Barbara Baird
Associate Professor
Discipline of Women's & Gender Studies
College of Humanities, Arts & Social Sciences

GPO Box 2100
Adelaide SA 5001

Tel: 08 8201 3437
barbara.baird@flinders.edu.au

https://www.flinders.edu.au/people/barbara.baird

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Dear SALRI colleagues

Reform of SA abortion laws

I am an interdisciplinary scholar working in the area of Women's and Gender Studies and History, currently at Flinders University. I have been researching abortion in Australia for nearly 30 years and I am regarded by my academic colleagues and many abortion provision and advocacy communities as the leading historian of abortion in C20th and C21st Australia. It is from this background that I make this submission. My research and my advocacy concerning abortion in Tasmania, in South Australia and nationally is based on the principle of putting the needs of the person who is pregnant and does not wish to be so, and respect for their reproductive autonomy, at the centre of thinking about abortion. I also proceed from the principle that the provision of affordable, accessible and timely patient centred abortion care is necessary, a public good, and a sign of a caring society based in attention to human rights and collective responsibility for the welfare of individuals and the community.

Traditionally we have understood that it is women who need abortions and women have suffered much in the face of inadequate and unsafe access to this health care. People who do not identify as women may also need access to abortion care and they may face discrimination and compromised access to health care across many domains. In this submission I write of both women and people who need abortions to recognize the diversity in the relevant patient population.

It is nearly 50 years since the criminal law concerning abortion was reformed in SA. According to Dr Clare Parker,[i] the historian of this reform, the parliament's intention at the time was to clarify existing law (which was being interpreted restrictively) and to end the practice of unsafe abortions. The parliament did not seek to instate women's rights, nor to centre the patient in any respect. They aimed to clarify the situation for doctors (referred to in the legislation by male pronouns). In this sense **the law was a liberal reform but was and is also paternalistic to patients, and constraining to doctors who wish to afford women and other pregnant people autonomy and self-determination.**

There were attempts to further reform the law, to restrict access beyond the conditions of the 1969 reform, in 1972, 1988 and 1990. All were unsuccessful. The law has been used to press criminal charges twice since 1969. In 1973 a doctor was prosecuted and acquitted on one count and had his conviction quashed on appeal on the other.[ii] In 2005 another case was successful when an appeal was dismissed in a case where a man had been convicted of a range of sexual abuse offences against his daughter and of attempting to cause her abortion.[iii] Arguably the abortion element of this extraordinarily violent case could have been prosecuted under other parts of the CLCA (eg Division 7 or 7A). My point here is that **the liberal reform of 1969 has not been successfully wound back, nor found applicable in any criminal case to the provision of any health care service.** The case of the violent father is not a case of health care, but of extraordinary

inspiring achievement

abuse and assault. The law reform opened the possibility for much improved health care. Clare Parker comments that in the wake of reform abortion quickly became liberally available to women, in ten years it reached numbers and rates that have been more or less consistent since. She notes that this was probably beyond the expectations and possibly the intent of the 1969 parliament. Indeed, at least since the early 1990s most people in SA have not known that abortion was defined in the criminal law and upon learning this are shocked and think that this should not be the case.[iv] Those who provide services are *perforce* certainly aware of the legal restrictions but the law here works to regulate rather than punish or even deter.

The 1969 reform opened the way for the development of mostly good services which through the 1970s and 1980s were increasingly provided in the public sector. After community activism and government investigation of declining accessibility of services in the 1980s the Pregnancy Advisory Centre was established in 1992 as part of the QEH and has become a centre for excellence in abortion care. It currently provides about 60% of all abortion services in SA. **That SA has been committed to publicly provided abortion care distinguishes it from every other jurisdiction, to our great credit.**

But much has changed since 1969 and notwithstanding the high quality of services at the PAC and other metropolitan hospitals, the current law now stands in the way of the provision of services that match this change. This is acutely so in relation to the requirement that all abortions are provided in prescribed hospitals and that two doctors must approve an abortion. These requirements weigh heavily on women in rural and remote locations (88% of whom must travel to Adelaide to access a service) and obstruct the provision of Early Medication Abortion (EMA) by GPs in primary health care settings. Mifepristone, one of the two pharmaceutical drugs that induce EMA, has been available in Australia since 2006 and subsidized by the PBS since 2013. The residency requirement also obstructs the provision of care to those over the border and newly arrived. Other states provide abortion services and Adelaide is not a destination for those seeking an abortion. Recent interpretation of the 'born alive' clause in the law has lead to unnecessary and unhelpful constraints and pressure on people needing abortions later in pregnancy. The best example of sympathy for and rising awareness of the needs of people who present for abortion in the second trimester of abortion or later is the popular and critical success of the performance *19 Weeks* at the 2017 and 2018 Adelaide Fringe Festivals. *19 Weeks* has just finished a season in Canada. Audience response was overwhelmingly positive. On the two occasions I attended this ground-breaking performance the audience seemed to be a combination of people learning about a woman's experience of later term abortion and those whose own experience was being affirmed. The experiences of those who need abortion in the second and third trimester of pregnancy must be at the centre of our thinking about abortion law reform.

Women's expectations of their own reproductive autonomy and of access to health care, **community attitudes** about women and health care, **clinical possibilities, the relative roles of doctors and nurses** and other health care practitioners, **and cultural norms of health care** (to increasingly centre the patient) have all changed since 1969. **The 1969 law is no longer fit for purpose, nor for opening the development of abortion services in SA to future changes**.

SA is currently behind most jurisdictions in Australia, the majority have decriminalized abortion. The national trend towards decriminalization in the states and territories and liberalization at the nation level began in the ACT in 2002. Victoria, Tasmania, the Northern Territory and Queensland have all followed. It should be noted however that in the introduction of abortion provisions in health law in each case, the decriminalised law is uneven across the country and in some cases criminal law restrictions have been moved into health law, or abortion specific law. But with the federal parliament's vote in 2006 to remove previously restrictive laws that had stood in the way of the import of EMA medication alongside the move to decriminalise, the national trend is towards decriminalisation and liberalisation. **SA has the advantage over all other jurisdictions** (with the partial exception of the NT, where services have never been adequate, despite 1973 law reform partly following the SA model) **of approaching significant decriminalizing reform with the experience of 50 years of stability in law, and on the back of generally good quality abortion care** (for metropolitan women up to 20 weeks of pregnancy). Research produced from the PAC gives us an excellent state-specific knowledge base from which to move ahead.[v]

While approaching decriminalization later than most jurisdictions, SA can approach law reform with confidence and a view to the future that is informed by the past. This is not a past of general lack of access to services (except for the people mentioned above, who must be at the centre of thinking about reform) but a past of good services with significant problems that are caused in part by out of date law and which prevent solutions to those problems. We must be able to think about reform keeping in mind the changes since 1969 in attitudes among women and the community as a whole and changes in the social and clinical provision of health care, not be held back by old attitudes, and indeed confected ignorances, that inevitably constrain the development of the best health care for each patient.

It should be noted that decriminalization in other jurisdictions has not necessarily resolved problems with the delivery of health care nor women's access to abortion services.[vi] This is because the provision of services in every other jurisdiction except the NT is predominantly in the private sector and so determined by market forces, including the economic viability for GPs of providing abortion care. Most state and territory governments fail to address the issue of adequate abortion care in their health policy and operations. The training of doctors, and their willingness or lack of to provide abortion care, and the willingness or lack of by public hospitals to prioritise abortion care are other key factors. It is only when decriminalization removes specific parts of law that have been restrictive that there is any necessary improvement in the provision of services. This was the case in the ACT and the NT where legislation previously imposed specific restrictions (eg waiting periods before an abortion in the former, only in prescribed hospitals in the latter, among others). In both these jurisdictions decriminalization quickly resulted in the amelioration of previous problems in the ACT and the expansion of services beyond the hospitals and into community health clinics in the NT. **Decriminalisation in SA will not immediately create change to address problems of access,** except presumably for those who would not meet current residency requirements, **but it will immediately remove the obstructions to change**. The new environment will continue to be regulated by health policy, clinical guidelines, professional codes of ethics and

so on, as it should be. Should all reference to abortion be removed from the criminal law, and not reinstated in health law or specific abortion law, the challenge will be to persuade and enable doctors to offer EMA, for health teams to develop protocols and skills for the optimal care of women and others needing abortions later in their pregnancies that are unconstrained by legally imposed limits, and for government and the professions to educate all about the new legal environment and so to contribute to the end of abortion stigma.

While it is oft repeated that abortion is a controversial issue this is not the quotidian experience of those who provide the service, nor for most of those who have abortions and their partners, families and friends. Most are, however, aware of the stigma that some individuals and institutions attach to abortion. **SA can lead in the development of law and health care that extends from past experience, in knowledge of what best services can be, and with reflection on how 1969 law reform once enabled good services but now obstructs them.**

Consequently my response to the SALRI Consultation Questions is as follows:

Questions 1-4: I do not think that there should be any reference to abortion in the criminal law. My answer is 'no' to each of these questions.

Question 5: Yes, I think that all suitably qualified and trained health practitioners should be able to authorise, perform and assist in performing abortions. This group includes doctors but should not be confined to them. I realise that current regulation of abortion care beyond the SA law has bearing on this matter. See my response to Questions 30-31 below.

Questions 6 – 11: A woman should be allowed to access abortion at any stage of pregnancy. No, there should not be any gestational limits in law nor any specification of grounds on which women can be given access to abortion, except her informed consent.

Question 12-14: No, doctors or others who may provide access to abortion care should not be required to consult with any other practitioners unless clinically indicated and with the permission of the pregnant person.

Question 15-16: A health care practitioner with a conscientious objection to abortion should declare this to patients and immediately refer to a practitioner that they know does provide this care. But there does not need to be any specific legislation to this effect; current professional codes of ethics for doctors and others are adequate in this respect and should be promoted and respected. Abortion does not need to be made an exceptional case in this matter.

Question 18: There should be no mandated requirement for counselling for people who seek abortion.

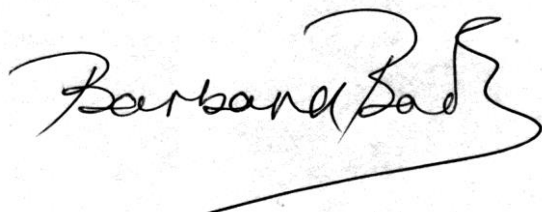
Questions 19-24: Safe Access Zones should be legislated for in SA, on the model that exists in Victoria which has found to be constitutionally sound and has been explicitly supported by High Court judges.

Question 25: There should be no mandated collection of data about abortion, separate to that which is routinely collected in relation to other health care.

Questions 26-28: There is no need for specific legislation in relation to people in rural and remote areas who need abortion care. Abortion via telehealth should be available to all who need it.

Question 29: There should be no residency requirement to access abortion care in SA.

Question 30-31: The current requirement that abortions be performed only in prescribed hospitals should be removed.
The reference to 'capable of being born alive' in section 82 a of the CLCA should be removed.
There are two matters that are beyond the law in SA that need to be addressed in order to maximize access to appropriate and adequate abortion care. It should be recommended to the SA government that they seek to have the TGA remove restrictions on the prescription of EMA drugs so that not only doctors could prescribe it and that they seek to have an item number added to the Medicare schedule that is specific to EMA .



Associate Professor Barbara Baird

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[i] Parker, Clare. "A Parliament's Right to Choose Abortion Law Reform in South Australia." *History Australia* 11.2 (2014): 60-79.; see also Heath, Mary, and Ea Mulligan. "Abortion in the Shadow of the Criminal Law: The Case of South Australia." *Adel. L. Rev.* 37 (2016): 41.
[ii] *R v Anderson* (1973) 5 SASR 256
[iii] RvC, OM [2005] SASC (23 February 2005
[iv] Ryan, Lyndall, Margie Ripper, and Barbara Buttfield. *We Women Decide: Women's Experience of Seeking Abortion in Queensland, South Australia and Tasmania, 1985-1992*. Women's Studies Unit, Faculty of Social Sciences, Flinders University, 1994.
[v] Eg Mulligan, Ea, and Hayley Messenger. "Mifepristone in South Australia: the first 1343 tablets." *Australian family physician* 40.5 (2011): 342.
[vi] Baird, Barbara "Decriminalization and women's access to abortion in Australia." *Health and human rights* 19.1 (2017): 197.