Public Health Association of Australia submission to the Queensland Law Reform Commission on the Termination of Pregnancy

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# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>The Public Health Association</td>
<td>3</td>
</tr>
<tr>
<td>Vision for a healthy population</td>
<td>3</td>
</tr>
<tr>
<td>Mission for the Public Health Association</td>
<td>3</td>
</tr>
<tr>
<td>Preamble</td>
<td>4</td>
</tr>
<tr>
<td>Response to the Terms of Reference</td>
<td>4</td>
</tr>
<tr>
<td>Principles</td>
<td>4</td>
</tr>
<tr>
<td>Background and research</td>
<td>5</td>
</tr>
<tr>
<td>Responses to the Commission’s Consultation Questions</td>
<td>6</td>
</tr>
<tr>
<td>Actions to implement in Queensland</td>
<td>11</td>
</tr>
<tr>
<td>Conclusion</td>
<td>12</td>
</tr>
<tr>
<td>References</td>
<td>13</td>
</tr>
</tbody>
</table>
Introduction

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia. The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian and state and territory Government should provide a comprehensive national cross-government framework on promoting a healthy ecosystem and reducing social and health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Preamble

PHAA welcomes the opportunity to provide input to the Law Reform Commission’s inquiry into the Termination of Pregnancy. We welcome the fact that the Government of Queensland has by implication made the political decision to achieve repeal of the criminal sanctions, and has directed the Commission to develop an optimal legislative solution.

Summary of our position

PHAA’s fundamental position is that abortion is a safe, common medical procedure which should be regulated in the same way as other medical procedures, without additional barriers or conditions. Universal access to safe abortion is an essential element of the provision of high quality reproductive health for women in Australia.

Accordingly, the regulation of abortion should be removed from Australian criminal law.

Comprehensive abortion care and services must be guided by evidence-based strategies and plans at the national and State/Territory level. Both medical and surgical abortions should be included in health service planning.

In Australia, there are limited evidence-based guidelines and training to support the delivery of abortion services by skilled health professionals. States and Territories should actively work toward equitable access (including geographic and financial access) to abortion services, with a mix of public and private services available.

Response to the Terms of Reference

Our principles

PHAA believes that the following key principles for a comprehensive sexual and reproductive health strategy will deliver the optimal health outcomes:

a. Criminal law is an inappropriate vehicle for regulating the provision of abortion.

b. Timely affordable access to early abortion services and emergency contraception is needed to reduce the risks associated with increasing gestation.

c. Medical and surgical abortion options should be provided as part of comprehensive sexual and reproductive health service throughout Australia.

d. Australian overseas aid should support wide availability of contraception and the provision of pre- and post-abortion care and abortion provision.
Background and research

As a consequence of abortion remaining in the criminal statues of some Australian States, women and health professionals are at risk of criminal sanctions for obtaining or delivering appropriate health care.

Universal access to safe, legal abortion services is essential to optimal reproductive health outcomes including reducing maternal morbidity and mortality globally\(^1\) and is consistent with achieving the United Nations Sustainable Development Goals.\(^2\)

Preventing unintended pregnancy is a public health goal. Improved access to and uptake of contraception is associated with lower rates of unintended pregnancy and abortion.\(^1\)

Contraceptive failure, sexual violence and other factors can lead to unintended pregnancies where abortion is the preferred option.\(^2\) New or progressing maternal illness, fetal anomaly or illness may lead to the consideration of abortion.

Abortion is a common gynaecological procedure.\(^3\) When performed by skilled providers using evidence based medical techniques and medications, particularly if performed within the first 14 weeks of pregnancy, induced abortion is a safe medical procedure.\(^1\)

Regulatory and service delivery developments relating to the provision of medical abortion presents an opportunity to improve geographic and economic access to early abortion.

There are high quality evidence-based guidelines to support abortion service delivery.\(^4\)

Comprehensive safe abortion care encompasses the provision of elective abortion services at the request of the woman, along with counselling for contraceptive use, medical after-care, and attention to other issues that are relevant to the woman’s health.\(^1, 5\)

Most Australians support women’s access to safe, legal abortion.\(^9, 6\)

There is a lack of systematic data collection on abortion in Australia.\(^5\)

Australian and international experience shows that removing legal barriers to abortion does not affect abortion rates. Laws which criminalise and/or restrict abortion are not associated with lower abortion rates, but with rather higher maternal mortality and unsafe abortion rates.\(^7\)

Barriers to safe and timely abortion include legal restrictions, inability to pay, lack of social support, delays in seeking health care, providers’ negative attitudes, poor quality services and a lack of policy and resources to ensure adequate service provision. These barriers largely affect adolescents and women who are from ethno-cultural minorities, low income, rural or remote living and experience violence and/or abuse.\(^1, 8\)
Responses to the Commission’s Consultation Questions

Who should be permitted to perform or assist in performing terminations?

Q-1 Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

Terminations should be regarded as a normal form of health service. As such, consistent with the regulation of other comparable health services, terminations should be performed by qualified and registered medical practitioners and assistant professionals.

In addition, the termination of pregnancy should not be singled out to be performed in a particular form of medical facility. Such conditions would potentially limit access to medical abortion, which may be safely conducted by taking prescribed medication outside a medical facility, for example in the woman’s home.

An argument could also be made for qualified nurses, midwives and pharmacists to be permitted to conduct terminations, as is provided for in the Victorian abortion legislation.

Q-2 Should a woman be criminally responsible for the termination of her own pregnancy?

No. The criminal law is an inappropriate vehicle for regulating the provision of abortion. The regulation of abortion should be removed from criminal laws and codes of the state and regulated under existing health care legislation.

Women should be able to exercise full autonomy over their bodies, as is the case with respect to all other health care.

Gestational limits and grounds

Q-3 Should there be a gestational limit or limits for a lawful termination of pregnancy?

No.

Q-4 If yes to Q-3, what should the gestational limit or limits be?

We acknowledge that the Commission may wish to react to specific community attitudes relating to late-term terminations. It should also be noted that genetic malformations may be discovered late in pregnancy.

One available model is the Australian Capital Territory legislation, where termination is a legal and regulated health service under the Health Act. As such there are not specific gestational limits for a lawful termination.

The Victorian legislation may also be used as a guide. This law makes abortion legal on request of a practitioner up to 24 weeks, and after 24 weeks if two practitioners agree it is in the patient’s best interest.
Q-5 Should there be a specific ground or grounds for a lawful termination of pregnancy?

Should the current criminal laws be repealed, the informed consent of the woman would remain as a legal requirement, consistent with the general law on other medical procedures.

Q-6 If yes to Q-5, what should the specific ground or grounds be?

None of the possible conditions raised by the Commission’s questions are either appropriate or necessary. As above, under the general law the informed consent of the women is all that should be required. Empowered decision-making should remain with the women concerned, and should not be subject to the judgement or approval of others.

Q-7 If yes to Q-5, should a different ground or grounds apply at different stages of pregnancy?

No.

Consultation by the medical practitioner

Q-8 Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy?

No requirement to consult should be legislated.

A medically unnecessary requirement for secondary approval could negatively affect the quality and timeliness of a termination procedure.

If a particular case presents unusual medical issues, for example in regard to a difficult or late-term pregnancy, then any question of a medical practitioner deciding that it is appropriate to consult with other sources of expertise should be regarded as a normal part of the practitioner providing the best possible medical care.

If yes to Q-8: Q-9 What should the requirement be? and Q-10 When should the requirement apply?

As above, no specific requirements should be imposed by law.

Conscientious objection

Q-11 Should there be provision for conscientious objection?

Yes. Given the social values involved in the issue of terminations, individual clinical practitioners should be able to refuse immediate involvement in terminations based on their consciences.

Since this is an individual issue of conscience, this privilege should only apply to individuals closely involved with the proposed treatment, and should not be available to persons engaged in more distant ancillary services (such as administrative staff or general providers of facilities or services to health centres), nor should it be an entitlement available to corporations or other non-individual entities.
Q-12 If yes to Q-11:

(a) Are there any circumstances in which the provision should not apply, such as an emergency or the absence of another practitioner or termination of pregnancy service within a reasonable geographic proximity?

Conscientious objection should not be claimable in emergency situations where life is at risk.

(b) Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?

Yes. The acknowledged right of an individual to conscientiously object to personal participation in a termination does not mean that they have a right to deny patients access to information about legal health care services.

The general right of women to information about, and access to, termination health services should not be compromised by the privilege of conscientious objection which any individual may wish to assert. This is of particular importance to women in rural and remote areas, where denial of information and access may seriously restrict women’s options.

Accordingly, health professionals with a conscientious objection to abortion care should inform their patients and refer patients to another health professional. Registration, professional and educational bodies should reinforce awareness of these responsibilities.

Counselling

Q-13 Should there be any requirements in relation to offering counselling for the woman?

Counselling is an ordinary service available to every person in addressing their personal circumstances, and is not limited to health care issues.

Counselling should be available to all women in regard to termination of pregnancy or any related (or unrelated) issues, just as with many other health issues and services.

As part of the ordinary course of their provision of care, medical practitioners should inform women about available counselling services.

However, there should certainly not be any imposed requirement for women to utilise any form of counselling before exercising their right to determine their own health care.

In addition, organisations that are committed to an anti-abortion philosophy and which provide counselling services with an objective of dissuading women from terminating pregnancies should be required to identify that philosophical direction in their advertising, as well as to women who contact such organisations seeking services.
Protection of women and service providers and safe access zones

Q-14 Should it be unlawful to harass, intimidate or obstruct:

(a) a woman who is considering, or who has undergone, a termination of pregnancy; or

(b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

Yes. All such harassment is clearly an improper interference in women’s rights to access information and services which – after the proposed reform of the Queensland law – would be entirely lawful.

Q-15 Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

Yes.

If yes to Q-15:

Q-16 Should the provision:

(a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or

(b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria should the Minister be required to apply when making the declaration?

Option (a) is the correct approach, because every premises should be covered at all times – not merely at ministerial discretion – while it is operating as a provider of the relevant services.

The terms of such a provision should not permit an individual Minister acting on their own values to exercise personal discretion so as not to establish a safe access zone at any location. Such a result would be contrary to the objectives of the legislation.

However, the legislation might usefully include a different version of option (b) which allowed for the making of specific declarations relating to any given safe access zone so as to take into account local physical circumstances, consistent with the objectives of the law.

Victoria, Tasmania and the Northern Territory have legislated for 150m safe access zones, and the ACT has a 50m zone definition which we understand is increased in practice. The Commission should review these jurisdictions’ experiences with the effectiveness of zone definition. Unless there is evidence to the contrary, consistency with the emerging 150m standard would be appropriate.
Q-17 What behaviours should be prohibited in a safe access zone?

Obstruction/prevention of access, harassment and intimidation of women seeking services are the main concerns.

Harassment and intimidation of staff working at health facilities should also be covered.

The situation regarding protests is more complex, because if done reasonably some forms of protest may be carried out without causing harassment and intimidation. There is a legal concern that legislation which broadly banned communicative protest activities might possibly render legislation constitutionally invalid on the grounds of interference with political communication. The Victorian legislation seems to have crafted an appropriate balance on this issue, and the Commission should review the status of legal challenges to that Victorian law.

Q-18 Should the prohibition on behaviours in a safe access zone apply only during a particular time period?

The prohibition should apply at all times when it is relevant to protect women seeking information or services, or staff providing services. In practice, legislating a ban at all times would prevent needless legal questions arising over whether those carrying out prohibited behaviours had knowledge that health centres were open for business, that women seeking services were actually present, and so on.

In addition, protections against harassment should be legislated for the benefit of the staff of health centres, who may be present outside of hours when the centres are open for patient services.

Q-19 Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

Yes. Recordings are a breach of personal privacy, and the act of making them itself constitutes a form of harassment and intimidation.

Collection of data about terminations of pregnancy

Q-20 Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?

Yes. Data on all health services is useful for many purposes including quality control, monitoring of health care service provision and the overall planning of service delivery. Such data is available in the national health systems of New Zealand and the United Kingdom.

In particular, experience in Queensland and other jurisdictions indicates that the absence of data as to where services are in demand hinders service delivery and in turn hinders access.
PHAA submission on the Termination of Pregnancy in Queensland

Actions to implement in Queensland

PHAA recommends that the Parliament, Government and other responsible authorities in Queensland should take the actions listed below.

**Legality and availability of services**

- Termination of pregnancy should be removed from criminal laws of Queensland and regulated under existing health care legislation.
- Barriers and restrictions to access, such as requirements for multiple opinions or mandated counselling should not be applied through legislation, regulation or policy.
- Medicare rebates for abortion should be sufficient to prevent cost presenting a barrier to access.
- Legal protection should safeguard clients and staff of legal abortion services from harassment. This should include the provision of exclusion zones.
- Abortion service providers should offer optional, non-directive, comprehensive pre and post-abortion counselling.
- Health care organisations should provide fertility control and women-centred decision-making that included pregnancy options counselling, information about access to abortion services and choice of methods, contraception counselling and referral without judgement or coercion.
- A mix of private and public services should be available in all jurisdictions.
- Health professionals with a conscientious objection to abortion care should inform their patients of their personal position, and promptly refer patients to another health professional without recrimination. Registration, professional and educational bodies should reinforce this responsibility.

**Health service development and planning**

- Service development and funding arrangements should be put in place to increase access to medical abortion.
- Abortion services should be included in service planning for all state and territory health authorities and delivered in accordance with evidence-based standards of best practice and informed consent.
- Abortion related research, training and workforce planning and development should be adequately funded, promote evidence-based quality care, and ensure equitable access to services and continuous quality improvement.
- National routine, complete and systematic data collection on abortion should be implemented in Australia.
Conclusion

PHAA fully supports the reform of the criminal law regarding termination of pregnancy in Queensland, and just as importantly urges the state government to enhance systems of service provision to women in Queensland.

The PHAA appreciates the opportunity to make this submission to the Law Reform Commission. Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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References


