

The Abortion Issue All Over Again

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Many people may have thought that the arguments over abortion had been resolved, but the subject never really goes away. Since the last election, and with Tony Abbott as Minister for Health, the anti-abortion lobby has become vocal again.

Most people nowadays do not recall the time before the law changes in South Australia in 1969, the Menhennit ruling in Victoria in 1969, the Levine ruling in NSW in 1972 and the subsequent changes in other states which have broadened the conditions under which abortion can be legally performed. As a result of these changes, and the subsequent introduction of Medibank and later Medicare which have kept costs down, women have been encouraged to report earlier and can have easier access to safe, skilled abortion with confidence and dignity.

The anti-abortion lobby has been circulating misinformation about the long-term effects of abortion, a so-called epidemic of abortions and the numbers of 'late' abortions. Senator Boswell has even persuaded the Senate not to approve a motion in support of the UN Millennium Development Goal of reproductive rights for women, which he considered could imply the right for women to have access to abortion (1); this in spite of the fact that every international women's conference and population conference since the 1960s has included a clause on the rights of women and couples to determine the number and spacing of their children.

In addition, in September 2005, legislation was introduced into the Federal parliament which would give the Health Minister power to determine that Medicare benefits would not be payable for medical services in certain circumstances (as yet unspecified), but theoretically for new procedures under existing Medicare numbers (2). This could be a cover for withholding some payments for abortion and IVF, especially new procedures.

On the other side, Senator Natasha Scott Despoja has introduced a bill into the Senate, aimed at ensuring that abortion counselling services receiving government support be required to take an unbiased view on abortion (3). At present the Federal Government provides some \$240 000 for abortion counselling services which are in effect Right to Life organisations aimed at trying to persuade women against proceeding with an abortion. No funds are provided for organisations such as Bessie Smyth, which provide non-directive counselling.

Women's groups have started to organise again to ensure we do not go back to the days of illegal abortion. On 22 June, at Parliament House, Canberra, a new national pro-choice coalition was launched to be known as Reproductive Choice Australia representing 21 women's organisations from all states,

including Children by Choice, FPA Health, Women's Electoral Lobby, Association for the Legal Right to Abortion (ALRA, WA), Women's Abortion Action Campaign, the Bessie Smyth Foundation and others. The launch was attended by representatives of the Liberal and Labour parties, the Democrats and Greens, and the President of the ACT Members Assembly.

Historical background

Throughout history, and on every continent, women have tried to control their births either by trying to prevent pregnancy or to 'bring on their periods' which would reassure them that they were not pregnant, but also that they were healthy and fertile. Women have shared their knowledge; they used magic spells, physical exertion, local plant extracts, sometimes highly toxic, pummelling their bellies, douching and insertion of foreign bodies into the uterus.

In the 10th century the Persian doctor Rhazes wrote advice for women which included coitus interruptus, spermicides to prevent pregnancy, and herbs to induce menstruation; and finally "if the semen has become lodged, there is no help for it but that she insert into the womb a probe or a stick cut into the shape of a probe, especially good being the root of a mallow" to be left in all night and a full day as well. In 1-2 weeks the menses would appear; if not successful, the procedure could be repeated (4).

A survey at one Melbourne Hospital on 1882 showed that among 500 married women outpatients, 180 had had 6 or more children, 262 had had one or more abortions, 16% of all pregnancies; eight had had six or more abortions (5). In 1885 a chemist, Thomas Sheridan, was gaoled for 10 years after the deaths of four of his abortion patients (6). On his release, his first abortion patient died and he was subsequently hanged.

The NSW Royal Commission on the Decline in the Birthrate and the Mortality of Infants in 1903-4 described the ways in which women attempted to obtain an abortion (7). Newspapers carried thinly disguised advertisements for abortifacient drugs, some highly toxic and many ineffective.

The number of abortions carried out clandestinely by doctors, mid-wives, abortionists and women themselves is can only be guessed. Women who had means could attend a skilled abortionist; otherwise they went to someone less skilled or tried to abort themselves.

In 1908, a doctor in Australia called for restriction on the sale of gum elastic catheters because of the number of women using them to produce an abortion (8). Even within my own experience, women have reported that they inserted a knitting

needle into the cervix at the time of the monthly period to ensure they were not pregnant: a precursor to menstrual regulation.

Abortion attempted by women themselves or performed by unskilled operators using poor techniques has resulted in high complication rates and deaths from infection and haemorrhage. Many abortion deaths may have been disguised by false death certificates. In spite of the introduction of antibiotics and blood transfusion, and improvements in technique, abortion still remained the highest single cause of maternal death in Australia until the 1970s, when the laws were relaxed. Annual deaths from abortion declined from 125 in 1941 to 14 in 1970, but in the triennium 1973-75 there were only 2 abortion deaths and from 1988 to 1999 there have been only 3 deaths associated with abortion (9).

Attempts to restrict abortion have been made in Federal and State Parliaments. Abortion law is a state responsibility but Medicare comes under the Federal Government.

In 1979, Federal member Stephen Lusher unsuccessfully sought to have abortion removed from the Medical Benefits Schedule (Medibank). He lost his seat at the next election (10).

In 1998, in Western Australia and the Australian Capital Territory, attempts to introduce more liberal abortion legislation resulted in restrictive amendments. In the ACT, the end result was the withdrawal of the legislation in 2002 so that abortion is now decriminalised.

In other countries, attempts to impose severe restrictions on the availability of abortion because of religious objections or to increase the birth rate, have usually resulted in an increase in maternal mortality and morbidity with only a temporary rise in births, as happened in Romania under Ceaucescu (11).

Women have been prepared to risk their lives rather than face an unwanted pregnancy. They do not lightly undertake abortions. The decision is complex, involving personal and family consequences, and the health and welfare of the woman and the foetus. Abortion has protected family honour, saved family income and relieved men from the responsibilities of parenthood.

Improved access to abortion

Following the relaxation of abortion laws there was an increased demand on public hospitals, which led them to impose limits on the number of cases admitted each week. Women who had to wait frequently needed to seek private abortionists, facing the problem of costs and delays.

The opening of the Leichhardt Women's Centre and the Preterm Foundation in Sydney in 1974 and later free-standing clinics, helped to relieve the pressure in public hospitals and were welcomed by hospital doctors. There are now over 20 free-standing abortion clinics in NSW run by trained doctors offering high quality services. The important conse-

quences of these changes are that costs have been kept down, and women can be encouraged to report earlier.

Costs and Medicare

Abortion was covered first by Medibank and since 1984 by Medicare, although not all the services which are now regarded as routine are included. In addition, the Common Fee rebate provided by Medicare has not kept pace with rising costs. Some clinics offer special help to women who cannot afford regular fees.

The Health Commission has recently queried some of the claims made under Medicare, with the result that patients are having to pay higher fees up-front. Most abortion clinics place a time limit on their cases, and for pregnancies over 20 weeks women have to go to a hospital or to one of the clinics which cater for 2nd trimester abortions where costs are correspondingly higher.

The new anti-abortion campaign has again raised the question of restriction of Medicare funding. This may result in the introduction of more stringent restrictions on abortion and withdrawal or limitation of Medicare funding.

However dire the legal implications, women would still seek avenues for termination of pregnancy and the consequences would include:

- making abortion much more expensive, obliging many women to postpone the abortion while they saved up for the fees; which could mean a more risky 2nd trimester operation
- more women trying to have a public hospital abortion which would increase the pressure on hospital waiting lists, and result in the re-introduction of a quota system and also delays in admission
- a potential move to cheaper abortions by less-equipped doctors or even an increase in attempts at self-abortion.

All of these factors could increase the risks of abortion and cause maternal deaths to rise again.

In 1993-94 members of Right to Life unsuccessfully took legal proceedings against the Commonwealth Department of Health and Human Services to try to prevent WHO sponsored research projects investigating the use of RU486 as a post-coital contraceptive and as an abortifacient. RU 486 (mifepristone) was found to be an effective post-coital contraceptive which could help to reduce the number of unplanned pregnancies.

Following a motion by Senator Brian Harradine in 1996, the Federal government regulated that abortifacient drugs such as RU 486 cannot be imported into Australia without the approval of the Minister and first tabling in Parliament(17).

Statistics

Full national statistics on abortion are not available. South Australia is the only state which requires notification of all

abortions and publishes a detailed Annual Report. All abortions in SA must be performed in an approved institution. More than half are performed as public cases in the Pregnancy Advisory Centre established in 1992 to reduce waiting times and to cater for later abortions which previously had to be transferred interstate (12).

These are shown in the Annual Reports but only private cases appear in Medicare statistics. With some fluctuations the number and rate of abortions in South Australia has started to decline. The 2003 report states that the abortion rate for women aged 15-44 years had declined to 16.7 per 1000 women from around 17.2-17.8 over the previous 7 years (13). The decline in rates was more marked in the younger age groups

Age	
15 - 19 years	decrease from 25.0 to 22.3
20 - 24	31.7 to 29.4
25 - 29	22.7 to 21.9

The 2003 SA report states that the teenage pregnancy rate was the lowest since 1991, an indication of better use of contraception in this age group. It also found that the number of women reporting previous abortions, which had been stable for some years, had shown a slight decline. Assuming that the SA statistics reflect women's experience in other States there is no evidence of an 'epidemic' of abortions.

Medicare statistics record only those cases where a rebate has been paid. This does not include public hospital patients, or those cases where the woman does not make a claim.

It has been generally accepted that overall, Medicare figures may underestimate the number of abortions by 10-20% which could mean that the number of abortions performed each year is around 80,000-90,000 over the past 10 years. The shift from public hospitals to private free-standing clinics means more cases come under Medicare.

The number of abortions recorded under Medicare has actually declined from 75 813 in 1993-94 to 72 554 in 2003-04, which reflects a decline in abortion rates (14). Medicare data show age trends similar to those in SA. The decline is more marked among the younger women.

The introduction of the 'morning after pill' over the counter, and the newer contraceptives may have contributed to the decline in abortions. The 2001 National Health Survey showed that the younger age groups were more likely to report use of the 'morning after' pill (15). Teenage births have declined by more than 60% since a peak around 1971(16).

In recent years the mean age at confinement has risen by 5 years. Women aged 30-34 and 25-29, now have the highest birthrates. This means that women postponing their births are at risk of an unplanned pregnancy for a longer period.

SA data show that the proportion of 2nd trimester abortions (after 14 weeks) increased after the opening of the Pregnancy Advisory Centre as fewer women now had to travel interstate

for their operations. The report for 2003 indicates that this figure has started to decline (from 8.1% in 2002 to 7.2% in 2003). The proportion of abortions after 20 weeks also declined from 1.3% to 0.9% (13). The NSW Premier Bob Carr has quoted a figure for NSW under one percent.

The reasons for termination after 20 weeks gestation in SA are almost equally divided between the mental health of the mother and abnormality in the foetus. This may be representative of the national figures.

Abortions may be delayed till after 20 weeks as a result of lack of access to abortion services, as for country women, or women having to save up for the fee, or failure to recognise pregnancy earlier in very young women and in pre-menopausal women; but most frequently because of serious complications for the mother or abnormalities in the foetus which cannot be detected earlier.

Conclusions

The lack of detailed national data allows the opponents of abortion to run scare campaigns about the number of abortions particularly those in the second trimester. Data in this detail is not collected for any other medical procedure and its purpose should not be to form a basis for restricting women's access to abortion. It is obvious that the main thrust in any campaign to reduce the number of abortions should be to improve sex education, information and access to contraception in order to reduce unplanned pregnancies.

The Doctors Reform Society policy on Women's Reproductive Health supports the rights of people to determine the number and spacing of their children and women's right to have access to free, safe termination of pregnancy; considers that abortion should be governed by laws relating to good medical practice; and deplores attempts to restrict access to safe abortion or removal of abortion from the Medicare Schedule (18).

Women should not be forced to continue an unwanted pregnancy or to have an abortion against their will. Attempts to increase the birthrate should not result in restricting women's right to determine their own fertility, or to have access to improved methods of contraception, post-coital contraception and abortion. Likewise, women should not have to give up the gains made in the last few decades in their right to equal education and employment opportunities, equal pay and removal of discrimination on the basis of their sex.

References

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