LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING
Mr Johnathan Davis (Chair), Mr James Milligan MLA (Deputy Chair),
Mr Michael Petterson MLA

Submission Cover Sheet

Inquiry into Abortion and reproductive choice in the ACT

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Standing Committee on Health and Community Wellbeing,

ACT Legislative Assembly, GPO Box 1020,

Canberra ACT 2601

15 August 2022

Dear Officer,

RE: Inquiry into Abortion and Reproductive Choice in the ACT

The Australian National University Law Reform and Social Justice Research Hub ('ANU LRSJ Research Hub') welcomes the opportunity to provide this submission to the Standing Committee on Health and Community Wellbeing, responding to the terms of reference of the Inquiry into Abortion and Reproductive Choice in the ACT.

The ANU LRSJ Research Hub falls within the ANU College of Law's Law Reform and Social Justice program, which supports the integration of law reform and principles of social justice into teaching, research and study across the College. Members of the group are students of the ANU College of Law, who are engaged with a range of projects with the aim of exploring the law's complex role in society, and the part that lawyers play in using and improving law to promote both social justice and social stability.

Summary of Recommendations:

1. Invest in researching and finding alternatives to mandating unnecessary ultrasound and blood testing prior to proceeding with a self-managed or community health professional-managed medical abortion, where clinically safe and suitable to do so.
2. Investigate options for lifting the gestation period for self-managed medical abortions.
3. Expand the number of practitioners who are able to provide medical abortion services, including increasing resource provision for self-managed options.
4. Consider altering section 84A of the *Health Act 1993* (ACT) to insert a requirement for conscientious objectors to provide a referral to an equivalent service, in line with both international best practice standards, as well as comparative Australian jurisdictions.

5. Inquire into the impacts of Calvary Hospital's objection on abortion and reproductive choice access in the ACT, and reconsider allowing Calvary Hospital to maintain its position as a public hospital exempt from providing these services in the ACT.
6. Cooperate with the Federal Government and other State governments to create a more unified, national approach to abortion access.
7. Advocate for the Commonwealth to provide further subsidies to improve access to abortion in the ACT, particularly moving towards Medicare coverage for medical and surgical abortions.
8. Push for reform of Commonwealth legislation and regulations to promote the equitable access to abortion for all Australians.
9. Funds should be made available for people who have to travel interstate to access an abortion after 16 weeks.

If further information is required, please contact us at anulrsjresearchhub@gmail.com.

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Introduction

This submission is in relation to the Inquiry into abortion and reproductive choice in the ACT. It highlights key areas where the ACT can look to make changes to further promote equitable access to abortion.

As is stands, the ACT has been aleader in Australia in relation to the decriminalisation of abortion, and the ACT continues to strive for the equitable accessibility and affordability of these medical treatments. We commend the ACT Legislative Assembly in this regard, and welcome the additional funding which has been allocated in recent years to facilitate access to abortion treatments and ancillary services.

The ACT has shown exceptional leadership in this area. We hope that the Legislative Assembly will consider and implement our recommendations in order to safeguard and strengthen the rights of people accessing abortions in the ACT. This is essential as access to safe and legal abortion, and to quality post-abortion care, is crucial to reducing maternal mortality rates, preventing adolescent and unwanted pregnancies, and to ensure people accessing abortions have bodily autonomy.

This Inquiry comes at an important moment given the growing global awareness of the fragility of abortion and reproductive rights, exposed by the extremely disheartening developments in the United States with the Supreme Court's decision in *Dobbs v Jackson,*[1] which struck down the near half-century legal precedent in the United States protecting abortion rights.

Given these developments, it is essential to continue to pursue a progressive approach in relation to preserving and promoting free and fair access to abortion and associated care. Australia has obligations to protect and promote abortion and reproductive choice as a party to the *Convention on the Elimination of All Forms of Discrimination against Women,* which includes the right to bodily autonomy – encompassing women and girls' sexual and reproductive freedom.[2]

In the ACT, the primary legislation governing abortions is the *Health Act 1993* (ACT) ('the Act'). The Act defines 'abortion' as 'causing a woman's miscarriage by administering a drug, using an instrument or by any other means' , which therefore applies to both surgical and medical abortions.[3] Gestational limits for abortion are not specified in Division 6.1, however practically there is a local limit of abortions only being available up to 16 weeks gestation.

[1] *Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health, et al. v. Jackson Women's Health Organization, et al.* 597 US 2022 WL 2276808.

[2] *Convention on the Elimination of All Forms of Discrimination against Women,* opened for signature on 18 December 1979, 1249 UNTS 13 (entered into force on 3 September 1981), art 12; additionally, art 16(e) protects women's rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights

[3] *Health Act 1993* (ACT) s 80.

1. Opportunities for Decentralising Service Provision

First, it should be acknowledged that in many ways, the ACT represents one of the most progressive jurisdictions in Australia with regards to abortion access and reproductive choice. The Research Hub welcomes the ACT's decriminalised approach to abortion, and the theoretical removal of a gestation limit on accessing abortion services.[4] Abortion and reproductive choice are health issues, and more broadly, issues pertaining to public health equity. Therefore,broad access to those services is a necessary component of promoting and protecting the rights, lives, livelihoods, and health of all people.

However, the theoretical content of the law must be distinguished from its substantive application in the ACT, where only a few providers are able to provide medical or surgical abortions. Those providers are *Marie Stopes Australia* and *Gynaecology Centres Australia*, who can provide medical and surgical abortions up to 14-16 weeks' gestation, and in specific circumstances, *Canberra Hospital*, including at later weeks of gestation.[5] The Research Hub notes that there are general practitioners across the ACT who are trained to provide medical abortions, as well as telehealth services and services provided through *Marie Stopes Australia* which facilitate medical abortions up to 9 weeks' gestation.[6]

Decentralising service provision is a key strategy in increasing the accessibility of abortion and other reproductive services. The World Health Organisation's 'Abortion Care Guideline' ('the Guideline') recommends enabling a wide range of community and public health workers to administer part or all of medical abortion procedures.[7] Those potential providers include community health workers, pharmacists and pharmacy workers, traditional and complementary medicine professionals, nurses, auxiliary nurses, midwives, generalist and specialist medical practitioners.[8] Evidence provided to the expert panel behind the recommendations affirmed that 'the potential to increase equitable access to quality abortion care… is high', where service provision can be decentralised and a diverse range of health workers are empowered to provide the service.[9] Further, the Guideline recommendsthat medical abortion services administered by non-physicians should be available up to 10 weeks' gestation, and for services administered by physicians, up to 12 weeks' gestation, pending assessment of the procedure's safety for the pregnant person.[10]

Past 12 weeks' gestation, the Guideline further recommends the decentralisation of surgical abortion services where safe to do so. Notably, it suggests equipping nurses, auxiliary nurses, midwives, and

[4] Ibid pt 6.
[5] ACT Health, *Abortion Access* (Web Page, 17 June 2022) <https://www.health.act.gov.au/services-and-programs/sexual-health/abortion-access> ('*Abortion Access*').
[6] Ibid.
[7] Guidelines Review Committee, Sexual and Reproductive Health and Research, World Health Organisation, *Abortion Care Guideline* (Guideline, 8 March 2022) 69 ('*Abortion Care Guideline*').
[8] Ibid.
[9] Ibid.
[10] Ibid.

associate clinicians, with the tools to undertake surgical abortion procedures '[i]n contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications'.[11] It is recommended that generalist and specialist medical practitioners across a range of backgrounds and services also be equipped to perform the procedure.[12]

Furthermore, best practice international standards for abortion and reproductive choice services now acknowledge the individual seeking treatment as an able provider of those services.[13] The Guideline recommends 'the option of self-management of the medical abortion process in whole or any of the three component parts of the process:

- self-assessment of eligibility (determining pregnancy duration; ruling out contraindications);
- self-administration of abortion medicines outside of a health-care facility and without the direct supervision of a trained health worker, and management of the abortion process; and
- self-assessment of the success of the abortion'.[14]

This recommendation was made for medical abortions at under 12 weeks' gestation, with more evidence supporting the success of self-managed abortions under 10 weeks' gestation.[15]

1.1 Decentralised Abortion Services in the ACT

The Research Hub notes that under 9 weeks' gestation, pregnant people have the option of accessing a medical abortion through trained general practitioners, telehealth providers, and *Marie Stopes Australia*.[16] We acknowledge that this demonstrates a commitment to increasing the accessibility of medical abortion services for people in the ACT. However, we note that there may be a number of areas for improvement of the accessibility of these services.

Recommendation 1: Invest in researching and finding alternatives to mandating unnecessary ultrasound and blood testing prior to proceeding with a self-managed or community health professional-managed medical abortion, where clinically safe and suitable to do so.

[11] Ibid 71-72.
[12] Ibid.
[13] Caitlin Gerdts et al, 'Beyond safety: the 2022 WHO abortion guidelines and the future of abortion safety measurement' (2022) 7 BMJ Global Health 1.
[14] *Abortion Care Guideline* (n 7) 98.
[15] Ibid.
[16] *Abortion Access* (n 5).

Provision of options for self-management or community management of medical abortion services are an important step in increasing accessibility of abortions for pregnant people who otherwise face barriers to accessing these services. Particularly, those people who often lack facilities to safely and discreetly access abortion services are able to benefit from self-managing their own procedures, or from accessing the procedure through a community health professional. This includes:

- rural and regional people;
- people from culturally and linguistically diverse backgrounds;
- non-permanent residents and non-citizens;
- people experiencing domestic and family violence, including coercive control;
- young people;
- people with disabilities;and
- LGBTQIA+ people, particularly transgender and intersex people.[17]

Where blood testing or ultrasounds are mandated prior to the dispensing of medications for a self-managed medical abortion, but are not required for clinical reasons, the accessibility of this option is often undermined by the necessity to travel to specialist health providers for these services, compromising the secrecy or safety of accessing the procedure for the individual.[18]

The Guideline recommends against the mandating of clinically unnecessary ultrasound scanning as a pre-requisite to providing medical or surgical abortion procedures, noting that doing so will 'increase the availability of abortion in settings where ultrasound is difficult to access'.[19] Accordingly, the Research Hub recommends that alternatives to ultrasounds and blood tests be explored for use in decentralised and self-managed procedural settings where it is clinically safe to do so, such as the deployment of high-sensitivity pregnancy tests to community health providers.[20]

Recommendation 2: Investigate options for lifting the gestation period for self-managed medical abortions

With the objective of bringing the ACT into alignment with WHO's recommendations, the Research Hub recommends investigating options for raising the gestation period for self-managed medical abortions to 12 weeks, conditional on a physician assessment of patient safety.[21]

Recommendation 3: Expand the number of practitioners who are able to provide medical abortion

[17] Women With Disabilities Australia, *WWDA Position Statement 4: Sexual and Reproductive Rights* (Position Statement, September 2016).
[18] *Abortion Care Guideline* (n 7) 47.
[19] Ibid.
[20] Ibid.
[21] Ibid 69.

services, including increasing resource provision for self-managed options

The Research Hub acknowledges and welcomes the equipping of selected general practitioners with the tools and training to facilitate medical abortions across the ACT.[22] We note that it is a criminal offence for an individual other than a doctor to supply an abortifacient to a patient for the purposes of facilitating a medical abortion.[23] Decentralising provision of medical abortion services may therefore require that the number of doctors equipped with the skills and understanding to prescribe abortifacients be increased, and also that telehealth and other remote options for discreet and accessible prescription of abortifacients be increased.

Ultimately, the Research Hub acknowledges that the larger objective outlined in the Guideline is a shift away from grounds-based service provision towards medical abortion on request of the pregnant person.[24] Achieving this objective will require modifications to the prescription authorisation processes for surgical abortion medications, or alternative mechanisms to be put in place, to enable a wider range of accessible health practitioners, such as community health workers, nurses, auxiliary nurses, midwives, and associate clinicians, to facilitate access to those medications and services for abortion seekers.[25]

We recommend that the tools and training necessary to administer medical abortion procedures be extended to a greater number of general practitioners, as well as to community health workers, nurses, auxiliary nurses, midwives, and associate clinicians.[26] Such a move would be instrumental to increasing accessibility of abortion services across a range of geographical areas and socio-economic contexts within the ACT.

A highly suggested component of this recommendation is also increasing deployment of resources for the self-management of medical abortions across service providers.[27] Options for increasing access, through completely or partially self-managed means, is an important consideration for accessibility of abvortion services overall, and particularly for groups who otherwise face barriers to accessing reproductive choice services.

2. Regulating Conscientious Objection

[22] *Abortion Access* (n 5).
[23] *Health Act 1993* (ACT) s 81.
[24] *Abortion Care Guideline* (n 7) 26.
[25] Ibid 98.
[26] Ibid 69.
[27] Ibid 98.

The current legislative framework regarding conscientious objection is section 84A of the Act.[28] The section provides that 'an authorised person [a doctor or nurse[29]] may refuse to prescribe, supply or administer an abortifacient, or carry out or assist in carrying out a surgical abortion, on religious or other conscientious grounds'.[30] The authorised person may not object in situations where a surgical abortion is necessary to preserve the life of the pregnant person, or where medical assistance is required by a person because of an abortion.[31] The section further protects conscientious objectors from liability for a breach of any statutory or contractual duty as a result of their conscientious objection.[32] The person who is conscientiously objecting must inform the patient seeking an abortion that they are refusing to provide the service by reason of conscientious objection.

Notably, the current legislative framework in the ACT does not require conscientious objectors to provide information to people seeking an abortion regarding alternative, equivalent services they may use in order to access an abortion.[33] This is out of alignment with both national and international standards.

Across Australian jurisdictions, the ACT is an outlier in its lack of a requirement for conscientious objectors to refer patients to alternative, equivalent services. Comparative jurisdictions have taken action to enshrine such a requirement into legislation.For instance, in New South Wales sections 9(3) and 9(4) of the *Abortion Law Reform Act 2019* (NSW) regulates conscientious objection, providing that:

> (3) If the request by a person is for the registered health practitioner (the first practitioner) to perform a termination on the person, or to advise the person about the performance of a termination on the person, the practitioner must, without delay—
>
> (a) give information to the person on how to locate or contact a medical practitioner who, in the first practitioner's reasonable belief, does not have a conscientious objection to the performance of the termination, or
>
> (b) transfer the person's care to—
>
> (i) another registered health practitioner who, in the first practitioner's reasonable belief, can provide the requested service and does not have a conscientious objection to the performance of the termination, or
>
> (ii) a health service provider at which, in the first practitioner's reasonable belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection to the performance of the termination.
>
> (4) For the purposes of subsection (3)(a), the first practitioner is taken to have complied with the practitioner's obligations under that paragraph if the practitioner gives the person information approved by the Secretary of the Ministry of Health for the purposes of that paragraph.

[28] *Health Act 1993* (ACT) s 84A.
[29] Ibid s 84A(5).
[30] Ibid s 84A(1).
[31] Ibid s 84A(2).
[32] Ibid s 84A(3).
[33] Ibid s 84A.

The Guideline outlines the following in relation to conscientious objection:

> In spite of the human rights obligation to ensure conscientious objection does not hinder access to quality abortion care, and previous WHO recommendations aimed at ensuring conscientious objection does not undermine or hinder access to abortion care, conscientious objection continues to operate as a barrier to access to quality abortion care. It is critical that States ensure compliance with regulations and design/ organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible… international human rights law provides some guidance as to how States can ensure that human rights of abortion seekers are respected, protected and fulfilled. These include:
>
> - …prohibiting institutional claims of conscience;
> - requiring objectors to provide prompt referral to accessible, non-objecting providers…. [34]

Conscientious objections by health practitioners and providers of abortion services threaten the accessibility of those services for people seeking abortions in the ACT. Existing stigma, judgement, and structural and systemic barriers to accessing the procedure, particularly for more vulnerable or disadvantaged groups, may be compounded by the conscientious objection of a service provider.[35] Resulting outcomes may prevent the individual from seeking out or being able to access an abortion through another provider.

As outlined in the Guideline, where it is impossible to regulate conscientious objection in a manner that is consistent with people's rights to access a safe, easy, discreet abortion, conscientious objection may become indefensible.[36] Where conscientious objectors are not required to assist the patient by providing a referral to an equivalent service, the rights of the patient to access a service may be undermined.

Recommendation 4: The ACT legislature should consider altering section 84A of the *Health Act 1993* (ACT) to insert a requirement for conscientious objectors to provide a referral to an equivalent service, in line with both international best practice standards, as well as comparative Australian jurisdictions.

2.1 Calvary Hospital

In line with the recommendations of the ACT Health Services Commissioner in the 2019 Committee inquiry into Maternity Services in the ACT, the Research Hub recommends that the Committee inquire further into, and consider further regulation of the Calvary Hospital's objections to providing abortion

[34] *Abortion Care Guideline* (n 7) 60-61.
[35] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1.
[36] *Abortion Care Guideline* (n 7) 60-61.

and other reproductive choice procedures and services.[37] Calvary Hospital's 'Health Philosophy' principles note that:

> From the moment of fertilisation until the moment of natural death any directly intended termination of human life by active or passive means is not permitted… The use of abortifacient devices or medications, e.g. intrauterine devices, to prevent pregnancy is likewise prohibited… [Furthermore] a woman who has been sexually assaulted is morally permitted to try to prevent conception if it has not occurred, but the direct destruction of the human embryo or the use of abortifacients is morally wrong.[38]

The ACT Health Services Commissioner further noted in their submission to the Committee Inquiry into Maternal Services that 'some women are reluctant to use Calvary Hospital services for these reasons, or where they may be in a same sex relationship or marriage'.[39]

Calvary Hospital is one of two major hospitals in the ACT, and is the primary hospital serving patients in Canberra's Northern Suburbs.[40] Its operations are partially publicly-funded.[41] The Research Hub considers that Calvary Hospital's objection to providing abortion and other reproductive care services poses a significant barrier, particularly with limited availability of these services for persons seeking an abortion in the ACT.

Recommendation 5: Inquire into the impacts of Calvary Hospital's objection on abortion and reproductive choice access in the ACT, and reconsider allowing Calvary Hospital to maintain its position as a public hospital exempt from providing these services in the ACT.

3. Interactions with Commonwealth Law

Despite the primary responsibility for the regulation of abortion in the ACT lying with the ACT Legislative Assembly, it is important to consider the ancillary role that Federal law plays in this space. Following the successful referendum in 1946, section 51(xxiiiA) was introduced into the Australian Constitution, allowing for the Commonwealth to legislate for the provision of social services. Under this power, the Commonwealth has initiated various bills and regulations which have subsidised both surgical and drug-based abortions.

[37] ACT Health Services Commissioner, Submission No 36 to Standing Committee on Health, Ageing and Community Services, ACT Legislative Assembly, *Inquiry into Maternity Services in the ACT* (4 February 2019) 4.
[38] Little Company of Mary Health Care, *Philosophy* (Guideline, August 2011) 11.
[39] ACT Health Services Commissioner (n 38).
[40] Calvary Care, *Calvary Public Hospital Bruce* (Web Page, 2022) <www.calvarycare.org.au/public-hospital-bruce/>
[41] Ibid.

The Commonwealth currently assists in ensuring Australians have access to safe and legal termination and sterilisation procedures by subsidising a number of procedures performed in surgical abortions, through the Medicare Benefits Schedule.[42] The Commonwealth also subsidises a range of medicine for the contraception and medical termination of pregnancy through the Pharmaceutical Benefits Scheme (PBS). Finally, the Commonwealth provides funding for the delivery of education to health professionals and individuals relating to abortion access.

However, the role of the Commonwealth, has serious implications for the affordability and accessibility of abortion in the ACT. The subsidisation of certain medications or procedures does not always translate to lower costs for people accessing abortions on the ground, as evidenced by the cost of medical abortions often being the same as surgical abortions performed throughout Australia, even after Medicare rebates.[43] The rebates fail to account for the myriad costs involved for people accessing abortions, other than the procedure and medication. Furthermore, there are currently significant gaps in the rebates provided. In Opposition, Labor proposed a policy of Medicare-funded abortion during the 2019 election, however this policy was shelved and has not been revisited.

Commonwealth legislation and regulation can impact people accessing abortions in several ways. Regulations can limit the ability of health care providers to provide information about the availability of medical abortion. A particular example is the since-removed restrictions in the Therapeutic Goods Advertising Code,[44] which barred advertising drugs that have an 'abortifacient action' including mifepristone and misoprostol. Furthermore, restrictions persist on the prescription of medical abortions, particularly using the drug RU486, a gold-standard for medical abortions which has been used in over 100,000 abortions in Australia with a 95% success rate.

Until 2006, the Federal Health Minister had what was essentially a veto power over the use of RU486 by people accessing abortions in Australia, fortunately removed on 3 March 2006 by the *Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Act 2006* (Cth). The provision of drugs for medical abortions is now controlled by the Therapeutic Goods Administration ('TGA') as part of the Department of Health. Persistent issues remain, however, due to severely outdated guidelines being employed by the TGA, which have failed to recognise the utility for drugs such as RU486 for pregnancies past 12 weeks' gestation. The continued over-policing of medical abortions through Commonwealth regulations continues to stigmatise the access of abortions in the ACT.

Recommendation 6: Cooperate with the Federal Government and other State governments to create a more unified, national approach to abortion access.

[42] This includes (but is not limited to) partial cover for evacuation of contents of the gravid uterus by suction curettage or curettage (Item 35643), and curettage of the uterus of various types (*Medicare Benefits Schedule (MBS) 2017*).
[43] Mridula Shankar et al., 'Access, equity and costs of induced abortion services in Australia: a cross-sectional study,' (2017) 41(3) *Australian and New Zealand Journal of Public Health* 309, 312.
[44] *Therapeutic Goods Advertising Code 2015 (Cth)*, app 6, pt 1.

Recommendation 7: Advocate for the Commonwealth to provide further subsidies to improve access to abortion in the ACT, particularly moving towards Medicare coverage for medical and surgical abortions.

Recommendation 8: Push for reform of Commonwealth legislation and regulations to promote the equitable access to abortion for all Australians.

4. Prohibitive Costs of Interstate Travel to Access Abortions

The recent announcement from the ACT Government that abortions will be free for all ACT residents up to 16 weeks, from 2023 onwards, is an important step forward in removing a significant financial barrier to those seeking an abortion[45]. However, there is still a prohibitive financial factor in the requirement for people to travel interstate to access an abortion after 16 weeks[46]. Currently, there are no clinics available in Canberra for the procedure, with it only being conducted within the ACT under limited circumstances through Canberra Hospital.

The necessity of abortion access after 16 weeks is a legal one, as there are no gestational limits prescribed under the Act [47]. With the inaccessibility of abortion after this time from ACT medical services, the interstate travel requirement therefore creates an inequity between people who can afford interstate travel, and those who cannot. It is also a health safeguarding issue, as having very limited facilities that are able to perform these procedures creates a potential for waiting lists to become a barrier to access. Therefore, until such facilities become more readily available in clinics in the ACT, funds should be made available to facilitate travel into NSW for those seeking an abortion. This would ensure that cost is not a prohibitive factor to accessing this important medical service. These funds should be administered on a needs-based scale, in order to ensure it actually meets the needs of all individuals accessing it.

Recommendation 9: Funds should be made available for people who have to travel interstate to access an abortion after 16 weeks.

[45]Berry, Y. and Stephen-Smith, R., 2022. *Canberrans to have free access to safe abortion services - Chief Minister, Treasury and Economic Development Directorate*. [online] Cmtedd.act.gov.au. Available at: <https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/yvette-berry-mla-media-releases/2022/canberrans-to-have-free-access-to-safe-abortion-services> [Accessed 14 August 2022].

[46] *Abortion Access* (n 5).

[47] "Australian Abortion Laws | State Legislation On Abortion", *Tabbot.Com.Au* (Webpage, 2022) <https://www.tabbot.com.au/about/australian-abortion-laws.html>.