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OPINION

Systemic delays to abortion access undermine the health and rights of abortion seekers across Australia

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Across Australia, 2022 brought significant delays for those accessing abortion-related care. People seeking an abortion and entering health systems in their first trimester have experienced barriers and delays resulting in an increase in unnecessary second trimester procedures, as reported by organisations that support them. At that stage, individuals face increased financial, emotional, and physical burdens[1,2] and have reduced options for abortion methods and facilities.[3] For some abortion seekers, delays result in forced continuation of the pregnancy, as health services deny pregnant people legal, compassionate abortion care based on arbitrary, service-imposed gestational limits.

This article was written by Children by Choice (a non-profit organisation providing evidence-based information, pregnancy options counselling, referrals, education and training) in partnership with sexual and reproductive health care providers, advocates, and researchers from the SPHERE coalition (which aims to collectively advocate for evidence-informed policy and practices in women's sexual and reproductive health care). It was motivated by the alarming observations about the negative consequences of delayed and insufficient access to abortion care across Australia discussed among coalition members in 2022. The implications for reproductive autonomy, choice and rights are particularly concerning, and must be addressed if Australia is to fulfil its commitment to achieving universal access to abortion made in the Australian 2020–2030 Women's Health Strategy.[4]

INEQUITABLE ACCESS TO ABORTION CARE EXACERBATES DELAYS FOR ABORTION SEEKERS

Inequitable access to public abortion care drives and exacerbates delays for abortion seekers. Abortion access across Australian states and territories is commonly described as a 'post-code lottery', meaning that where pregnant people live determines whether and how easily they can access public abortion care.[5] There is also inequitable access to primary care and private abortion services, depending on an abortion seeker's location, income, and health profile. Nevertheless, most abortions in Australia are provided through private providers,[6] illustrating the dearth of public service availability.[7]

Delays to abortion care and other challenges hindering access are compounded for Australia's most marginalised abortion seekers, including those experiencing family violence or sexual abuse, substance use disorders, disabilities, child protection involvement, poverty, and other complexities.[7,8] Even where public services are accessible, clients without Medicare are often unable to access them and must resort to spending thousands of dollars in private clinics, worsening the financial and health insecurity often experienced by these groups.[7]

Private providers, who shoulder much of the burden of abortion provision in Australia[6] when governments fail to secure access in the public sector, are often equipped to deliver high-quality and patient-centred abortion care. However, dependency

on the private sector to provide essential abortion healthcare carries risks, putting women and pregnant people at the mercy of the policies and capacity of private organisations, which may limit or delay abortion access. For example, Australia's main provider of private abortion services is unable, for logistical reasons, to service patients of certain ages, body mass indexes and with various comorbidities. There are also private hospitals that receive public funds and refuse to provide abortion or contraceptive services due to religious governance,[9] further creating inequities and barriers to accessing timely abortion care.

In Queensland, where access to abortion services through public hospitals is required by government directive, private-public partnerships are frequently used to fill gaps where abortion services aren't publicly provided. However, the precariousness of such private-public provision models was illustrated as several regional private abortion clinics, the main providers for northern Queensland, were closed in 2021. Since then, pregnant people have been forced to travel hundreds of kilometres to access care because no public services exist in their regions; to do so, they often need to arrange for an accompanying support person, accommodation, childcare, and extended work leave, among other burdens. Due to the complexity and diversity of pathways in Queensland, which vary in each hospital and health service, many women and pregnant people rely on non-government organisations like Children by Choice to help them navigate these inequitable and burdensome systems, to conduct daily internal and systemic advocacy on their behalf, and to ensure that they have access to legal and essential abortion healthcare.

Stigma reportedly influences whether and how abortion is provided in many hospitals, particularly where conscientious objectors hold positions of power. According to Children by Choice's clients and the authors' national practice experiences, care in hospitals is often, officially or unofficially, prioritised for 'medically indicated' and 'deserving' abortions – such as for fetal conditions. Narratives of 'good/therapeutic' and 'bad/social' abortions, driven by and driving stigma,[10] continue to be used to justify arbitrary restrictions to compassionate abortion care. As a result, Children by Choice has seen multiple clients who were seeking care at public hospitals pushed beyond gestational limits due to delays, resulting in denial of abortion care altogether. The personal and social 'complexities' experienced by these clients are often cited as reasons for exclusion from care, despite hospitals being well equipped to serve psychosocially complex and marginalised patients, who they frequently manage in other areas of care provision. In 2022, one client of Children by Choice presented at nine weeks to their local public hospital and was told they would be able to access abortion when a bed became available. With further delays and obstructions, the pregnant person reached 24 weeks gestation, and care was denied. This illustrates that hospital-based abortion care often deviates from equity-based public health principles, which would prioritise care for people with complex psychosocial circumstances and intersecting experiences of marginalisation.

Across the Australian health system, delays to accessing abortion care are driven by a range of social, political, and institutional factors that are underpinned by abortion stigma. For example, unnecessarily complicated referral and access pathways contribute to delays, as they often require abortion seekers to see multiple health providers and obtain services such as ultrasound before receiving referrals to and appointments for abortion. The reliance on referrals means that abortion seekers may experience gatekeeping by providers who do not support abortion access.[11] Research shows that abortion seekers in Queensland are frequently deliberately misdirected or given misinformation by health providers.[12] In Tasmania, despite the availability of public abortion services in the three major hospitals, these services have historically not been publicised due to abortion stigma.[13] These structural and institutional forms of stigma have led to a lack of embedded, accessible public abortion services and increase the social, personal, and financial costs of abortion.[14]

DELAYS DRIVE NEGATIVE EMOTIONAL, PHYSICAL, SOCIAL, AND FINANCIAL OUTCOMES

As gestation increases, so do costs and complexities of abortion procedures and the required length of hospital stays. Delays to abortion access also generate significant burden on the very few services and practitioners who offer surgical abortions after 16 weeks. For example, in Darwin, where most abortions are publicly funded, providers have access to only one half-day list dedicated to surgical abortions per fortnight. Pregnant people presenting at higher gestations are necessarily prioritised, extending wait times for those who present at earlier gestations. There is only one provider of surgical abortion after 16 weeks servicing the whole of the Northern Territory, further delaying access in the second trimester, even in a service and policy context favourable for public abortion access.

The psychosocial impacts of dealing with uncertainty, delays and potential denial of abortion care are significant. The multitude of published research from the largest longitudinal study of people denied wanted abortions in the US clearly demonstrates myriad significant physical, mental, and socio-economic consequences of being denied care.[15] An Australian study has found that delays to abortion care experienced in 2022 caused discomfort and anxiety for abortion seekers, who described waiting for their abortion service as 'horrible', 'like an eternity', 'awful', 'anxious' and 'nerve wracking', and 'the worst part [of the process]'.[16] Anxiety and stress due to delays in accessing care can be exacerbated by the physical discomfort of increasing pregnancy symptoms as pregnancy advances. Some abortion seekers who can afford to do so travel interstate to access timely care rather than waiting for local services.[16] This has resulted in unmanageable burdens on regions and services with good public provision, including at higher gestations.

As gestation increases, pregnant people seeking abortion also face increased social scrutiny, stigma, medicalisation and removal of choice and bodily autonomy. These consequences are forced on abortion seekers by systems that are unable to provide timely, compassionate abortion care. Re-centring power away from pregnant people and into doctors' hands and subjecting pregnant people 'to increased legal and medical oversight and surveillance'[17] re-introduces the gatekeeping and barriers to healthcare that decriminalisation was hoped to minimise.

COMPASSIONATE SERVICES AND SYSTEMS PROVIDE A BLUEPRINT FOR CHANGE

Characteristics of services and systems providing high-quality, compassionate, timely, equitable and accessible abortion care throughout Australia include: a trauma-informed approach; capacity to provide abortion for all who seek it irrespective of age or health conditions; and dedicated personnel and financial resources to facilitate the provision of holistic, wrap-around services. The provision of wrap-around care to patients, inclusive of social work support, is a particularly important element of compassionate care. For example, services in Victoria and South Australia offer comprehensive, holistic abortion care in single day visits, an approach minimising the risk of abortion seekers encountering stigmatisation, delays, and objections: stigmatisation and conscientious objection appear to be more commonly experienced in health settings that are not specialist sexual reproductive health or abortion services.[12,18]

Nurse-navigator roles in some hospitals in Queensland have been instrumental in supporting patients and providers, helping to embed timely responsiveness and care. In several states abortion seekers receive support for accommodation and transport for themselves and support people when required to travel between towns. In the Northern Territory, key internal advocates within public hospitals have been pivotal to improving accessibility, and public partnerships with a private ultrasound provider have reduced costs and delays in ultrasound access for Medicare-eligible abortion seekers. Furthermore, the importance of democratising access to information about abortion care and pathways by making them transparent and publicly available cannot be understated.

WHERE TO FROM HERE

In order to universalise abortion access and address the suite of negative consequences caused by delays to and denial of abortion care, early medication and surgical abortions must be provided in the public sector. Explicit recognition of the time-sensitive nature of abortion is vital, as is the acceptance of abortion as an essential service and surgery. This necessitates countering the stigmatising norms and stereotypes that delegitimise abortion as a health service.

National standards of clinical care, compassionate care guidelines, and funding of service delivery according to population health needs, are crucial. When equity of access is achieved, forced travel and its social and financial costs will be reduced. Additionally, consistent, transparent, and enforceable regulation of conscientious objection is necessary to hold health practitioners and services accountable for abortion care delays and denial. Health services receiving public funding should not have the institutional right to conscientious objection and must provide compassionate abortion care as a public good.[19]

An equitable approach to delivering accessible, timely and compassionate abortion care also requires amelioration of access barriers for people without Medicare. Further, there must be particular attention to access for people in regional, rural, and remote areas, who commonly face forced travel and conscientious objection by local providers. Over-reliance on telehealth, private providers, and medical termination of pregnancy (MTOP), as was recently found in the UK,[20] risks limiting the range of options and thereby hindering accessibility and choice of abortion care.

We sincerely hope the national inquiry into universal access to reproductive health care leads to some if not all these changes. Further, we call for explicit political and medical recognition of the need for urgent and meaningful changes in the Australian healthcare system to ensure reproductive health and rights for all are achieved, and inequities reduced, in line with local and international commitments.

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