Women’s Health Victoria

Difficulties in Access to Termination of Pregnancy Services

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Prepared by Kerrilie Rice
Policy and Research Officer
Introduction
Accessing termination of pregnancy services is difficult for many women in Victoria. Access limitations exist for a variety of reasons, including the unstable legal context, lack of inclusion in health policy planning, and unregulated practice guidelines. These are often compounded by geographical and financial constraints. Such barriers mean that women have limited options when faced with an unplanned or unwanted pregnancy. This is a concern given that unplanned and unwanted pregnancies can have negative life consequences for a woman in terms of education, employment, financial security and health\(^1\).

Women’s Health Victoria (WHV) believes that access to safe, legal and affordable terminations is a public health right. In order for women to be able to assert this right, access to termination of pregnancy services needs to be readily accessible.

Access in rural and regional Victoria
In rural and regional areas of Victoria, the situation for women seeking to access termination services is critical. No private clinics operate outside metropolitan areas, access to terminations in public hospitals is limited or unavailable, privacy and confidentiality are less able to be ensured, and financial pressure is often increased. This is particularly troubling given that the general health of people living in rural and remote areas is significantly worse than that of their urban counterparts\(^2\).

In 1998 and 1999 Human Rights and Equal Opportunity Commission members and staff visited regional, rural and remote areas in every State and the Northern Territory as part of the Bush Talks consultations. During these talks it became apparent that termination of pregnancy services was inadequate. In the Loddon Mallee region, particular apprehensions were raised about the low numbers of General Practitioners, long waiting lists and confidentiality issues surrounding the need to access termination of pregnancy services.

These factors can result in women being unable to control their own reproductive lives. The story of a Victorian woman identified as having a risk-laden pregnancy demonstrates how this may manifest:

A woman with monochorionic twins had a thickened nuchal translucency of 6.3mm at 11 weeks. Abortion was recommended but she was unable to reach a decision until 18 weeks; but because of the current political situation the hospital clinic was then not prepared to offer an abortion\(^3\).

Thickened nuchal translucency has been repeatedly linked with chromosomal abnormalities, cardiac and other structural defects, an increased risk of either spontaneous abortion or premature delivery, as well as a wide range of genetic syndromes or single gene disorders, in particular Noonan syndrome\(^4\). In instances such as this it is vital that women be provided with enough information, in accessible formats, to allow them to make informed decisions and not feel pressured to either continue with or terminate a pregnancy.

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\(^3\) DeCrespigny (2005). Australian abortion laws: a health hazard?, O&G, 7:1 Autumn

The example above makes it clear that access to high quality education, counselling, and services needs to be consistently provided and that women should not be penalised for taking the time to make a well informed decision. Such legislative change will allow for termination of pregnancy to be included in health service planning and delivery and continue to be regulated like other medical procedures.

While the woman in the above example would have been able to access termination of pregnancy services earlier in her pregnancy, other women face restricted access regardless of gestation due to a lack of services. Only a limited number of public hospitals offer termination of pregnancy services and these are clustered around metropolitan Melbourne. Women in rural and regional areas are subject to the whim of the small number of potential service providers in the private sector. Even where termination of pregnancy services do exist, privacy and confidentiality are sometimes compromised due to the tight relationships and smaller populations associated with regional and country living. As a result, women in rural and regional areas often travel elsewhere to ensure privacy and confidentiality.

Travelling to metropolitan areas to access services can place further emotional and financial strain on women already making the difficult and often challenging decision to terminate. The need to travel and the associated factors inevitably results in increased stress. This point is illustrated through the story of a woman from country Victoria who was seeking a TOP. She had travelled by train to Melbourne with three young children under 5. This woman’s story is told from the perspective of a worker at the clinic which provided the procedure:

She could not get anyone to look after her children. Once here she realised she would be unable to care for her children during the process. She happened to mention this problem to the local service station staff. One of the women there took her children for a number of days during which she had her procedure. Can you imagine having the abortion which is stressful enough but to know you had left your kids with a stranger, how traumatic for her. We arranged for her to see her kids each day and kept her in contact as much as possible.

This example reveals some of the complexities associated with accessing services. Had an appropriately resourced and confidential service been accessible locally, the woman would not have found herself in a situation where she had to rely on strangers to look after her children. This woman’s story also raises questions about what happens to women who are unable to negotiate child care, cannot afford to travel, do not have the skills to navigate unknown cities, or do not have access to information about service providers.

Financial Constraints

Financial barriers can limit a woman’s access to terminations. Information supplied by the then Federal Shadow Minister for Health Julia Gillard estimates that women attending private clinics are charged between $120 and $250 above the Medicare rebate to have a termination. After 12 weeks gestation, these out-of-pocket expenses can rise to as much as $750. If Medicare rebates are withdrawn, as the Federal Government has previously suggested, these costs will rise further and, as a result, women may delay having a termination until they can afford it. Such delays increase health risks for women associated with the procedure, the costs and the difficulty in accessing services.

The financial burden placed upon women based in rural and regional areas who are unable to secure services locally is even more considerable. Transport, childcare and accommodation costs must all be met. These immediate costs may bear upon decisions made. For instance, in 2005 a service provider relayed the following story:

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A 38 year old married mother of 4, living in regional Victoria has an unplanned pregnancy which will produce undue financial and emotional stress on her family. There are no termination services in the area where she lives. As her husband works, there is no-one available to care for her children during the overnight stay required for her to access a termination in Melbourne. Due to these difficulties and the financial cost in obtaining an abortion, she reluctantly agrees to continue the pregnancy.

This illustrates how financial barriers to services may prevent women from pursuing their preferred course of action. However, it also raises questions about why women seek terminations in the first instance. This example indicates that financial strain motivated both the woman’s desire to terminate her pregnancy and her continuation with the pregnancy. When women opt either to terminate or continue with pregnancy because of financial pressure it is clear that our social support system is inadequate. Improved access to safe and affordable abortion thus only addresses half of the problem.

Service Provision
Women living in rural and regional areas are also more likely to experience anti-choice attitudes by medical practitioners. Hospitals and doctors are more readily able to avoid their responsibility to provide reproductive health services, including termination of pregnancy, because it is difficult to attract health professionals to these areas. As a consequence, those that do provide services to these areas have significant influence over what information is made available to pregnant women. This coupled with the indeterminate legal status of termination presents doctors in rural and regional areas with the opportunity to deny women access and information about these services. General Practitioners also have the power to refuse to provide referrals or to coerce women into continuing with an unwanted or unplanned pregnancy. In seeking women’s stories it has become apparent that women are commonly not provided with a full list of options. Knowledge about options is necessary to enable women to make informed decisions.

The uncertain legal situation fosters a hostile environment even in areas where doctors offer comprehensive support for termination of pregnancy services. These doctors are not uncommonly targeted, harassed and intimidated. For instance, at one regional hospital, of the three obstetricians employed, only one performed terminations. He was targeted by the Right to Life, harassed at his home and clinic, and the hospital was picketed. He has since retired and the terminations that now take place at the hospital are ‘hidden’ as a dilatation and curettage. This continues to affect staff morale and local women now often choose to go to Melbourne rather than be subjected to the punitive atmosphere. In other cases doctors have had their homes sprayed with graffiti, been followed, had their children threatened, been picketed and verbally abused. Unsurprisingly, this harassment makes it extremely difficult to attract doctors and nurses to work in termination services.

Restricted access, concerns about privacy and confidentiality, and anti-choice activism make access to termination of pregnancy services a pressing issue for many women, and especially for those in rural and regional Victoria. Improvements are desperately required in order to secure access.

Further, the current inclusion of termination of pregnancy in the Victorian Crimes Act inhibits the provision of regulated, reliable, well-planned services. This results in patchy and inequitable access and raises practise issues. It acts as a deterrent to doctors who would otherwise train in terminations and provides ammunition for those who harass and abuse.

This adds to the crisis in service provision as younger doctors do not replace retiring doctors. A range of alternative legislative models do exist. The most appropriate being the approach adopted in the Australia Capital Territory (ACT).

Various practice issues arise for doctors because of the uncertain legal context. These concerns would be abolished if termination was removed from the Victorian Crimes Act. Regulation in health service delivery is undertaken through a variety of mechanisms. This includes clinical guidelines and credentialing for medical procedures which are developed by professional bodies and other associated organisations (e.g. hospitals, universities, government departments, medical and nursing colleges, the National Health and Medical Research Council, and health services). These bodies hold expertise in their field and are trusted by the profession and the community alike to set such standards. Termination of pregnancy is a health service and should be treated as such. This would help to improve service accessibility, regulation and delivery.

Conclusion
Equity in access to termination of pregnancy services is a pressing issue. Financial status, geographical location, and the legal context all bear upon how readily services are able to be accessed. Women’s Health Victoria views removal of abortion from the Crimes Act as an important step toward eradicating these access issues. Decriminalisation provide doctors with the confidence and security to deliver appropriate and value-free services, it would provide the community with a reliable and visible avenue for seeking information about reproductive health, it would act as a deterrent for anti-choice activists who regularly intimidate and harass termination of pregnancy doctors and their clients and, most importantly, it would safeguard a woman’s right to control over her own reproductive capacity.