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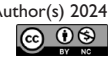

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Public responsibility for abortion care and the role of law

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Abstract

As part of a global liberalising trend, the last two decades have seen abortion decriminalised in each of Australia's States and Territories. In this article, we focus on New South Wales (NSW) – the country's most populous jurisdiction – and locate the State's abortion law reform in its global context. Abortion was decriminalised in NSW in 2019. As part of this, the State introduced a new legal framework that continues the long history of exceptionalising abortion in the legal regulation of heath care. Furthermore, while decriminalisation is a necessary modernising reform, it is not a guarantee of improved access to services. This has been the experience in a number of decriminalised jurisdictions, including NSW. In this, we argue that services remain simultaneously over- and under-regulated. Responding to this, and centring public responsibility for abortion care, we propose a model designed to advance universal access to abortion services. In this regard,

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there remains a central role for law and policy in improving health equity. In addressing the role of law in post-decriminalisation jurisdictions, we advance understandings of law as a determinant of health.

Keywords
Abortion, decriminalisation, health equity, health services, legal determinants of health, abortion law

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Introduction

Universal access to abortion care is essential to sexual and reproductive health and the human right to health. It is an effective public health measure that promotes pregnant people's health, well-being, and the realisation of other rights beyond health.[1] The Sustainable Development Goals (SDGs) commit governments to 'ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs' by 2030.[2] Even though abortion has been provided lawfully in Australian States and Territories since the 1970s, access to abortion care remains challenging for many. This is especially the case for those on low incomes; who live in rural, regional, and remote areas; and who are young, poorly informed, or without access to Medicare, the country's publicly funded universal health care insurance scheme.[3] The National Women's Health Strategy 2020–2030 (national strategy) outlined maternal, sexual, and reproductive health as a priority, identifying equitable access to abortion care as a key measure of success.[4] Despite this, the report of the recent inquiry conducted by a committee of the Australian Senate – *Ending the postcode lottery: Addressing barriers to sexual, maternity, and reproductive healthcare in Australia* (Senate inquiry) – noted that in 2023: 'Australians do not currently have consistent access to sexual, reproductive and maternal healthcare services, and that this particularly disadvantages people living in regional and remote Australia'.[5]

This article proposes a way forward for the improvement of access to abortion services in Australia. It does this by centring the principle that as a public good, abortion

1. R. Sifris and S. Belton, 'Australia: Abortion and Human Rights', *Health and Human Rights Journal* 19(1) (2017), pp. 209–220.
2. United Nations General Assembly, *Resolution 70/1: Transforming our World: The 2030 Agenda for Sustainable Development* (Geneva, United Nations, 25 September 2015), p. 16.
3. B. Baird, *Abortion Care Is Health Care* (Melbourne, Melbourne University Publishing, 2023).
4. Department of Health and Aged Care, *National Women's Health Strategy 2020–2030* (Canberra, Commonwealth of Australia, 2019).
5. Commonwealth of Australia, *Ending the Postcode Lottery: Addressing Barriers to Sexual, Maternity and Reproductive Healthcare in Australia* (Canberra, Commonwealth of Australia, 2023), p. 2.

services should be a public responsibility. Both the national strategy and the Senate inquiry identify improved access to adequate and culturally appropriate abortion care as an issue of priority concern. In doing so, several recommendations from the Senate inquiry involve the commitment of Federal and State or Territory resources. This reiterates the call for public responsibility for, and resourcing of, abortion services that has been made in each of the national reports that have considered abortion in the last 50 years.[6] We address what such public responsibility requires and the role of law in delivering this. In doing so, our analysis is relevant to other jurisdictions where guaranteeing universal access to abortion care remains a pressing issue, including in countries where legal barriers have been removed.

Australia has recently concluded a wave of decriminalisation measures. This began in the Australian Capital Territory (ACT) in 2002 and concluded in Western Australia (WA) in March 2024.[7] Decriminalisation is generally used to connote the removal of all reference to abortion in the criminal law. The term is widely used in Australia to refer to the reforms that have taken place since 2002, although it should be noted that each jurisdiction retains a criminal offence for unqualified persons who perform abortion. Law reform in all jurisdictions has also been accompanied by new law that regulates how abortion care is provided. At a minimum, decriminalisation means that the pregnant person and qualified health care professionals are exempted from criminal prosecution.[8] Each jurisdiction also introduced safe access zones, which prohibit 'protest' around abortion-providing facilities.[9] These legislative initiatives have been part of an unfolding 'global abortion revolution'[10] evidenced in the last two decades.[11] Decriminalisation has been a notable aspect of this trend, with recent years seeing partial or full decriminalisation in a number of countries including Aotearoa/New Zealand (2020), Argentina (2020), South Korea (2021), Mexico (2021), and Colombia (2022).[12] It is also recommended in the World Health Organization (WHO) *Abortion Care Guidelines*.[13] This article contributes

6. E. Evatt, F. Arnott, and A. Deveson, *Royal Commission on Human Relationships, Final Report* (Canberra, Australian Government Publishing Service, 1997) III; National Health and Medical Research Council (NHMRC), *An Information Paper on Termination of Pregnancy in Australia* (Canberra, Commonwealth of Australia, 1996).
7. For an analysis of this process, see: Baird, *Abortion Care Is Health Care*.
8. See, B. Baird and E. Millar, 'When History Won't Go Away: Abortion Decriminalisation, Residual Criminalisation and Continued Exceptionalism', *History Australia*, 21(3) (2024), pp. 416–433.
9. R. Sifris, T. Penovic, and C. Henckels, 'Advancing Reproductive Rights Through Legal Reform: The Example of Abortion Clinic Safe Access Zones', *University of New South Wales Law Journal*, 43(3) (2020), pp. 1078–1079.
10. L.M. Morgan, 'Global Reproductive Governance after Dobbs', *Current History*, 122(840) (2023), pp. 22–28, 28.
11. At the same time, we also note a persistent and rising anti-abortion movement based in the United States. On US abortion exceptionalism, see E. C. Romanis, 'The End of (Reproductive) Liberty as We Know It: A Note on *Dobbs v Jackson Women's Health* 597 USC (2022)', *Medical Law International*, 23 (2023), pp. 71–87.
12. Op. cit.
13. World Health Organization, *Abortion Care Guidelines* (Geneva, World Health Organization, 2022).

to a growing body of literature that addresses this liberalisation trend in different jurisdictions,[14] and particularly experiences of decriminalisation.[15]

While decriminalisation is an overdue and necessary part of the modernisation of health care, it does not – of itself – guarantee equitable access to services. Indeed, access to services for some has worsened in the period since decriminalisation. As Parsons and Romanis succinctly observe, 'Framing matters, but access matters more'.[16] This raises questions about the role and limits of law, not just in the direct regulation of services, but in shaping health outcomes more generally. Our analysis explores this, contributing to the growing body of work that seeks to position law within the Social Determinants of Health (SHD) framework.[17] This work has sought to address the situation whereby law can have a profound effect on health – both for good and ill – yet it remains 'underutilised and poorly understood' within the wider public health enterprise.[18]

The *Lancet-O'Neill Commission* report, *The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development*, observed in terms of the health damaging effects of law, that '[t]hroughout history, misguided, outdated, arbitrary, or discriminatory laws have caused great harm. Punitive laws, for example, can discourage marginalised individuals from accessing care, restrict reproductive rights, and enable discrimination'.[19] While decriminalisation may be characterised as an

14. For example: F. De Meyer, 'Abortion Law Reform in Europe: The 2018 Belgian and Irish Acts on termination of pregnancy', *Medical Law International*, 20(1) (2020), pp. 3–30; F.H. Pedersen, J. Rothmar Herrmann and L.T.D. Hansen, 'The Factors Influencing the Trajectory of Danish Abortion Law: From Progressive to 50 Years of Stagnation', *Medical Law International*, 22(4) (2022), pp. 277–301.
15. A. Carnegie, and R. Roth, 'From the Grassroots to the Oireachtas: Abortion Law Reform in the Republic of Ireland', *Health and Human Rights*, 21 (2019), pp. 109–120; J. Snelling, 'Beyond Criminalisation: Abortion Law Reform in Aotearoa New Zealand', *Medical Law Review*, 30(2) (2022), pp. 216–242.
16. J.A. Parsons and E.C. Romanis, *Early Medical Abortion, Equality of Access, and the Telemedical Imperative* (Oxford, Oxford University Press, 2021), p. 165.
17. L.O. Gostin, J. Monahan, J. Kaldor, M. DeBartolo, E.A. Friedman, K. Gottschalk, S.C. Kim, A. Alwan, A. Binagwaho, G.L. Burci, L. Cabal, K. DeLand, T.G. Evans, E. Goosby, S. Hossain, H. Koh, G. Ooms, M. Roses Periago, R. Uprimny, A.E. Yamin, 'The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development', *Lancet*, 393 (2019), pp. 1857–1910; J.C. Kaldor, L.O. Gostin, J.T. Monahan, and K. Gottschalk, 'The Lancet-O'Neill/Georgetown University Commission on Global Health and Law: The Power of Law to Advance the Right to Health', *Public Health Ethics*, 13(1) (2020), pp. 9–15; M. Thomson, 'Legal Determinants of Health', *Medical Law Review*, 30(4) (2022), pp. 610–634; J. Coggon and B. Kamunge-Kpodo, 'The Legal Determinants of Health (In)justice', *Medical Law Review*, 30(4) (2022), pp. 705–723; L. Montel, 'Social Determinants of Health, Human Rights, Law, and Urban Development', *Medical Law Review*, 30(4) (2022), pp. 680–704; M. Thomson, 'Law as a Determinant of Health: COVID-19 and Gender', in Aziza Ahmed and Linda McClain, eds., *Routledge Companion to Gender and COVID-19* (New York, Routledge, 2024), pp. 16–27.
18. Gostin et al., 'The Legal Determinants of Health, p. 1857.
19. Op cit.

example of the removal of 'out-dated' laws, the post-decriminalisation period in Australia illustrates that more is required from law. Decriminalisation is an essential move, yet on its own it may do little to address structural and social barriers to universal abortion care. These structural and social factors are not natural or inevitable. Rather, they are human made, including through the failure to enact remedial law and legal policy.[20] Furthermore, decoupling abortion from the criminal law can see the introduction of new regulatory frameworks that have unpredictable effects on how abortion services are provided.[21] In both regards, decriminalisation is best understood as a step – rather than endpoint – towards achieving positive social change.[22] Acknowledging this helps to move understandings of law as a determinant of health beyond a narrow focus on legislation, to the broader policy work needed to address structural barriers. As McGuinness and Montgomery argue, we 'need to consider what happens after decriminalisation' and how legal institutions can support 'access to abortion and address a wide range of barriers to care'.[23] This is necessary to move from an abortion-permissive regime to one which supports universal access to abortion care.[24]

Against the background of distinct histories of abortion law and provision of services across Australian jurisdictions, New South Wales (NSW) is the focus of this article for a number of reasons. NSW is the State with the largest population, and its geographical size means that the problems of seeking access to sexual and reproductive health care for people living in rural and remote areas can be acute. Notwithstanding the different models of provision in States and Territories, in the most populous States there is limited public provision of abortion care and this means a significant reliance on private providers.[25] Within this national picture, there is reason to believe that the NSW Government's responsibility for and provision of abortion services lags behind each of the other States and Territories. While the calculation of the number of abortions involves a range of data sources and can be contested, reports suggest a withdrawal of public

20. A.K. McGowan, K.T. Kramer, and J.B. Teitelbaum, 'Healthy People: The Role of Law and Policy in the Nation's Public Health Agenda', *Journal of Law, Medicine & Ethics*, 47(S2) (2019), p. 66.
21. B. Baird, 'Decriminalization and Women's Access to Abortion in Australia', *Health and Human Rights*, 19 (2017), pp. 197–208; F. De Londras, 'A Hope Raised and Then Defeated? The Continuing Harms of Irish Abortion Law', *Feminist Review*, 124 (2020), pp.33–50.
22. I. Vanwesenbeeck, 'Sex Work Criminalization Is Barking up the Wrong Tree', *Archives of Sexual Behavior* 46(6) (2017), pp. 1631–1640; A. Wodda and V. Panfil, 'Sex-Positive Criminology: Possibilities for Legal and Social Change', *Sociology Compas*s, 15(11) (2021), p. e12929.
23. S. McGuinness and J. Montgomery, 'Legal Determinants of Health: Regulating Abortion Care', *Public Health Ethics*, 13(1) (2020), p. 37.
24. E.C. Romanis, 'Abortion Access and the Benefits and Limitations of Abortion-Permissive Legal Frameworks: Lessons from the United Kingdom'. *Cambridge Quarterly of Healthcare Ethics* 32(3) (2023), pp. 378–390.
25. S. Srinivasan, J.R. Botfield, and D. Mazza, 'Utilising Health Pathways to Understand the Availability of Public Abortion in Australia', *Australian Journal of Primary Health*, 29(3) (2022), pp. 260–267.

sector services in NSW over the 30-year period since 1990.[26] In 2020, Family Planning NSW (FPNSW) produced a report that proposed a framework for access to abortion in NSW.[27] They wrote,

> While legislation changes in NSW *enable* access to abortion services, availability of services needs to be urgently addressed. Increasing access to low- and no-out-of-pocket cost services for economically disadvantaged women and for women in rural areas are the highest areas of need.[28]

The framework proposes State Government action, including commitment of funding in some respects, to enable improved access but falls short of an explicit call for public responsibility.[29] In this article, we build on this work. In doing so, we acknowledge that it is now 5 years since abortion was decriminalised in the State and that further important national changes which deregulate abortion provision have taken place in this time. In the post-decriminalisation period, we identify the further work needed to deliver universal access to abortion care. In addressing this, we do so in a way that is relevant to current debates on decriminalisation and improvements in access to services in the United Kingdom and elsewhere.[30] We address how abortion care can be simultaneously over- and under-regulated. That is to say, it is often subject to regulation that exceeds the demands of the clinical risk involved, while service delivery often lacks a law and policy framework to ensure equitable access to appropriate care.

The article starts by briefly describing current models of abortion care across the eight Australian jurisdictions. We then set out the position in NSW to demonstrate the inadequacy of the current *de facto* private model to provide adequate and culturally appropriate access to care.[31] We respond by arguing for an integrated public system of abortion provision through public hospitals, publicly funded community clinics, and NGO providers working alongside existing private providers. In foregrounding the importance of public hospital provision, we also acknowledge the important role of these institutions for workforce development of surgical abortion skills in future general practitioners (GPs) and obstetricians and gynaecologists, and in leading the creation of a culture where

26. NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p. 4; NSW Health, Review of Termination of Pregnancy for the Purpose of Sex Selection in NSW (NSW Health, 2020), pp. 15–16.
27. Family Planning NSW, Women's Health NSW, and Chair of Sexual and Reproductive Health Special Interest Group of RANZCOG, *Framework for Abortion Access in NSW* (Family Planning NSW, 2020).
28. Op. cit., p. 4 emphasis added.
29. Op. cit., pp. 18–19.
30. De Meyer, 'Abortion Law Reform in Europe'; S. Sheldon and K. Wellings, *Decriminalising Abortion in the UK: What Would it Mean?* (Bristol, Policy Press, 2020).
31. The recent Senate inquiry detailed the additional obstacles to appropriate sexual and reproductive health, including abortion care, that First Nations women and girls experienced, as well as culturally and linguistically diverse migrant and refugee women and girls. See, Commonwealth of Australia, *Ending the Postcode Lottery*, pp. 90–95.

abortion provision is normalised for students, trainees, and all hospital staff. We also highlight other workforce priorities, including securing GP engagement with early medical abortion (EMA) and furthering the move towards enabling nurse and midwife prescribing. This accords with the WHO *Abortion Care Guidelines*.[32]

In making an argument for accessible public provision of abortion care, we are motivated by a belief in the necessity of not just public provision but also public responsibility. In this, we identify the post-decriminalisation period as an opportunity for NSW to develop a principled and equitable model of service provision. Law has an essential role in such work. As Gostin et al. argue, 'By establishing the rules and frameworks that shape social and economic interactions, laws exert a powerful force on all the social determinants of health'.[33] This is particularly the case when we acknowledge law's role in promoting equality and non-discrimination.[34]

Models of abortion care in Australia in 2024

As experienced by a number of jurisdictions internationally, the 1970s witnessed liberalisation of abortion laws in Australia. Two major models of care subsequently developed across the country's eight jurisdictions: predominantly publicly resourced provision and predominantly private clinic provision. Since 1975, a rebate from Medicare has been available which approximately halves the cost of privately provided services.

Approval in 2012 for importing mifepristone, and its subsequent listing as MS-2 Step on the Pharmaceutical Benefit Scheme (PBS), has made EMA widely – if unevenly – available in Australia.[35] It is currently restricted to pregnancies up to 9 weeks. It should be noted that a number of other countries, such as Scotland, allow EMA up to 12 weeks. More recently, COVID-19 hastened and normalised the provision of EMA via telehealth when the Federal Government provided a Medicare rebate for this service.[36] This measure was made permanent in 2024.[37] As in other jurisdictions, the arrival of EMA, and subsequently telehealth, has been a significant change to the clinical mode in which abortion is provided and has changed the nature of both public and private provision.[38] Its potential to broaden access in Australia, particularly in rural and remote areas, is still unfolding.

32. World Health Organization, *Abortion Care Guidelines*, p. 64.
33. Gostin et al., 'The Legal Determinants of Health', p. 1857.
34. Thomson 'Legal Determinants of Health'.
35. B. Baird, 'Medical Abortion in Australia: A Short History', *Reproductive Health Matters*, 23(46) (2015), pp. 169–176.
36. Y. Cheng, C.J. Boerma, K. McGeechan, and J. Estoesta, 'Impact of Policy Changes of Medicare-Rebated Telehealth Services on Medical Abortions Provided at a Family Planning Service During the Coronavirus (COVID-19) Pandemic', *Sexual Health*, 20(4) (2023), pp. 357–359.
37. D. Mazza, SPHERE NHMRC Centre of Research Excellence Federal Budget Response available at https://www.monash.edu/news/articles/monash-expert-sphere-nhmrc-centre-of-research-excellence-federal-budget-response (accessed 20 August 2024).
38. For a detailed discussion of EMA see, Parsons and Romanis, *Early Medical Abortion*.

The public provision model

South Australia (SA) and the Northern Territory (NT) have enjoyed provision predominantly through public hospitals at no cost to the patient since liberalisation. Until the decriminalisation of abortion, provision in SA and the NT was governed by legislation from 1970 and 1974, respectively, which required that abortion care be provided in prescribed hospitals. In 2016, public hospital provision was over 90% in each jurisdiction.[39] Following the decriminalisation of abortion in NT in 2017, the NT Government has funded the Family Planning Welfare Association of NT to provide EMA at no cost to patients.[40] In a short time, this service provided about 70% of all abortions in the NT. Decriminalisation in SA, effective from July 2022, has thus far made only small change to the nature of provision.

From 1992 until 2018, private clinics provided most abortion services in Tasmania. The challenge of providing services in a small market saw the last clinic close in 2018 and the numbers of people travelling interstate increased. In 2021, after years of persistent advocacy led by Women's Health Tasmania, public provision rose to significant levels. Surgical abortion is provided up to 16 weeks by public hospitals at no cost. State Government financial support is available for EMA for those in financial stress or suffering significant disadvantage.[41]

In the ACT, where conservative law reform from 1979 was undone in 1992, nearly all abortion services from 1992 were delivered by a community-sector clinic which in 2004 was purchased by the UK-based charity Marie Stopes Australia (MSI Australia since 2022). Since early 2023, in response to advocacy led by Sexual Health and Family Planning ACT and Women's Health Matters, abortions up to 16 weeks of pregnancy have been provided free to all residents, regardless of Medicare eligibility.[42] The ACT Government funds MSI and some general practices to provide both EMA and surgical services.[43]

The private provision model

Legal liberalisation of abortion care was achieved in Victoria following *R v Davidson* [1969] in the Victorian Supreme Court.[44] In this case, Menhennitt J considered and

39. S. Belton and K. Dempsey, 'Termination of Pregnancy: Trends, Women's Characteristics and Implications for Public Health Planning in the Northern Territory', unpublished, 2016; South Australian Abortion Reporting Committee, *Annual Report for the Year 2016* (Adelaide, Wellbeing SA, 2018).
40. J. Murdoch, K. Thompson, and S. Belton, 'Rapid Uptake of Early Medical Abortions in the Northern Territory: A family Planning-Based Model', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 60(6) (2020), pp. 970–975.
41. Baird, *Abortion Care Is Health Care*, pp. 28, 30, 34, 79.
42. Op. cit., p. 79.
43. Women's Health Matters, No Cost Abortion Services in Canberra available at https://www.womenshealthmatters.org.au/womens-health-wellbeing/termination-of-pregnancy/no-cost-abortion-services/. (accessed 20 August 2024).
44. *R v Davidson* [1969] VicRp 85.

followed the ruling in the UK case of *R v Bourne* [1938].[45] The Menhennitt ruling was subsequently the model for the Levine ruling in NSW in 1972 and the McGuire ruling in Queensland in 1986.[46] It was assumed to apply in WA and Tasmania until law reform in WA in 1998 and in Tasmania in 2001. There has been no legal requirement that abortions be provided in hospitals in Victoria, NSW, Queensland, and WA and provision in these four jurisdictions has been and remains predominantly by private clinics. In 2000, Marie Stopes Australia entered the Australian abortion-providing market when they purchased a private clinic in Perth, WA. They have since grown to operate clinics in NSW, Victoria, Queensland, and the ACT (as above), and since 2015 a national telehealth service, with the aim of generating a surplus to contribute to their family planning work in the region. At the time of writing, they provide approximately 40% of all abortions in Australia.[47] Provision of abortion by non-government organisations in the private provision States, principally by family planning organisations, is small but significant.[48] Provision of medical abortion in all States by GPs – who are all private providers in Australia – makes a small and slowly growing contribution to overall provision.

As in the other predominantly private model jurisdictions, the majority of abortions in NSW are performed in private clinics in large urban areas. EMA and surgical abortion – to varying upper limits – is provided in these private clinics and EMA by some GPs. In most cases, this is for a fee.[49] In NSW in July 2023, there were 1,178 certified prescribers of MS-2 Step and 1,661 certified dispensers. These prescribers comprise less than 10% of all GPs in NSW.[50] Some Government-funded community health services have embedded medical abortion in their provision of sexual health services. Family Planning Association clinics in Sydney and broader NSW have developed medical and surgical services, sometimes located with other community health services, based on mixed funding models, including patient fees for those over 18 and without concessional entitlements.[51] There is limited care available through public hospitals and other public organisations. In 1990, public hospitals provided around 10% of all abortions, limited in most cases to patients who met the eligibility criteria.[52] Notwithstanding the lack of accurate reporting, it is likely that public provision in NSW has declined in

45. *R v Bourne* [1938] 1 KB 687. For a discussion of the case and its significance in the development of abortion law in England and Wales, see M. Thomson, 'Abortion Law and Professional Boundaries', *Social & Legal Studies*, 22(2) (2013), pp. 191–210; S. McGuinness and M. Thomson, 'Medicine and Abortion Law: Complicating the Reforming Profession', *Medical Law Review*, 23(2) (2015), pp. 177–199.
46. *R v Wald* (1971) 3 DCR (NSW) 25; *R v Bayliss & Cullen* (1986) 9 QLR 8.
47. Baird, Abortion Care Is Health Care, pp. 113–144.
48. See, for example, M. Sarder, C. Mogharbel, T. Kalman (2024) *Realising Access: Abortion and Contraception Inequities and Enablers in Victoria* (Women's Health Victoria. Melbourne; Women's Health Victoria Knowledge Paper; 6). p. 62.
49. Family Planning NSW et al., Framework for Abortion Access in NSW.
50. Dispenser and Prescriber Program. MS Health, June 2023 Update. Available at https://resources.mshealth.com.au/20230704-MS-Health-June-2023.pdf.
51. Family Planning Australia, 'Clinics' available at https://www.fpnsw.org.au/clinics (accessed 20 August 2024).
52. NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p. 4.

the years since.[53] In 2020, FPNSW described 'public sector funded services' as 'very limited . . . except in cases of severe maternal health conditions, or fetal anomaly' and later that year the State Government reported that only 0.7% of abortions for the year from October 2019 were provided in public hospitals.[54] A news report in late 2024 stated that 'only two public hospitals in NSW offer formal termination services', one in Sydney and the other in Newcastle. In some others it is offered inconsistently, even erratically.[55]

Common features of the public and private models

Regardless of the predominant model of delivery, there are a number of common features across all Australian jurisdictions. Inequities in access to abortion care mirror the patterning of other health inequities and are shaped by factors such as income, literacy, access to information, residency status and entitlement to Medicare, and geographic location.[56] While adequate public provision of abortion services in some jurisdictions mitigates socioeconomic disadvantage, those without financial means are poorly served in the private model jurisdictions. People who are First Nations, live in a rural area, have poor access to contraception and health care information, are disabled, young, or from migrant or refugee backgrounds, are all potentially made more vulnerable to unintended and unwanted pregnancy, and have poor access to abortion care. So too are those experiencing sexual and reproductive coercion and domestic violence.[57] Cultural safety and provision of appropriate care - for example, trauma informed care - are not guaranteed.[58] While these mirror health inequities in other contexts, the precarity of some services, and the inadequate and compromised provision of abortion care for those presenting later in pregnancy, are inequities particular to abortion.[59] All of these factors can sometimes lead to the continuation of

53. Baird, *Abortion Care Is Health Care*.
54. Family Planning NSW et al., *Framework for Abortion Access in NSW*, p. 12; NSW Health, *Review of Termination of Pregnancy for the Purpose of Sex Selection in NSW*, p. 15.
55. L. Barbour, 'Orange Hospital Directs Staff to no Longer Provide Abortions to Patients Without 'Early Pregnancy Complications'', *ABC News*, 8 November 2024, available at https://www.abc.net.au/news/2024-11-08/orange-hospital-directs-staff-to-stop-providing-some-abortions/104537862 (accessed 8 November 2024).
56. R. Sifris, and T. Penovic, 'Barriers to Abortion Access in Australia Before and During the COVID-19 Pandemic', *Women's Studies International Forum*, 86 (2021), p. 102470.
57. H. Rowe, S. Holton, M. Kirkman, C. Bayly, L. Jordan, K. McNamee, J. McBain, V. Sinnott, and J. Fisher, 'Prevalence and Distribution of Unintended Pregnancy: Understanding Fertility Management in Australia National Survey', *Australian and New Zealand Journal of Public Health*, 40(2) (2016), pp. 104–109.
58. B. Baird, *Abortion Care Is Heath Care*, pp. 48–53; L. Mainey, C. O'Mullan, and K. Reid-Searl, 'Unfit for Purpose: A Situational Analysis of Abortion Care and Gender-based Violence', *Collegian* 29(5) (2022), pp. 557–565.
59. On the issue of access to abortion services in rural and remote regions, see: A. Noonan, K.I. Black, G.M. Luscombe, and J. Tomnay. 'Almost Like It Was Really Underground: A Qualitative Study of Women's Experiences Locating Services for Unintended Pregnancy in a Rural Australian Health System,' *Sexual and Reproductive Health Matters*, 31(1) (2023), pp. 1–16; A. Noonan, K.I. Black, G.M. Luscombe, J. Tomnay, *Australian Journal of Primary Health*, 29(3) (2023), pp. 244–251.

an unwanted pregnancy.[60] It should also be noted that data collection is inconsistent at State and Territory levels, and it is impossible to provide an accurate picture of service provision across the country.[61] Accurate data is, of course, essential for public health planning and service development. The current state of abortion care across States and Territories therefore engages important questions of social justice and should be addressed within a health equity framing that acknowledges the special status of health.[62]

While the nature of provision has been generally ad hoc and, in most cases, unplanned (even in public provision states), there are recent indications of positive change in government policy making. In 2017, Victoria, for example, became the first State or Territory to introduce a statement of 'key priorities in women's sexual and reproductive health' in which abortion featured prominently. The statement was accompanied by an action plan and a modest budget and was renewed in 2022.[63] Early in 2024 the Queensland Government released its Termination of Pregnancy Action Plan 2032, which includes a commitment to spending $41.8 million over 5 years.[64] These are the jurisdictions with the clearest stated policy commitments, although not necessarily the best access to abortion services. There is no Government policy on abortion in NSW.

Finally, in terms of common features across public and private models of service provision, we note the determinative role of campaigning individuals and groups in delivering positive change. Further developments will depend on such individuals and groups.[65]

Abortion care in NSW: provision and challenges

Framework of provision

The Abortion Law Reform Act 2019 (NSW) repealed reference to abortion in the criminal law, aiming to 'regulate the conduct of registered health practitioners in relation to

60. P. Flowers, 'Late Termination of Pregnancy: An Internationally Comparative Study of Public Health Policy, the Law, and the Experiences of Providers', Report for the Catherine Helen Spence Scholarship 2018, November 2020, available at https://www.sa.gov.au/__data/assets/pdf_file/0004/713290/Late-Termination-of-Pregnancy-CHS-Report.pdf; K.I. Black, H. Douglas, and C.de Costa, 'Women's Access to Abortion After 20 Weeks' Gestation for Fetal Chromosomal Abnormalities: Views and Experiences of Doctors in New South Wales and Queensland', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 55(2) (2015), pp. 144–148.
61. L.A. Keogh, L.C. Gurrin, and P. Moore, 'Estimating the Abortion Rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data', *Medical Journal of Australia*, 215(8) (2021), pp. 375–376.
62. S. Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Cambridge, Polity Press, 2011).
63. Victoria Department of Health and Human Services, *Women's Sexual and Reproductive Health: Key Priorities 2017–2020* (Melbourne, Victorian Government, 2017); Victoria Department of Health, *Victorian Women's Sexual and Reproductive Health Plan 2022-30* (Melbourne, Victorian Government, 2022).
64. Queensland Health, *Termination of Pregnancy Action Plan 2032* (Brisbane, State of Queensland, 2024).
65. Baird, *Abortion Care Is Health Care*, p. 239. This point is also made about the United Kingdom, see Romanis, 'Abortion Access', pp. 384–385.

terminations'.[66] In summary, a medical practitioner can perform an abortion on a person up to 22 weeks of pregnancy if they give informed consent (Section 5), and after that time if they are a specialist medical practitioner and consult with another specialist, and if certain (liberal) conditions are met (Section 6). Any registered health care practitioners who are asked to provide or assist in an abortion and who have a conscientious objection to performing an abortion must inform the person who asked and provide them with information about, or referral to, a known provider (Section 9). The Act also mentions the provision of counselling to the person requesting an abortion (Section 7), prohibits abortion for reasons of sex selection (Section 16), provides for the care of a 'person born after termination' (Section 11), and requires the provision of information by doctors to the Ministry of Health (Section 15), among other matters. As noted above, the decriminalising legislation also amended the NSW Crimes Act 1900 to create an offence when an 'unqualified person' performs or assists in a termination.[67]

While an important change, decriminalisation of abortion fails to challenge the medical power that has been a defining feature of the legal regulation of abortion since the nineteenth century.[68] Furthermore, and mirroring experience elsewhere, abortion remains singled out for extraordinary regulatory treatment.[69] Legislated conditions for conscientious objection, for example, are not only exceptionalising, they can add to the dignitary harms that pregnant people may experience in seeking abortion care.[70] While there is a duty to refer onwards in an attempt to minimise harm, there are no sanctions if a referral does not take place. Furthermore, and as Zoe Tongue notes, while the obligation to refer complies with the approach of international human rights bodies, it does not address the overuse and misuse of conscience provisions leading to the obstruction of access to services.[71] This is an example of where legal frameworks may hamper clinically optimal

66. NSW Abortion Law Reform Act 2019.
67. NSW Crimes Act 1900 No 40, Part 3, Division 12.
68. E. Millar, 'Abortion, Decriminalisation and the Medico-Legal Paradigm', *Social Science & Medicine*, 355 (2024), p. 117098. S. Sheldon, *Beyond Control: Medical Power and Abortion Law* (London, Pluto Press, 1997); Thomson, 'Abortion Law and Professional Boundaries'; McGuinness and Thomson, 'Medicine and abortion law'.
69. E. Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Oxford, Hart Publishing, 2001); C. Corbin, 'Abortion distortions' *Washington and Lee Law Review*, 71 (2014), pp. 1175–1210; E. Millar, 'Maintaining Exceptionality: Interrogating Gestational Limits for Abortion', *Social & Legal Studies*, 31(3) (2022), pp. 439–458.
70. S. McGuinness and M. Thomson, 'Conscience, Abortion and Jurisdiction', *Oxford Journal of Legal Studies*, 40(1) (2020), pp. 819–845; L.A. Keogh, L. Gillam, M. Bismark, K. McNamee, K. Webster, C. Bayly, and D. Newton, 'Conscientious Objection to Abortion, the Law and Its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers', *BMC Medical Ethics*, 20 (2019), p. 11; Z.L. Tongue, 'On Conscientious Objection to Abortion: Questioning Mandatory Referral as Compromise in the International Human Rights Framework', *Medical Law International*, 22(4) (2022), pp. 349–371.
71. Op. cit.

care.[72] It also points to the phenomenon whereby legal determinants can intersect with gender norms to potentially amplify health inequities.[73]

Challenges

The current historically determined model of provision of abortion care in NSW, which is dominated by reliance on private providers, does not adequately meet the needs of people seeking abortion care.[74] While barriers are complex, the most significant are financial and geographical. The costs that accrue to individual patients can see people going into debt or seeking support elsewhere. A nationwide study of patients conducted in 2014–2015 (about one quarter from NSW clinics) found that one third of those who sought abortion care needed financial assistance from others. This was for direct and indirect costs.[75] Out-of-pocket costs present a significant barrier to accessing health care, particularly for people on low incomes.[76]

Not all private clinics advertise their fees so no account of costs to the patient for the various modes of abortion care can be comprehensive or comparable over time. Suffice to say, there is significant difference across the small number of clinics that do state their fees, discounts for patients with Health Care Cards are small where indicated, and patients without access to Medicare might pay at least twice as much as those with access. The cost for surgical procedures increases each week after 12–13 weeks of pregnancy.[77] A patient's need to travel, organise childcare, take off days from work, and so forth will also increase costs. MSI Australia currently state that surgical abortion is available in their Sydney clinic up to 20 weeks gestation.[78] Other private clinics in NSW have lower limits.[79] Most recently, the 'cost of living crisis' in Australia is having significant impact on the accessibility of health care, although researchers have not yet turned to its specific impact on access to sexual and reproductive health services.[80]

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72. A.F. Lavelanet, S. Schlitt, B.R. Johnson, and B. Ganatra, 'Global Abortion Policies Database: A Descriptive Analysis of the Legal Categories of Lawful Abortion', *BMC International Health and Human Rights*, 18 (2018), p. 44.
73. S. Hawkes and K. Buse, 'Socially Constructed Determinants of Health: The Case for Synergies to Arrive at Gendered Global Health Law', *Public Health Ethics*, 13(1) (2020), pp. 16–17; Thomson, 'Law as a Determinant of Health: Gender and COVID-19'.
74. Commonwealth of Australia, *Ending the Postcode Lottery*.
75. M. Shankar, K.I. Black, P. Goldstone, S. Hussainy, D. Mazza, K. Petersen, J. Lucke, and A. Taft, 'Access, Equity and Costs of Induced Abortion Services in Australia: A Cross-Sectional Study', *Australian and New Zealand Journal of Public Health*, 41(3) (2017), pp. 309–314.
76. Op. cit.
77. Family Planning NSW et al., *Framework for Abortion Access in NSW*, p. 8.
78. MSI Australia, Abortion Services in Sydney, NSW available at https://www.msiaustralia.org.au/abortion-services/sydney/ (accessed 17 July 2024).
79. NSW Health, *Review of Termination of Pregnancy for the Purpose of Sex Selection in NSW*, pp. 15–16.
80. N. Black, A. Harris, D. Jayawardana and D. Johnston, *High Inflation and Implications for Health*. Centre for Health Economics Monash University and VicHealth, March 2024, available at https://www.vichealth.vic.gov.au/sites/default/files/VH_High-Inflation-Paper_FINAL_1.pdf.

The current model's reliance on private actors means a concentration of providers in large urban centres with regional and rural areas underserved. Public hospital and publicly funded community provision is sparse in the significant rural and regional parts of NSW. This means many rural populations in NSW experience an 'abortion desert', a term coined to describe locales where people seeking abortion care need to travel at least 100 miles or 160 km to reach abortion services.[81] This has exacerbated financial burdens as travel is necessitated.[82] Abortion care after 20 weeks of pregnancy is further limited. Shortages of appropriately skilled and willing staff in both the private and public sectors, lack of training, lack of institutional will, and hospital resourcing constraints in the public sector are particularly acute in the case of abortions after 20 weeks.[83]

The potential to expand access to EMA exists, particularly in concert with the gains made with telemedicine.[84] Service users have already expressed satisfaction with this mode of service delivery.[85] Here, further work can be done to leverage clinical guidelines for self-managed abortion that have been developed, as well as increase the uptake of provision by GPs and – in the future – by nurses and midwives.[86] The Therapeutic Goods Administration (TGA) recently relaxed its initial strict conditions under which EMA could be prescribed, but the prescription by nurses and midwives and other qualified health care practitioners – which the TGA now allows – is limited by legislation in NSW (and in NT, Tasmania, and the ACT) and by regulation nationwide.[87] The relaxation of training and registration requirements for doctors and pharmacists is positive, but it may not be adequate to significantly increase access to EMA through GPs. Doctors provide a variety of reasons for not delivering this service. These include religious objections, fear of being overwhelmed by demand, stigma and reputational concerns, and lack of support

81. A.K. Subasinghe, K. McGeechan, J.E. Moulton, L.E. Grzeskowiak, and D. Mazza, 'Early Medical Abortion Services Provided in Australian Primary Care', *Medical Journal of Australia*, 215(8) (2021), pp. 366–370.
82. A. Noonan et al., 'Almost Like It Was Really Underground'; A. Noonan, E. Millar, J.E. Tomnay, G.M. Luscombe, and K.I. Black, '"Imagine If We Had an Actual Service. . .": A Qualitative Exploration of Abortion Access Challenges in Australian Rural Primary Care". *Rural and Remote Health* 24(4) (2024), p. 9229.
83. Baird, *Abortion Care Is Health Care*, pp. 201–231; Black et al., 'Women's Access to Abortion After 20 Weeks' Gestation for Fetal Chromosomal Abnormalities'.
84. Parsons and Romanis, *Early Medical Abortion*.
85. T.A. Thompson, J.W. Seymour, C. Melville, Z. Khan, D. Mazza, and D. Grossman, 'An Observational Study of Patient Experiences With a Direct-to-Patient Telehealth Abortion Model in Australia' *BMJ Sexual & Reproductive Health*, 48(2) (2022), pp. 103–109.
86. A.R.A. Aiken, P.A. Lohr, J. Lord, N. Ghosh, and J. Starling, 'Effectiveness, Safety and Acceptability of no-Test Medical Abortion (Termination of Pregnancy) Provided via Telemedicine: A National Cohort Study', *BJOG: International Journal of Obstetrics and Gynaecology*, 128(9) (2021), pp. 1464–1474.
87. Therapeutic Goods Administration, 'Amendments to Restrictions for Prescribing of MS-2 Step (Mifepristone and Misoprostol)' (2023) available at https://www.tga.gov.au/news/media-releases/amendments-restrictions-prescribing-ms-2-step-mifepristone-and-misoprostol (accessed 20 August 2024).

for a service perceived to be difficult.[88] Regardless of the rationale, doctors in NSW demonstrate how medical professionals have long played a determinative gate keeping role in the legality and provision of abortion care in different jurisdictions globally.[89] Finally, provision of EMA needs to be supported by expertise in public hospitals to provide care when complications arise.

There is no available data for NSW that allows easy comparison between the time before and after decriminalisation. Research into abortion access conducted since decriminalisation makes little reference to this temporal framing. Recent literature continues to detail poor access,[90] with this supported by post-decriminalisation media reports.[91] There are various possible reasons for this, including the factors already addressed. It should also be noted that the process of decriminalisation in the NSW Parliament in 2019 was arguably the most chaotic and divisive of any around the country.[92] This was reflected in the final Abortion Law Reform Act (NSW) which included requirements and restrictions that had not been present in decriminalising legislation in Australian jurisdictions to that time. While FPNSW, now as Family Planning Australia (FPA), women's health centres, and the Women's Electoral Lobby continue to advocate for change in NSW, the two main activist groups which mobilised to achieve decriminalisation did not continue, and there is no singular organisational force to lead advocacy in the State. These factors considered together suggest the dimensions of the political challenge ahead to improve abortion services.

Proposed solution: a model of public responsibility and provision

In this section, we set out proposals for public responsibility and provision of abortion services in NSW. A number of these proposals are relevant to other jurisdictions where

88. K. Ogden, E. Ingram, J. Levis, G. Roberts, and I. Robertson, 'Termination of Pregnancy in Tasmania: Access and Service Provision from the Perspective of GPs', *Australian Journal of Primary Health*, 27(4) (2021), pp. 297–303; A.J. Dawson, R. Nicolls, D. Bateson, A. Doab, J. Estoesta, A. Brassil, and E.A. Sullivan, 'Medical Termination of Pregnancy in General Practice in Australia: A Descriptive-Interpretive Qualitative Study', *Reproductive Health*, 14 (2017) pp. 1–13.
89. Sheldon, *Beyond Control*; Thomson, 'Abortion Law and Professional Boundaries'; McGuinness and Thomson, 'Medicine and Abortion Law'.
90. Noonan et al., '"Almost Like It Was Really Underground"'; Noonan et al., '"Imagine If We Had an Actual Service. . ."'.
91. K. Aubusson, 'The Women Who Can't Afford an Abortion and Can't Afford to Wait', *Sydney Morning Herald*, 5th October 2024, available at https://www.smh.com.au/national/nsw/the-women-who-can-t-afford-an-abortion-and-can-t-afford-to-wait-20241002-p5kf7q.html; Editorial, 'We Are Fortunate Abortion Is No Longer a Hot Topic, but NSW must ensure access', *Sydney Morning Herald*, 5th October 2024, available at https://www.smh.com.au/national/nsw/we-are-fortunate-abortion-is-no-longer-a-hot-topic-but-nsw-must-ensure-access-20241005-p5kg2b.html (accessed 23 December 2024).
92. Australian Associated Press, 'Abortion Decriminalised in NSW After Marathon Debate', *The Guardian*, 26 September 2019, available at https://www.theguardian.com/australia-news/2019/sep/25/abortion-decriminalisation-bill-passes-nsw-upper-house (accessed 20 August 2024).

liberalisation, including decriminalisation, has taken place but where addressing the need to improve access has not. Reform of abortion law in many European countries has, for example, left the task of securing equitable and safe services unaddressed.[93] In our model for NSW, we envisage a future where access is improved through an integrated network of public hospital and community clinic provision. This, as well as service delivery through the private sector, is essential for equitable access and to ensure all people are to enjoy their human right to full reproductive health care.[94] While our focus is a model of public responsibility, we envisage Government engagement with private and community sectors, and professional and activist stakeholders, in developing a system to deliver adequate access to different service user groups.

In setting out this model of public responsibility, we illustrate what is demanded of law to promote health equity. In doing so, we share the definition of 'law' deployed by the *Lancet-O'Neill Commission*, where law is understood to mean 'legal instruments such as statutes, treaties, and regulations that express public policy, as well as the public institutions . . . responsible for creating, implementing, and interpreting the law'.[95] As such, we see law as encompassing not just statutory responses to abortion care – such as the introduction of safe access zones through public health legislation[96] – but also abortion policy developed, implemented, and monitored by Federal and State health agencies or bodies.

In terms of our understanding of law, our proposals highlight the work to be done across different parts of the health care ecosystem, thereby demonstrating the role of law in the social coordination needed to create the conditions for greater health equity.[97] In this, legal determinants of health can be seen as situated within the political determinants of health, which as John Coggon notes, are 'the overall aspects of power, control and coordination that reside . . . with governmental actors and agencies (legal and otherwise)'.[98] Here, the focus is on the 'control and co-ordination' needed to support universal abortion care. Elizabeth Chloe Romanis has recently called for further work on what a comprehensive abortion-supportive regime might look like.[99] While her focus is the

93. De Meyer, 'Abortion Law Reform in Europe'.
94. See the argument made by: A. Dawson, D. Bateson, J. Estoesta, and E. Sullivan, 'Towards Comprehensive Early Abortion Service Delivery in High Income Countries: Insights for Improving Universal Access to Abortion in Australia', *BMC Health Services Research*, 16 (2016), p. 612.
95. Gostin et al., 'The Legal Determinants of Health', p. 1857.
96. In NSW, the Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018 amended the Public Health Act 2010 to create 150 metre safe access zones around premises where abortions are provided.
97. M. Verweij and A. Dawson, 'The Meaning of "Public" in "Public Health"', in Angus Dawson and Marcel Verweij, eds., *Ethics, Prevention, and Public Health* (Oxford, Oxford University Press, 2009), pp. 13–29.
98. J. Coggon, 'Legal, Moral and Political Determinants Within the Social Determinants of Health: Approaching Transdisciplinary Challenges Through Intradisciplinary Reflection', *Public Health Ethics*, 13(1) (2020), p. 43.
99. Romanis, 'Abortion Access', p. 386.

United Kingdom, we respond in the context of NSW, addressing the specific mechanisms for securing access but believe our starting points will also be appropriate elsewhere.[100]

Policy

The NSW *Women's Health Framework*, released just prior to the Abortion Law Reform Act 2019, makes one passing reference to 'termination of pregnancy'.[101] The 'Framework for Termination of Pregnancy in New South Wales' explains the new law and provides guidelines for abortion providers. It is not a statement about quality, equity, or systems of provision.[102] In order to achieve equitable access for all, the State must assume responsibility, articulating in policy an approach to the adequate and equitable provision of abortion care. Such policy could be developed within a dedicated unit responsible for its development, implementation, and monitoring. Such a unit, located within NSW Health, could also enable NSW to lead on establishing a long overdue programme of uniform data collection across States and Territories.[103] Its remit could also extend to overseeing the development of clinical guidelines for abortion across all gestational stages. This is currently lacking in the State.[104]

Public provision

Formally mandating that publicly funded medical and surgical abortion care is available in all public hospitals across the state will significantly improve timely, affordable, and geographically accessible abortion care.[105] NSW has more than 220 public hospitals that vary significantly in size.[106] Provision of medical and surgical abortions can be distributed across these facilities in line with their size and by reference to their catchment and the availability of other sites of public provision. This has been historic practice in SA and the NT and has been more recently achieved in Tasmania.[107] Public hospitals are the

100. This can be contrasted with arguments for enshrining a right to abortion, in a constitution or other instrument. This, we argue, can detract from the pressing need to address access as it provides an addition frontier for contestation without necessarily enhancing access. At the same, in some instances, such constitutional developments can support greater access, see Morgan, 'Global reproductive governance'.
101. NSW Health, *NSW Women's Health Framework NSW 2019* (Sydney, NSW Health, 2019).
102. NSW Health, 'Policy Directive: Framework for Termination of Pregnancy in New South Wales', 2021, https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2021_018.pdf (accessed 20 August 2024).
103. Keogh et al., 'Estimating the Abortion Rate in Australia'.
104. Family Planning NSW et al., *Framework for Abortion Access in NSW*, p. 11.
105. Such a policy has been introduced in Canada. See, C. Kaposy, 'Improving Abortion Access in Canada', *Health Care Analysis*, 18(1) (2010), pp. 17–34.
106. NSW Health, 'Hospitals and Health Services', 2024 available at https://www.health.nsw.gov.au/Hospitals/Pages/default.aspx (accessed 20 August 2024).
107. In Queensland, public provision has improved since decriminalisation in 2018. This was affected by the Minister for Health requiring all public hospitals to provide a service (or a referral pathway). Nevertheless, the scale is still small, and uneven. See: Children by Choice, 'Queensland Public Pathways for Abortion', https://www.childrenbychoice.org.au/information-support/queensland-public-pathways-for-abortion/ (accessed 20 August 2024).

obvious place for surgical abortion when private or community clinics are not present, and for the provision of abortion later in pregnancy. The patient's reason for requesting an abortion should not determine their likelihood of accessing care or the choice of method. Their ability to access care close to home should also be ensured.[108] Both individual hospitals and NSW Health have a role to play in this. Returning to the Senate inquiry, the committee recommends that all public hospitals within Australia be equipped to provide surgical pregnancy terminations, or timely and affordable pathways to other local providers. This will improve equality of access, particularly in rural and regional areas, as well as providing essential workforce development.[109]

Public hospital provision can be supported with access to abortion care through publicly funded community clinics which are resourced specifically to provide abortion care. This can be achieved by harnessing existing networks; that is, abortion provision by FPA clinics, and by developing abortion care within dedicated community clinic settings as happens beyond NSW (e.g. as pioneered by the Cairns Sexual Health Services and Gateway Health Victoria).[110] These centres often foreground nurse-led practices, highlighting a key workforce issue. The fully funded outsourcing of abortion care to the private sector in the ACT – at an initial cost of $4.6 million over 4 years – is also a model for NSW to consider.[111] The financial support for patients who access EMA through a GP – the Tasmanian model – could also be considered. In this context, we note that the Senate inquiry recommended that the Australian Government reviews the existing Medicare arrangements with the aim of ensuring adequate remuneration for practitioners to deliver these services while also ensuring patient privacy.[112]

It is important to note that public hospitals and publicly funded community-based clinics are best placed to lead in the development of culturally appropriate and safe services. Aboriginal Community Controlled Health Organisations, clinics designed to serve the needs of LGBTIQA+ people, and migrant health services could lead here, informing Government development of standards for the whole sector.[113]

108. Flowers, 'Late Termination of Pregnancy'.
109. Commonwealth of Australia, *Ending the Postcode Lottery*, p. 75.
110. S. Downing, H. McNamee, D. Penney, J. Leamy, C. de Costa, and D.B. Russell, 'Three Years On: A Review of Medical Terminations of Pregnancy Performed in a *Sexual Health* Service', Sexual Health, 7 (2010), pp. 212–215; J.E. Tomnay, L. Coelli, A. Davidson, A. Hulme-Chambers, C. Orr, and J.S. Hocking, 'Providing Accessible Medical Abortion Services in a Victorian Rural Community: A Description and Audit of Service Delivery and Contraception Follow Up', *Sexual & Reproductive Healthcare*, 16 (2018), pp. 175–180.
111. ACT Government, 'No Cost Abortions Now Available in the ACT', 20 April 2023, available at https://www.act.gov.au/our-canberra/latest-news/2023/april/no-cost-abortions-now-available-in-the-act (accessed 20 August 2024).
112. Commonwealth of Australia, *Ending the Postcode Lottery*, p. 77.
113. Baird, *Abortion Care Is Health Care*, pp. 51–52; S. Graham, K. Martin, K. Gardner, et al., 'Aboriginal Young People's Perspectives and Experiences of Accessing Sexual Health Services and Sex Education in Australia: A Qualitative Study', *Global Public Health, 18*(1) (2023), p. 2196561.

Early medical abortion

As well as the provision of EMA in public hospitals and State Government funded community health services, alongside existing private clinics, there is a need for further strategies to increase uptake of EMA prescription by GPs in private practice, especially in rural areas. This must be supported through the increase in the number of pharmacies which dispense the medication. Government can play a central role in addressing the need to expand both prescribers and dispensers. A 'decentralisation' strategy to encourage health care providers to provide EMA in rural areas could be undertaken.[114]

There is also a clear need to enable, in the first instance, nurse-led models of the provision of EMA and, then later, the prescription of EMA by nurses and midwives and Aboriginal Health Workers.[115] The development of this model of care to improve access to EMA will require collaboration with professional bodies and medical colleges, and eventually further law reform.[116] The combination of EMA and telehealth is an important tool in addressing some – but not all – of the service challenges in NSW and elsewhere.[117]

Provision of information

Accessible health information is an essential element of the right to health, where it is a prerequisite for accessible and equitable services. NSW needs to address the poor level of information currently available. Availability in a range of community languages should be ensured, acknowledging that such provision is essential for communicative justice and the realisation of the right to health.[118] Again, this could fall within the purview of a unit dedicated to the development and monitoring of abortion care.

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114. This could build on the existing SEARCH project, a new service model to improve access to abortion and other sexual and reproductive health services, focusing on Aboriginal and Torres Strait Islander people and those in regional and rural communities. This was implemented in 2023 by FPA with NSW Government funding: A. Hulme-Chambers, S. Clune, and J. Tomnay, 'Medical Termination of Pregnancy Service Delivery in the Context of Decentralization: Social and Structural Influences', *International Journal for Equity in Health*, 17 (2018); Family Planning Australia, The Search Project available at https://www.fpnsw.org.au/search-project (accessed 20 August 2024).
115. D. Mazza, M. Shankar, J.R. Botfield, J.E. Moulton, S.P. Chakraborty, K. Black, J. Tomnay, D. Bateson, J. Church, T.-L. Laba, J. Kasza, and W.V. Norman, 'Improving Rural and Regional Access to Long-Acting Reversible Contraception and Medical Abortion Through Nurse-Led Models of Care, Task-Sharing and Telehealth (ORIENT): A Protocol for a Stepped-Wedge Pragmatic Cluster-Randomised Controlled Trial in Australian general practice', *BMJ Open*, 13 (2023), p. e065137.
116. Subasinghe et al., 'Early Medical Abortion'.
117. Parsons and Romanis, *Early Medical Abortion*.
118. A. Grey, 'Communicative Justice and COVID-19: Australia's Pandemic Response and International Guidance', *Sydney Law Review*, 45(1) (2023), pp. 1–43.

Repeal abortion specific laws

Aspects of the Abortion Law Reform Act 2019 impede the improvement of quality and access to abortion care in NSW; for example, limiting of the provision of abortion care to medical doctors and the added requirements for abortions performed after 22 weeks. The requirement that health professionals with a conscientious objection provide patients with referral to other providers is regarded as positive, but this clause is obsolete when doctors already have this right and concomitant responsibility laid out in their existing code of conduct produced by the Australian Health Practitioner Regulation Agency.[119] Following assessment of existing health law, Judith Dwyer and colleagues concluded that current legal provisions adequately guarantee the safe and expert provision of abortion care.[120] This work bolsters the long-standing call from liberal, pro-choice, and feminist advocates for the repeal of all abortion-specific laws. Our proposed model ends with a call to repeal the Abortion Law Reform Act 2019, without the need to replace it with any other exceptionalising legislation or regulation. This is a model advocated for elsewhere[121] and supported by McGuinness and Montgomery's observation in the context of law as a determinant of health:

> Burdensome over-regulation hinders good medical practice. Regulations which govern access to abortion care need to recognise the range of barriers that women may face and should not themselves become a barrier. They should be designed in ways that facilitate and promote appropriate care pathways and interventions.[122]

We acknowledge that the model we propose is dependent on political will. This highlights the relationship between the legal and political determinants of health.[123] It also means that reform is likely to need concerted activism from organisations and individuals working in the sector. Indeed, 'community activists and organisations, and health care workers in their own unpaid time' have been a historically distinct and necessary force in the provision of abortion care.[124]

Conclusion

Australia has a long history of over-regulating abortion care. Settler-colonialism introduced criminal law prohibition.[125] This was subsequently mitigated by common law and

119. Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia – October 2020* (Medical Board of Australia, 2020).
120. J. Dwyer, M. Rankin, M. Ripper and M. Cations, 'Is There Still a Need for Abortion-Specific Laws? The Capacity of the Health Framework to Regulate Abortion Care', *Alternative Law Journal*, 46(2) (2021), pp. 141–148.
121. S. Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future', *Modern Law Review*, 79 (2016), pp. 283–316; Sheldon, *Decriminalising Abortion in the UK*.
122. McGuinness and Montgomery, 'Legal Determinants of Health', p. 36.
123. Coggon, 'Legal, Moral and Political Determinants'.
124. Baird, A*bortion Care Is Health Care*, p. 239.
125. Millar, 'Abortion, Decriminalisation and the Medico-Legal Paradigm'.

statutory reforms in the different States and Territories. The country has now completed a two-decade process of decriminalisation, joining a global liberalisation trend.[126] While States and Territories have approached decriminalisation differently, NSW now simultaneously over- and under-regulates abortion care. The Abortion Law Reform Act 2019 continues to exceptionalise abortion care in ways that potentially conflict with optimal clinical care and stigmatises people seeking services. At the same time, law and policy under-regulates access to, and the sustainability of, services. Here, it fails to adequately recognise and address barriers to care. This paradox helps to illustrate the role law should have in regulating abortion, and indeed health care generally. As Joanna Erdman argues, abortion-specific laws are only warranted to the extent they promote health outcomes.[127] The introduction of safe access zones is one example of such legislation.[128] An assessment of whether abortion-specific laws promote health outcomes should, however, extend beyond narrow understandings of physical and mental health to recognise the gendered harms that excessive regulation can compound.[129]

This examination of abortion regulation in a decriminalised jurisdiction demonstrates that law reform must be more than the removal of restrictive and harmful laws. Rather, it must positively address the structural and social barriers that limit access to services. This is necessary for the realisation of the right to health and the other rights that health underpins.[130] The current *de facto* private model of abortion care in NSW is failing to deliver an equitable and accessible service. Reliance on non-state actors, and the lack of commitment from public hospitals who act with impunity to obstruct services, add to the precarity of care. Not only does this concentrate clinics in large urban centres, but it can also see the closure of clinics as costs are rationalised. This was seen with the closure of an MSI clinic in regional NSW during the COVID-19 pandemic. It has not reopened. Furthermore, and of significant importance, reliance on private providers – marginalising provision within publicly run health care infrastructure – continues the construction of abortion care as in some way exceptional. It is important, as Nathan Emmerich writes, that this is challenged: 'Reproductive services should be a basic part of mainstream healthcare and they should therefore be delivered by the same health service that provides other basic services'.[131] Normalising abortion care within publicly run and funded health services is at the centre of our proposals.

126. Morgan, 'Global Reproductive Governance'.
127. J. Erdman, 'The Politics of Global Abortion Rights', *Brown Journal of World Affairs*, 22(2) (2016), pp. 39–57.
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Decriminalisation, medical abortion, and telehealth have each been heralded as potentially changing the landscape for the provision of abortion care. Each of these developments is important, yet as demonstrated with decriminalisation, each has significant limitations. EMA is currently restricted to the first 9 weeks of pregnancy. It also typically has a lower success rate and higher incidence of side effects than surgical abortion.[132] The increased availability of EMA, if not accompanied by a concomitant focus on sustaining and extending surgical services, has the potential to limit choice through the withdrawal of surgical abortions, in turn limiting the experience and skills of health care providers.[133] This has implications not only for choice, and those seeking care after 9 weeks of pregnancy, but also for the availability of surgical abortion where this may be necessary in a clinical emergency. Telehealth is an essential response to Australia's geography. The country is the size of the continental United States and yet has the population of Texas. This makes equitable service delivery across all sectors challenging. Telehealth does not, however, remove the need for all travel and does not meet the needs of all service users. It also relies on EMA, potentially amplifying the limitations that reliance on this method can create. In looking towards the 2030 time frame set by the National Women's Health Strategy and the SDGs with which we started, the promise of these developments cannot obscure a fuller consideration of their limitations. This is true for all jurisdictions addressing continuing inequities in access to abortion care.

This returns us to the role of law. As already noted, as a public health tool law can deliver the social coordination needed to create the conditions for greater health equity.[134] Thus, it has a key role in securing equitable service delivery after decriminalisation. This is essential to move from abortion-permissive to abortion-supportive regulatory regimes.[135] This includes driving policy that mandates provision of medical and surgical abortion in public hospitals and publicly funded clinics. Law can also address other service weaknesses including data collection and the provision of high-quality information that is accessible to different service users. As the *Lancet-O'Neill Commission* noted, the most just and effective public health laws are evidence-based, equity promoting, and multisectoral.[136] This will require political will, and – as such – organised political pressure from activists and advocates will continue to be essential.

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