

Access to abortion in Canada



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The study in *The Lancet Public Health* by Erin Brennand and colleagues¹ looking at abortion care in Alberta, Canada, tests an optimistic hypothesis held by many, that the 2017 implementation and deregulation of mifepristone for medication abortion would substantially improve access to care. Until 2017, abortion in Canada was almost exclusively available through procedures carried out by physicians in urban centres.² Using Ontario population-based administration data from 2012 to 2020, Schummers and colleagues³ found that after its introduction, medication abortion increased rapidly as a proportion of abortion overall. In 2019, Renner and colleagues⁴ surveyed Canada's abortion workforce and found 83% of the 465 respondents reported providing first-trimester medication abortion. Furthermore, nurse practitioners constituted 6% of respondents, and 44% of abortion in rural areas was through medication abortion. These studies pointed to the effect that medication abortion was swiftly making on practice. By 2022, the Canadian Institute of Health Information reported that 39.5% of abortion across the country was by medication.⁵ But was that effect equal across populations? Brennand and colleagues provide an overview of changing abortion care in Alberta specifically.

Each province and territory in Canada has unique geographies, regulations, and social norms that might affect medication abortion uptake and access. As Brennand and colleagues¹ explain, Alberta has a large population—roughly 12% of the Canadian population—and is a large land mass, roughly 7% of the country. It has had principally conservative leadership over the past 50 years. Ideally, adoption of medication abortion into primary care practice across the province would result in reduced driving distances for patients and improved accessibility. However, according to Alberta Health Services⁶ there are only three access points for abortion in the province (Women's Health Options, Edmonton, and the Kensington Clinic, Calgary, with later gestational care available through Peter Lougheed Centre at the Calgary General Hospital).

Brennand and colleagues' temporal analysis from 2012 to 2023 found that medication abortion constituted 13.8% of Alberta's abortions in 2022, and 20.3% by the end of the first half of 2023.¹ Likewise, from 2017 to 2022, the number of medication abortion prescribers increased

from 67 to 229, and pharmacies associated with dispensing from 52 to 208. Despite these increases, there was no substantial change in median travel time and distance to access abortion care over the study period. People outside of the metropolitan centres of Calgary and Edmonton are still travelling long distances, and uptake of medication abortion in Alberta is substantially lower than in Canada overall. These are disappointing and important findings. The question remains: why? As the authors note,¹ the reason is not attributable to legal restrictions: abortion has been completely decriminalised in Canada for more than 37 years.

The next step for researchers will be to establish potential causes for persistent inequity in geographical access despite expansion of the abortion workforce. Many people in rural areas have to travel to access care because they have no other option, they might also worry about threats to confidentiality or privacy if they seek care locally. It is also possible that patients simply do not know local primary care prescribers are an option, and default to contacting the major urban touchpoints.

Furthermore, as Brennand and colleagues note, they were unable to differentiate between the proportion of medication abortion provided by telemedicine versus in person. Guilbert and Bois^{7,8} found in Quebec, Canada, that not only was medication abortion infrequently offered, but that information provided by clinics about medication abortion was too poor to support informed patient decision making, and telemedicine was almost non-existent. Large international studies have shown the safety and popularity of telemedicine,^{9,10} and while uptake across Canada as a whole is steadily increasing, it remains an underused lever to reduce travel burdens.

From Brennand and colleagues' analysis¹ we learn that despite decriminalisation of abortion in Canada 37 years ago, and despite the promise of medication abortion to enhance access, there are persistently high travel burdens to abortion care. Alarming, the number of facilities and individual physicians providing procedural abortion has decreased over the past ten years. Questions remain as to how to optimise access to both procedural and medication abortion so that all abortion seekers have clear and convenient access to their chosen method of care.

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Martha Jane Paynter
martha.paynter@unb.ca

University of New Brunswick, Fredericton, NB, Canada.

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