnancy amounts to $185.46 in saved costs.

From January to December 2014, there were 1075 abortions at the Women's Health Centre. Of the 1075 abortions performed in that time window, 590 were performed at less than 10 weeks gestational age, where 137 were done via medical termination of pregnancy, and 453 were done via a surgical abortion. From a theoretical standpoint, if all 453 surgical abortions had been performed through medical termination of pregnancies, the potential amount saved by the public healthcare system would be **$84,013.41** in Regina alone.

In 2017, of 1040 termination of pregnancies done at the WHC, 420 patients had surgical termination performed at under 10 weeks of gestation. If all of the 420 surgical termination of pregnancies in that year had been performed as medical termination of pregnancies, the cost saved to the public healthcare system would have been **$77,893.00**.

Implementation

Providing universal coverage for Mifegymiso would not necessitate any program creation, healthcare infrastructure change or significant new funding. The current approach to termination of pregnancies, where women go see their physician for direct counselling and services would remain unchanged. Additionally, as of October 2018, nurse practitioners in Saskatchewan are able to prescribe Mifegymiso which allows for far greater reach as often nurse practitioners are the closest available prescribing healthcare practitioners in rural communities.

Currently, to obtain a prescription for Mifegymiso, patients must to a prescribing physician. (College of Physicians and Surgeons of Saskatchewan, 2019) According the Health Canada, prior to a prescribing the physician must ensure that the patient has access to emergency medical care 14 days post administration, schedule a follow-up appointment 7-14 days after Mifegymiso to confirm pregnancy termination, exclude an ectopic and confirm gestational age by ultrasound, and counsel patients on the risk and benefits. Written consent from the patient is not required. (College of Physicians and Surgeons of Saskatchewan, 2019) Following this, the patient has one of the three options:

1. The patient can go to a pharmacist of their choosing and have the medication delivered to the physician's office. They can then take the medication at the physician's office.

2. The patient can go to a pharmacist of their choosing, obtain the medication, and take the medication at home as instructed by their physician. There is no requirement for witnessed ingestion.
3. If a prescribing physician is authorized, they can sell/dispense the medication, and the medication can be taken in office, or at home (College of Physicians and Surgeons of Saskatchewan).

We are not proposing that any of this is changed, rather we ask that the cost of the medication be covered by the Saskatchewan Health Plan to prevent cost burden to the patient. Instead of billing the patient for the medication, billing from the pharmacy or the physician for the drug would be to Saskatchewan Health Benefits.

In addition to the change in coverage, we request the implementation of a billing code for medical abortions to ensure appropriate compensation for the prescription of Mifegymiso. An existing obstacle hindering accessibility to medical abortions is that physicians in Saskatchewan are not able to bill specifically for medical abortion counselling appointments. Counselling appointments for medical abortions are much more involved than a regular appointment visit, and typically require considerable greater amounts of time spent with patients. As seen in the example of "Jane Doe's Story", it is reasonable to foresee the reality that physician's may feel overwhelmed by the workload of their practice and the pressure to meet the financial expectations of a sustainable practice, to justify working such measures of time without remuneration, thereby reducing patient access to medical termination of pregnancies. A similar problem had arisen in Nova Scotia where Dr. Lianne Yoshida, medical co-director of the Termination of Pregnancy Unit at the QEII Health Sciences Centre in Halifax identified this as a problem in accessing abortion services (National Post, 2018). To remediate this barrier, Nova Scotia introduced a new billing code which compensates physicians for overseeing medical termination of pregnancies. (CKPG Today, 2018) Provinces such as Ontario have a flat billing fee for initial consultations appointments and a seperate fee for follow-up appointments (National Post, 2018). We recommend the Saskatchewan government to take example from provinces that have specific billing codes in place for medical abortion counselling to ensure Saskatchewan physicians are not deterred by bureaucratic factors to provide care.

Remote and rural impact

The Canadian healthcare system is renowned internationally as a model of universal healthcare, and broadly regarded as a great source of pride by Canadians. Built upon the pillars of public administration, accessibility, comprehensiveness, universality and portability, it's intent is to ensure that all Canadians, regardless of income, race, gender, sexuality or location receive the same quality of care and access to health services. However, it has been observed and reported by Canadians that in a multitude of facets the virtuous intent of our healthcare model is not delivered fairly. A lack of distinction between equitability and equality has caused a severe maldistribution of resources, where the needs of individuals and communities have been neglected. (Bowen, 2000) In Saskatchewan, this imbalance has been felt most impactfully by persons living in rural and remote locations, where there is significantly more difficulty accessing care in a timely matter, if at all, compared to those living in urban settings. Rural residents have a shorter life expectancy, higher mortality rates, higher infant mortality rates, higher rates of obesity and higher rates of depression and suicide. (CIHI, 2006) This is especially true for Aboriginal communities in Saskatchewan, who face the same issues in addition to significant barriers to appropriate and equitable treatment. (Bowen, 2000)

There are a multitude of factors at play that act as barriers to health services access, including (but not limited to): socio-economic status, geography, lack of infrastructure, jurisdictional issues, and cultural barriers. (National Collaboration Centre for Aboriginal Health, 2011) It is not a coincidence that nearly all of these factors are present in one way or another in Saskatchewan's remote and rural regions. In particular, geographic remoteness acts as a major barrier in Saskatchewan's rural, and northern communities. This also translates into extreme shortages of healthcare professionals, with half the proportion of physicians serving this population as compared to cities. (Rowan, 2007) The result of this absence of services available in rural settings, means that patients must travel away from their communities to access care, leaving behind their support networks, and families. Not only do patients have to physically have access to services to receive a positive outcome, but they must also have timely access. Due to the limited access to healthcare in their home regions, patients are expectedly less likely to seek professional help early on, and more often present to medical personal at later stages, in both disease processes and pregnancy. This contributes to higher mortality rates from diseases, and increased complications in pregnancy. (Morriseau, 2009)

These obstacles become even more significant when pregnant women in rural communities seek care regarding termination of pregnancies. Oftentimes, pregnant women have no other choice but to undergo extensive travel to distant medical centers, forcing them to take time away from work, and be apart from their families and communities. Travel itself can become impossible if patients have no access to transportation, cannot incur the travel costs or if weather conditions are treacherous. In the event that travel is provided to the patient, those costs are taken on by the public healthcare system. Given that Mifegymiso can be taken at home and

prescribed by family physician and nurse practitioners, providing universal access to Mifegymiso would allow women to have access to the care they require in a timely manner, and reduce the burden of travel.

Relating back to the pillars of the Canadian healthcare system, we believe that in its current state, Saskatchewan is not adequately providing universal and accessible care. Universality dictates that “All insured residents are entitled to the same level of healthcare.”, and accessibility mandates “All insured persons have reasonable access to health care facilities.” (Government of Canada, 2016, Canadian Health Care Act, 2007) This is due to both the geographic barriers that exist and current provincial pharmaceutical coverage of Mifegymiso. By providing provincial coverage for Mifegymiso and improving patient access and universality, the Saskatchewan government will be fulfilling its legal obligation as part of the Canada Health Act.

Supporting Statements:

Dr. Cattapan

My name is Alana Cattapan, and I am an Assistant Professor at the Johnson Shoyama Graduate School of Public Policy and an Associate Member of the Department of Community Health and Epidemiology in the Faculty of Medicine at the University of Saskatchewan. I am writing to articulate my support for the Student Medical Society of Saskatchewan's advocacy campaign for the universal coverage of Mifegymiso (RU-486).

Access to safe, effective abortion care is a matter of justice, and is integral to the well-being of women living in Saskatchewan. Since becoming available to Canadians in 2017, Mifegymiso has allowed women in Saskatchewan and elsewhere improved access to care, by enabling women to self-administer medication to induce abortions, under the supervision of a physician or nurse practitioner.

Mifegymiso is not only a safe and effective intervention, but it also enables a broader range of women, including those in rural and remote areas, improved access to abortion services. This is critical in Saskatchewan given our significant rural and Northern populations, as well as the lack of surgical abortion provision outside of Regina and Saskatoon. Most Canadian provinces—British Columbia, Alberta, Ontario, Quebec, New Brunswick, Nova Scotia, and Newfoundland—recognize the need for widespread access to Mifegymiso, and provide universal coverage. Early data from these provinces indicate that universal coverage of this intervention is working to reduce the number of surgical abortions and, while access to free, safe abortion care should not be contingent on cost, the use of Mifegymiso (rather than surgical abortions) is occurring at a savings to provincial health insurance programs.

It is worth noting that there have been important measures taken in Saskatchewan to improve access to care. These include the expansion of potential prescribers to include nurse practitioners, and the inclusion of Mifegymiso under the Saskatchewan Prescription Drug Plan. Yet, access to medical abortions in province remain out of reach for many, particularly those for whom the high cost is a critical barrier. In closing, I would like to reiterate that access to safe effective abortion care—and broader reproductive health services—is a matter of justice, fundamental to gender equality. Universal access to Mifegymiso would be a critical step towards addressing reproductive justice in the province. I laud the efforts of the efforts of the Student Medical Society of Saskatchewan for taking on this issue, and support their efforts.

Dr. Erin Beresh

I am writing today to voice my support for universal drug coverage for Mifegymiso in Saskatchewan. As a family physician with a practice focused on women's health, I can attest to the benefits this would provide for women in our province. In my experience, many women who present for therapeutic abortion would like to use the option of medical abortion in the privacy of their own home. The safest and most effective method of medical abortion is the combination of Mifepristone and Misoprostol, known as Mifegymiso, approved in Canada until 63 days of gestation.

In Canada, 1 in 5 women will have an unplanned pregnancy in their lifetime. (1) Among all pregnancies in Canada, 40% are unplanned. (2) When a woman has an unplanned unwanted pregnancy, there is no good choice. As physicians and public servants, it is our job to provide patients, regardless of situation and income, with the safe, legal, and indicated options for their health concern. Patients count on this autonomy in all aspects of their health care, and it is our role as health care providers to trust that patients make the treatment choices that are best for them.

Worldwide, the unplanned pregnancy rate is higher amongst younger, unmarried, and low-income women. (3,4,5) These women are more likely to suffer the associated financial hardship of unplanned pregnancy, which can affect future educational and employment opportunities. (6) Health Canada approval does not mean Mifegymiso is accessible to everyone. Many patients who qualify and would like to pursue therapy with Mifegymiso do not have third-party private insurance, and therefore must pay $300-450 for treatment. In my experience, the Saskatchewan women whose lives would be most affected by raising an unplanned child, in terms of financial hardship, lost education and wages, are also most often those without private drug coverage, and in many circumstances these women are unable to pay for treatment. As a physician who focuses on prevention, I want my patients to conceive when they plan to. I strongly prefer my patients spend the $400 on effective contraception until that time arrives than desperately try to come up with the funds to end an unplanned pregnancy. As a steward of our provincial health care funds, I must also point out the obvious cost savings to fund Mifegymiso. There are more than 180,700 unintended pregnancies in Canada annually, costing taxpayers $320 million. (7) Mifegymiso is a safe outpatient medication and is more cost effective than surgical termination of pregnancy for the women who qualify and would otherwise prefer the medical abortion option. Surgical termination of pregnancy in the first trimester is paid at a rate of $387.30 for care providers in Saskatchewan, and that does not include the fees required to provide the in-hospital medications, pathology, equipment and staffing costs. This does not include the patient's hidden costs of lost wages, child care, and transportation incurred by women who must travel for a surgical day procedure. I have encountered patients who have spent their entire savings account to travel to a tertiary site for a surgical abortion, a cost that could be avoided by utilizing medical abortion and telehealth.

As a proud Saskatchewan physician, I urge you to universally fund Mifegymiso in our province to ensure that our most vulnerable women receive the same access to health care as our most affluent individuals. This universal coverage would give many women in Saskatchewan a sense of control, in an otherwise helpless situation.

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Regina Sexual Assault Center

This letter is to express support for the University of Saskatchewan College of Medicine Government Advocacy and Action Committee's focus on securing universal coverage in Saskatchewan for Mifegymiso. Traditional options for abortions, such as attending to a women's centre or abortion clinic, creates considerable barriers for many women, particularly for those who live in rural or sparsely populated regions. Access to Mifegymiso through family doctors and pharmacies provides a safe and effective abortion with reduced need for travel and wait times. It also reduces concerns of privacy for women who would need to ask family, friends or medical taxis to transport them to appointments We believe the government should also be interested in, from a monetary perspective, the substantial costs to healthcare associated with performing early abortions in hospitals – salaries, administration, paperwork, and medical equipment – versus the cost of a single visit to a family doctor and a universally-covered prescription of Mifegymiso. Speaking from the perspective of our Centre, most of our clients have experienced childhood sexual abuse, which has affected many parts of their lives, including economic security (which impacts access to medications). The abuse often creates shame and a deep trauma that can be triggered by intrusive physical exams and procedures. It is safe to say this may be an issue for many in our province, considering the rate of sexual violence is 1 in 3 women. Equal, universal access to Mifegymiso provides all women with a safe option that supports their dignity, privacy and mental health, all of which is of concern for our government.

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