

Decriminalization and Women's Access to Abortion in Australia

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Abstract

This article considers the relationship between the decriminalization of abortion and women's access to abortion services. It focuses on the four Australian jurisdictions which are, with Canada, the only jurisdictions in the world where abortion has been removed from the criminal law. This paper draws on documentary evidence and an oral history project to give a "before and after" account of each jurisdiction. The paper assumes that the meaning and impact of decriminalization must be assessed in each local context. Understanding the conditions that shape access must incorporate analysis of the broader social, political and economic environment as well as the law. The article finds that decriminalization does not necessarily deliver any improvement in women's access to abortion, at least in the short term. Further, it is not inconsistent with the neoliberal policy environment that characterizes the provision of abortion care in Australia, where most abortions are provided through the private sector at financial cost to women. If all women are to enjoy their human rights to full reproductive health care, the public health system must take responsibility for the adequate provision of abortion services; ongoing and vigilant activism is central if this is to be achieved.

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Introduction

Four states/territories of Australia—the Australian Capital Territory, Victoria, Tasmania, and most recently the Northern Territory—stand with Canada as the only jurisdictions in the world where abortion is no longer regulated by criminal law. The Canadian Supreme Court decriminalized abortion in 1988; decriminalization in the Australian jurisdictions has happened in the 21st century. Legal scholar Kerry Petersen notes of Australia that this is “a trend to classify abortion mainly as a health matter.” These reforms “represent a significant socio-legal shift.”¹ This reclassification of abortion from crime to health care is a longstanding goal of feminist and pro-choice activists and is consistent with human rights principles.² This shift away from the criminalization of abortion is surely a valuable achievement, but identifying its effects to date in Australia is not so straightforward.

This article is a historical examination of the effects of three instances of decriminalization in Australian jurisdictions. It is too soon to assess decriminalization in the Northern Territory, which just occurred in 2017. That is, it concerns the law, politics, and provision of abortion in an affluent Western “liberal democracy.” The great majority of Australians are “pro-choice.”³ The nation has a comprehensive public health system, albeit one that struggles under the trends and pressures characteristic of neoliberal policy approaches. Australia has a strong tradition of social democracy but at the level of everyday cultural practice and of government social and economic policy, individualism, choice, and market-based solutions in all areas of life have become common sense. The role of the state is to facilitate markets.⁴ Health is understood largely as an individual responsibility, and the public health system (including public hospitals) negotiates competing principles in the context of ongoing pressure to privatize, limited resources, and constant restructuring.⁵ Abortion is provided liberally in Australia, but mostly by private providers. Well-informed women in metropolitan centers with reasonable economic means seeking first trimester abortions are adequately served.

Discussion of decriminalization in Australian political, scholarly, and media contexts often proceeds with little if any attention to the relationship between the change in law and change in the adequacy of access for women to abortion services. Regarding discussion of abortion worldwide, legal scholar Rachel Rebouché notes: “There appears to be faith in liberal laws promising liberal access, and in restrictive laws restricting access.” Yet “empirical studies, often in the field of public health, show this faith to be unfounded.” This article is driven by a feminist commitment to understanding and promoting the advancement of access to safe, legal, and affordable abortion services for all who need them. It follows Rebouché’s call for “an assessment of abortion laws in their functional capacity.” She concludes that this “approach suspends the assumption that law has a direct or immediate or even a necessarily casual [sic] relationship with health outcomes.”⁶

In this article, I argue that while decriminalization is consistent with feminist goals and human rights principles, unless there have been specific legal restrictions on abortion provision beyond defining the legality of doctors’ authority to decide, it will make little or no challenge to the sources of inadequate access to abortion in Australia. I conclude that while decriminalization may be a precondition for the improvement of access to abortion services, it is only when public health departments take responsibility that equitable access will be delivered. In the current neoliberal policy environment and in the context of continuing moral conservatism in Australia, this will only happen under pressure of ongoing activism—and even then there are no guarantees.

The article begins with a brief historical background to the law, politics, and provision of abortion in Australia. It then tells a before-and-after story of decriminalization in each jurisdiction, although for the Northern Territory the discussion is brief. Finally, the article offers a critical feminist analysis of these stories to identify the forces that shape women’s access to abortion in Australia. The article refers to women having abortions but, following the IPPF, acknowledges that “other people who do not identify as ‘women’ (such as trans men/

trans masculine people and non-binary people) can also experience pregnancy and abortion.⁷ It draws from a range of published sources, including government and NGO reports and mainstream and alternative media. It also draws from oral history interviews that I conducted with “key insiders” between 2013 and 2017 as part of a project that is investigating the provision of abortion services in Australia since 1990. The Flinders University Social and Behavioural Research Ethics Committee approved the oral history project (no 5958) which produced these interviews. Thirty-five interviews were conducted with people who were then or had been significantly involved for a sizeable period of time in public and private abortion provision, advocacy, or activism, or related women’s health work, in every jurisdiction. Some were approached through my own networks or because of their public profile, and others were recruited via a snowball method where interviewees recommended or referred others to me. Each interview was conducted in a semi-structured way to elicit a history of the provision of abortion in the jurisdiction(s) with which each person was familiar. All interviewees are identified by pseudonyms and are referred to in the narrative by their role in relation to abortion. The interview material adds subjective depth to what can be learned from documentary sources.

Abortion in Australia

Law concerning abortion in each state and territory in Australia followed the British 1861 Offences Against the Person Act. Legal liberalization began in 1969 and proceeded one jurisdiction at a time via legislative reform of the criminal law or court ruling in cases where doctors were facing abortion related charges.⁸ Rebecca Albury points out that it was the broader context of social change in the 1960s and 1970s, as well as the activism of Abortion Law Reform Associations and feminists and the liberalization of the law, that transformed Australian attitudes to fertility control and delivered liberal access to abortion by the end of the 1970s.⁹ The pattern of predominantly private provision that had been established by this time prevails at the time of

writing, albeit with significant variation across the eight jurisdictions and an aging cohort of medical providers that points to workforce sustainability problems.¹⁰ The listing of surgical abortion as a rebatable item on Medicare, the national universal health insurance scheme that was introduced in 1975, has been crucial in enabling access for women who attend private clinics. In the 2010s, though, the rebate covers only about half the cost of a first-trimester procedure and progressively less for procedures after 12 weeks.¹¹ Early medical abortion for women less than 9 weeks pregnant has slowly become available since 2006.¹² The medications are now imported commercially by a subsidiary of Marie Stopes International (MSI), a UK-based sexual and reproductive health care charity that operates internationally. MSI entered the Australian market as a private abortion provider in 2000 and now provides about one-third of all abortions in the country.¹³ Medical abortion is available mainly as an alternative in existing clinics where it is no cheaper than surgical abortion.¹⁴

Pro-choice activism from the 1970s has been state-based. The anti-abortion movement is an irritant but generally not a dominant political force in Australia per se. The overwhelmingly pro-choice opinions of Australians and the 21st century trend to decriminalize abortion in Australia nonetheless coincide with public discourse that stigmatizes women and abortion-providing doctors.¹⁵ More specifically, the period since 1996 has seen a re-energized Christian moral conservatism, most politically notable in the federal sphere, where Liberal governments were in place from 1996–2007 and since 2013.¹⁶ Federal and state governments in Australia in the post-war period have been held by either the more socially and economically conservative Liberal Party or the more socially progressive Australian Labor Party (ALP). Decriminalization in each case has been achieved under state/territory governments led by the ALP. The status of popular feminism has waxed and waned, but a neoliberal retreat from social policy that aims to promote gender equality has been a feature of both Liberal and ALP governments since the 1990s, if in different degrees.¹⁷ Notwithstanding this policy position, the

growing presence of women in all parliaments has made a significant difference in abortion votes.¹⁸

The Australian Capital Territory

The Australian Capital Territory is a small area enclaved within the state of New South Wales. The national capital Canberra, a city of about 380,000 people, is located here.¹⁹ Abortion was decriminalized in 2002 following the success of a private members' bill.

From 1994, women in the Australian Capital Territory had enjoyed access to an abortion clinic in Canberra owned and operated by the not-for-profit ACT Family Planning Association (ACT FPA). But in 1998, Paul Osborne, a Catholic independent member of the Legislative Assembly, in a deal with the then-Liberal government, was successful in passing legislation that significantly restricted abortion provision. Women had to be given prescribed information, including pictures of fetuses, and a 72-hour waiting period between a woman's first visit to the clinic and the procedure was mandated.²⁰

The FPA clinic did its best to resist and minimize the impact of the 1998 act on women.²¹ Nonetheless, one woman who at the time worked in the organization in a management role told me in 2015 that "it was actually not so much about delivering the service but making sure that we met our obligations in case they were ever scrutinized in court, because we were scrutinized a lot."²² Compliance with the 72-hour waiting period meant that women visited the clinic three times over a 10-day period. Following this decrease in the service's amenability, especially to rural women, some chose to go to a private clinic in nearby Queanbeyan (in New South Wales just outside the Australian Capital Territory), which had been established in the wake of the 1998 reform and was free of the legislative restrictions. As a consequence, the FPA clinic suffered a financially significant "decline in client numbers."²³

After the 2001 election, which returned an ALP government and an increased number of women to the Legislative Assembly, ALP backbencher Wayne Berry, with colleague Katy Gallagher, had

the opportunity to legislate. A new pro-choice community group was formed and campaigned intensively to counter the Right to Life organization, which was a significant force in opposition. Decriminalization legislation in 2002 delivered "the most minimal legal model regulating abortion in Australia."²⁴ Abortion no longer appears in the Crimes Act at all. New regulations concerning abortion were, however, put into the Health Act. There are no restrictions on women, but abortions must be performed by medical practitioners and only in approved premises. No person is required to perform or assist in an abortion.²⁵

The FPA manager who spoke to me described decriminalization as a "brand new day."²⁶ But it was not only the legislation that had been working against the clinic. In the early 2000s, the clinic had about 10 lawsuits going against it.²⁷ The plaintiffs were alleging various forms of poor practice on the part of the clinic, most in relation to abortion. Most women were supported by Catholic anti-choice agencies. Then the HIH Insurance company went into provisional liquidation, "Australia's biggest corporate collapse."²⁸ The FPA abortion clinic was one of a number which were forced, overnight, into much more expensive insurance arrangements, as were its doctors.²⁹ In this context, the clinic's commitment to means-tested fees and "payment plans," the opportunity for women to pay for their abortion over time, became "financially unviable."³⁰ The regular protestors outside the clinic were a minor irritant, but the 2001 murder of security guard Steve Rogers by an anti-abortion gunman at the Fertility Control Clinic in Melbourne led to added security measures.³¹ Hence, in the early 2000s, ACT FPA operated with a financial deficit. The financial, legal, and emotional pressure on the organization saw constant turnover in the membership of ACT FPA's governing council after 1998.³²

Marie Stopes International Australia (MSIA) saved the day. FPA ACT sold the abortion providing part of the organization to MSIA in early 2004. It was one of their early acquisitions. Access to insurance through their global operations, and a different business model—they did not offer pay-

ment plans—meant that they were able to, as the FPA manager put it, “save the space where women could access services in the ACT.”³³

In 2017, MSIA still operates in the Australian Capital Territory, providing abortions for women up to 16 weeks, as does Gynaecology Centres Australia in Queanbeyan, which provides abortions up to 14 weeks. Both offer medical and surgical abortions. The availability of early medical abortion from the Tabbott Foundation, a service established in 2015 offering medical abortion via telemedicine to Australian women at a relatively cheap price, is compromised for Australian Capital Territory women by the legal requirement that abortions must be carried out in approved premises.³⁴ Public provision in the Australian Capital Territory is minimal. (One of the two public hospitals in the Australian Capital Territory is run by the Catholic Calvary Group, which does not provide abortions).³⁵ In sum, decriminalization was part of the facilitation in the Australian Capital Territory of the restoration of services to a situation similar to that which had been operating prior to the 1998 anti-abortion reforms. MSIA have made abortions available at later gestations than had previously been accessible, but they discontinued the payment flexibility that the FPA clinic had offered.

Victoria

Victoria is the second-smallest Australian state (a bit larger than Great Britain). About 4.5 million of the 6 million total population live in greater Melbourne, the capital city. Abortion was decriminalized by a government-sponsored bill in 2008.

Prior to this time, abortion was a matter of criminal law and its provision clarified in the 1969 *Menhennit* ruling. Abortion was legal if “necessary to preserve the woman from a serious danger to her life or her physical or mental health” and “economic and social grounds” could be considered.³⁶ Abortion was liberally provided. The Royal Women’s Hospital (RWH) and some other metropolitan and regional public hospitals provided abortions at no cost, mainly to the poorest women, although they never met demand for this service.

Public hospital provision comprised about 20% of all abortions.³⁷ Private clinics in Melbourne provided the rest. One account of the campaign for decriminalization describes it as a response to the increasingly anti-abortion climate generated in federal politics after the 2004 federal election.³⁸ It took place over four years and was driven by a coalition of organizations and individuals with interests in women’s sexual and reproductive health and women’s rights. After a report from the Victorian Law Reform Commission (VLRC), a bill was sponsored by Women’s Affairs Minister Maxine Morand. The government eschewed complete repeal, the most radical of the VLRC’s proposed models. Its stated intention was to “modernise and clarify” the law, removing abortion from the criminal law “without altering current clinic practice.”³⁹ The bill passed without amendment.

The government’s 2008 bill removed abortion from the Crimes Act, although it created a new criminal offense to make it unlawful for “an unqualified person to perform an abortion.”⁴⁰ The Abortion Law Reform Act gives abortions up to 24 weeks the same status as any other matter of health care. It adds regulations, however, requiring that in cases where women are more than 24 weeks pregnant, two doctors must “reasonably believe that the abortion is appropriate in all the circumstances.” Any breach of this requirement is dealt with by professional disciplinary means.⁴¹ It also requires that doctors who have a conscientious objection to abortion must refer the woman to a practitioner who does not.⁴²

Decriminalization in Victoria has had clear “intended and achieved” positive effects.⁴³ One women’s health worker who I interviewed in 2013 said that “symbolically I think it’s extraordinarily significant in that it says women are adults who are capable of making decisions about their own lives and their own bodies.”⁴⁴ Another, who works with young people, stated that “from an education perspective it has been quite an improvement in relation to being able to clearly state what their rights to abortion access are.”⁴⁵ Decriminalization has also increased clarity and comfort for abortion-pro-

viding doctors.⁴⁶ In 2015, I interviewed a medical provider who has worked in the public hospital sector; she felt that decriminalization had changed the nature of her interactions with patients:

Before decriminalization, you had to prove to me that I should grant you an abortion ... and so women would sit there waiting to be granted an abortion, and I could see the moment where they thought "All right, I've got one," yeah. And so I feel a lot better about that interaction.⁴⁷

Those who expected more have been disappointed. The "experts in abortion" interviewed by Victorian public health academic Keogh and her colleagues did not think that there had been any decrease in the stigma attached to abortion, either for women or for providers.⁴⁸ The public sector medical provider quoted above reflected:

I probably thought that a little bit ... after abortion law reform, there'll be more providers willing to do this job ... But it hasn't panned out that way ... I thought that there might be more services opening at public hospitals ... That hasn't been the case.⁴⁹

Workforce sustainability is not the only unresolved problem. The "experts in abortion" thought that, coincidentally, "access to public services [had] shrunk." They were particularly concerned about the inadequacy and decline in services for women more than 20 weeks pregnant.⁵⁰ The only private clinic in Australia that offers abortions over 20 weeks for "social reasons" is operated by MSIA in Melbourne. ("Social reasons" for abortion are those that are principally the domain of the pregnant woman to identify. This term is used widely in Australia in comparison with "medical reasons" which are those that are diagnosed by doctors and/or medical science, typically maternal ill health and fetal anomaly.) Resources for the more complex procedure after 20 weeks are concentrated here and women travel from around the country to access the service. The clinic ceased offering services for women more than 24 weeks pregnant in 2012.⁵¹ The public hospital provider to whom I spoke reported that surgical abortions for "social reasons" are available at the RWH only for women up to 18

weeks.⁵² In both cases, these limits are imposed for reasons other than the law (although the limit at the MSIA clinic matches the post 2008 line after which legislated regulation applies). The other major disappointment concerned the lack of state government policy, described by the experts as "unfinished business."⁵³ In 2011, the Women's Health Association of Victoria produced a proposal for a sexual and reproductive health strategy as a means of pressuring the then-Liberal state government.⁵⁴ A public sector health care professional I interviewed in 2013 stated that while strategic planning was needed and "theoretically" decriminalization should make things possible, "law reform's happened and pretty much the bureaucrats and the politicians have said: 'Well we've done our bit, go away now, don't expect anything else.'" ⁵⁵

Keogh et al also comment on an unintended effect of decriminalization. Some of the "abortion experts" thought that the codification of conscientious objection had led to "whole institutions [being able to] justify not providing abortion services."⁵⁶ Overt resistance to decriminalization from an anti-abortion doctor and an independent member of parliament gained significant publicity in 2013–2014.⁵⁷ On the other hand, the coalitions forged in the decriminalization campaign have an ongoing legacy. This is evident in cooperation between public, private, and community agencies in the promotion of early medical abortion to rural doctors, notably without direct state government funding or coordination.⁵⁸ Keogh et al's experts note that the availability of early medical abortion since decriminalization has made abortion "a little bit more accessible."⁵⁹

Up until 2017, the direct effects of decriminalization on access in Victoria seemed to be limited to the hope that legal clarity and comfort for doctors might, at some point in the future, lead to a greater supply of abortion providers and less stigma for women. Many experts and insiders expressed frustration. Then, in March 2017, the socially progressive ALP state government released its first-ever women's sexual and reproductive health strategy.⁶⁰ Three of 14 key priorities for 2017–2020 address abortion, with a focus on improving awareness of

and access to medical abortion. The impact of this policy, for which many have lobbied, remains to be seen at the time of writing.

Tasmania

Tasmania is a small island state, located to the south of Victoria and about one-third its size. It has a population of about half a million. On most indicators, Tasmania is the poorest state in the nation. Abortion was decriminalized in Tasmania in 2013.

Prior to this time, the conditions under which it was lawful for doctors to provide an abortion were defined in a 2001 amendment to the criminal law. The woman was required to give informed consent, which meant being counseled about medical risks and being referred for further counseling. Two doctors had to certify that she could be given an abortion. There was no upper time limit.⁶¹ Through the 2000s, Tasmanian women were served by two private clinics in the capital city Hobart in the south and one in the city of Launceston in the north, all operating one day every two weeks with “fly-in-fly-out” doctors. The North West Coast was served intermittently until 2016 by a doctor who operated at a public hospital. One long-standing activist assumed that the two major public hospitals provided abortions for “medical reasons” only.⁶² Another interviewee, a public sector policy worker, thought it likely that some Tasmanian women were traveling to Melbourne to access a private clinic during the 2000s, for reasons of confidentiality or to avoid waiting.⁶³ By the end of the 2000s, community-based health agencies were regularly reporting to the health minister that access to abortion services was inadequate, particularly for young and poor women.⁶⁴ Some doctors were claiming that, despite the 2001 reform, the law was ambiguous. Not until 2008 had the health department produced a booklet to inform doctors about the law.⁶⁵ One doctor who I interviewed in 2013 who had been performing abortions in Tasmania during the previous two decades disputed the claim that the law was unclear. “I don’t think they’re [doctors] confused at all. You know, I think they just don’t want to—they just use that as an excuse not to refer women on.” Abortion providers “just go ahead and

do our own thing.”⁶⁶ The two-doctor rule was, however, a nuisance.

In 2010, Michelle O’Byrne, then health minister in the ALP government, indicated interest in the abortion issue. ProChoice Tas formed and community women’s and sexual and reproductive health organizations moved into action in 2011 and 2012.⁶⁷ O’Byrne’s bill passed, after amendments, in November 2013.⁶⁸ It removed abortion from the criminal law, except that it is a criminal offense for a person who is not a doctor to perform an abortion. It added conditions to the Health Act. An upper time limit of 16 weeks applies, beyond which two medical practitioners, one of whom must be an ob/gyn, must support the woman’s request. Similar to the Victorian law, doctors and counselors who hold conscientious objections must provide the woman with a list of services that provide all options.

Shortly after decriminalization came into effect, the Tasmanian government made efforts to educate the health community about the new law. According to the women’s health worker with whom I spoke in 2017, publicity material led to improved knowledge about the law among Tasmanian women. But the year after decriminalization, a Liberal government was elected and these efforts ceased. The women’s health worker stated that the new anti-abortion minister for health makes any ongoing activist efforts “like banging your head against a brick wall.” Even advocacy with the public hospitals on behalf of individual patients is fraught with caution for workers at women’s and sexual and reproductive health agencies that rely on funding from government.⁶⁹

In the wake of decriminalization in 2013, Tasmanian women’s access to abortion has significantly reduced, but not because of the law. In 2014, one of the two Hobart clinics closed. Then in 2016, the Launceston clinic closed. Both clinic owners cited the impending implementation of new regulations pertaining to day procedure centers (not specifically related to abortion provision), which would require upgraded premises. The Launceston clinic owner added that “additional costs of insurance, accreditation and compliance” made the business unviable. Further, this doctor report-

ed that the popularity of the Tabbott Foundation, which he had established in 2015, had produced a decline in demand for the Launceston clinic.⁷⁰ The clinic closure means, however, that women in northern Tasmania no longer have access to a local surgical abortion service.

Public hospitals remain unwilling to provide abortion in the wake of decriminalization, and knowledge of their approach to service provision is not freely available. According to one journalist, only about 6% of all abortions were provided by public hospitals in the early 2010s, mostly for “medical” reasons.⁷¹ If any GPs offer medical abortions, this is not widely known. Some private ob/gyns do so, but they require a referral: “the law doesn’t require it, but the hierarchy of the medical services does.”⁷² The women’s health worker quoted above added ongoing ignorance and uncertainty, despite decriminalization, to the account above of Tasmanian doctors’ conservatism and hypocrisy.⁷³ Rural women continue to be disadvantaged; even accessing medical abortion via the Tabbott Foundation may involve a trip to a city for the required ultrasound.

The Tasmanian Act established safe access zones around clinic premises to protect patients and staff from protesters. In the wake of this Tasmanian initiative, both the ACT Assembly and the Victorian parliament passed similar safe access zone legislation.⁷⁴

Northern Territory

The Northern Territory is the fourth Australian jurisdiction to decriminalize abortion. The Northern Territory covers a large area, more than six times the size of Britain, but has a population of just 245,000 people, 30% of whom are Indigenous. ALP government Health Minister Natasha Fyles’ reform bill passed through the Northern Territory Legislative Assembly in March 2017, and as of June 2017 is not yet enacted. Decriminalization comes after more than four years of campaigning and was achieved with the help of strong community support and the equal presence of women and men in the assembly.⁷⁵ Until the new law is enacted, the 1973 law reform applies. Provision since 1973 has been

mainly in the two large public hospitals, in Darwin and Alice Springs, and so the Northern Territory is an exception to the national rule of predominantly private provision. It is, however, vulnerable to dependence on small numbers of willing medical personnel. There is currently no access to medical abortion.⁷⁶ While abortions performed at the public hospitals incur little or no cost, access is particularly compromised for Indigenous women in remote communities and others who must travel significant distances to a hospital.

The new act will remove abortion from the criminal law, except a new section is added that makes the provision or procurement of an abortion by a non-medical person an offense. It imports some of the restrictive provisions of the 1973 law, although only one doctor, not two, is now required to decide on an abortion up to 14 weeks.⁷⁷ Arguably the most significant change will follow from the combination of the removal of the two-doctor rule and the removal of the requirement that abortion be performed in a hospital. Commentators are stressing the increased access women will have to early medical abortion “in general medical practices, health clinics and home settings.”⁷⁸

Discussion

Decriminalization in four jurisdictions in Australia puts in place principles that should, in theory, enable movement towards the improvement of all women’s access to abortion. It is important to acknowledge, however, that only one of these jurisdictions (the Australian Capital Territory) has achieved full decriminalization. In the other decriminalized jurisdictions, a new criminal offense applies to a person (not the woman) who is not a medical practitioner who performs an abortion. (This includes administering a drug). Further, requirements that were in the previous criminal law in the Australian Capital Territory and Northern Territory and entirely new ones regarding upper time limits in Victoria and Tasmania have been put into new law specifically about abortion. The continued requirement in all decriminalized jurisdictions that only doctors can perform abor-

tions, and in the Australian Capital Territory that abortions must be performed in approved premises, impedes the development of innovative ways in which early medical abortion, and other new technologies, might address the needs of women in regional and remote areas or in any primary health care setting. This continued exceptional status of abortion, not for clinical reasons, is evidence of the stickiness of moral discourse in relation to abortion and of the grip that medical authority has on this aspect of women's reproductive lives.

On the other hand, in legislating for safe access zones and, except in the Australian Capital Territory, requiring that doctors who have conscientious objections must provide women with information about doctors who do not, decriminalization contributes directly to the facilitation of timely and easeful access to abortion services. These measures will be most significant for clinics which have been the target of protesters and in rural areas, for example, where conservative doctors may hold sway. The comments from Victorian abortion experts about institutional use of the conscientious objection clause to avoid providing abortions is concerning and demonstrates the malleability of law as a cultural norm.

Fifteen years have passed since the Australian Capital Territory decriminalized abortion, and the provision of abortion has been stable there since 2004. The benefits delivered by decriminalization have been realized. They do not include a public hospital service, so all women have to pay. Perhaps it is too soon to assess the effects of decriminalization in Tasmania, another small, and conservative, place, or even Victoria. The decline in public hospital services in Victoria, presumably for systemic reasons internal to individual hospitals, has been coincidental with decriminalization but cannot be attributed to it. The decline in private clinics in Tasmania is also coincidental with, not caused by, decriminalization. It is, however, arguable that if there is no immediate positive change after decriminalization then the impetus of activist organization, government responsiveness (if it was present), and community awareness could be wasted. Certainly, the political climate in Tasma-

nia since 2014 has halted any further progressive change. Whether future ALP governments will intervene to improve women's access to abortion in that state will be a matter of community pressure, and any such future mobilization will start from scratch. The rewards of ongoing activism and advocacy in Victoria are clear in the increase in the availability of early medical abortion, including in some rural areas, and the government's first women's sexual and reproductive health strategy. Decriminalization may have smoothed the way for these developments but they are not its direct effects.

The new Victorian women's health strategy rightly focuses on the rollout of medical abortion as the best method to address poor access to abortion services, especially in rural areas (although this should not be to the detriment of access to surgical abortion).⁷⁹ Indeed, the slow but perceptible growth particularly since 2013 in the provision of medical abortion by GPs is the most promising factor in addressing the problem of the inadequacy of women's access to abortion in Australia.⁸⁰ The availability of medical abortion nationwide was due to MSIA's initiative and investment. The development of telehealth as a mode of delivery for medical abortion is also an initiative of a private sector health provider. Notably, the Tabbott Foundation delivers medical abortion to New South Wales, Queensland, and Western Australia, jurisdictions where abortion is still defined in the criminal law. That is, in jurisdictions where there is no hospital requirement, this innovation has not depended on decriminalization. There are limits, though, to what the private sector can deliver. As Baum and Dwyer state, "health is essentially a public good, where market principles do not work."⁸¹ Oversight and coordination, better public hospital provision, awareness raising among doctors and the general community and training of possible providers are all the domain of state governments.

Conclusion

Only in cases where the law was a specific impediment to the provision of abortion services, rather than a potentially threatening general atmosphere, can it be stated without qualification that decrim-

inalization has improved access. This was clearly the case in the Australian Capital Territory in the removal of the 72-hour waiting period, and will be so in the Northern Territory when abortions are no longer required to be performed in a hospital and only one doctor is required. On the other side of the coin, there is a risk when decriminalization creates change in a jurisdiction where abortion is provided predominantly by the public hospitals. If GPs, community-based health agencies, and the Tabbott Foundation begin to offer medical abortion in the Northern Territory, the hospitals might decide to pull back their surgical services, leaving women with less choice of procedure and having to pay. The removal of the two-doctor rule up to 16 weeks in Tasmania solves the second signature problem, but it will contribute to improved access only if GPs start to offer medical abortions.

The effect of the symbolism of decriminalization and the legal clarity it brings to abortion providers is harder to measure. While it makes current providers more comfortable, it has not yet motivated a significant number of doctors in Victoria or Tasmania who are not already committed. The idea that decriminalization will engender a slow process of attitude change that will eventually create greater willingness among doctors to become abortion providers assumes a liberal model of change that does not account for the multiple factors that shape doctors' motivations and their institutional and professional environments. Further, it begs the question of how to establish a period of time over which any attribution of change to decriminalization could be measured. It has not occurred significantly in Victoria after seven years. In any case, government policy and program initiatives are needed to capitalize on the safety delivered by decriminalization. The broader political climate, which Rebecca Albury claims was as much responsible for liberalization in the 1970s as was legal change, is relevant here.⁸² The neoliberal political mood and approach to policy that prevails in 21st century Australia is not fertile ground for the action required to improve access to abortion services. On the other hand, decriminalization makes no demands on the predominantly privatized model of service provision

that prevails in the Australian Capital Territory, Victoria, and Tasmania.

The value in adopting Rachel Rebouché's suspension of the assumption that law has any particular relationship with health outcomes is that it demands a fine-grained account of the specificity of whether and how state or territory law has obstructed access to abortion and what has worked, or might work in the future, to deliver better access.⁸³ This recalibrates the horizons of change beyond any simple faith in decriminalization. It brings into view a variety of mutually shaping forces which can rebalance in relation to each other when change is initiated in any one sphere. In the Australian case, this includes the law along with private-sector clinics, GPs, and specialists in private practice (all vulnerable to market logics), public hospitals, government health departments, health ministers, not-for-profit sector agencies, and community activists and advocates. This article shows that while solutions to problems can come from all quarters, it is the last group to whom the responsibility for keeping improved access to abortion at the forefront of the public agenda will inevitably fall.

References

1. K. Petersen, 'Decriminalizing abortion - the Australian experience,' in S. Rowlands (ed), *Abortion care* (Cambridge: Cambridge University Press, 2014), pp. 236, 242.
2. *Ibid.*, p. 236.
3. K. Betts, "Attitudes to abortion: Australia and Queensland in the twenty-first century," *People and Place*, 17/3 (1999), pp. 25-39.
4. M. Davis, "Neoliberalism, the culture wars and public policy," in C. Miller and L. Orchard (eds), *Australian public policy: Progressive ideas in the neoliberal ascendancy* (Bristol: Policy Press 2014), pp. 27-42.
5. F. Baum and J. Dwyer, "The accidental logic of health policy in Australia," in C. Miller and L. Orchard (eds), *Australian public policy: Progressive ideas in the neoliberal ascendancy* (Bristol: Policy Press 2014), pp. 187-208.
6. R. Rebouché, "A functionalist approach to comparative abortion law," in R. Cook, J. Erdmann, and B. Dickens (eds), *Abortion law in transnational perspective* (Philadelphia: University of Pennsylvania Press 2014), pp. 101, 112, 116.
7. IPPF, *How to talk about abortion: A guide to rights based messaging*, (London: IPPF, 2015).
8. National Health & Medical Research Council

(NHMRC), *An information paper on termination of pregnancy in Australia* (Canberra: AGPS, 1996), pp. 49-51.

9. R. Albury, *The politics of reproduction: Beyond the slogans* (Sydney: Allen & Unwin, 1999), p. 122, pp. 10-11.

10. NHMRC (see note 8); L.A. Keogh, D. Newton, C. Bayly et al., "Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia," *Journal of Family Planning and Reproductive Health Care* 43 (2017), p. 21.

11. R. Albury (see note 9), pp. 12-124, p. 112; M. Shankar, K.I. Black, P. Goldstone et al, "Access, equity and costs of induced abortion services in Australia: a cross-sectional study," *Australian and New Zealand Journal of Public Health Online* (2017), pp. 3-4.

12. B. Baird, "Medical abortion in Australia: a short history," *Reproductive Health Matters* 23/46 (2015), pp. 169-176.

13. Shankar et al (see note 11), p. 5.

14. Baird (see note 12).

15. P. Hayes, "I know it's selfish but ...: Public language and unplanned pregnancy decision-making in an anti-choice landscape," *Women Against Violence*, 19 (2007), pp. 27-36; M. Ripper, "Abortion: the shift in stigmatization from those seeking abortion to those providing it," *Health Sociology Review* 10/2 (2001), pp. 65-77.

16. M. Maddox, *God under Howard: The rise of the religious right in Australian politics* (Sydney: Allen & Unwin, 2005).

17. C. Johnson, "The ideological contest," *Australian Cultural History* 28/1 (2010), pp. 7-14; C. Johnson, "Gillard, Rudd and Labor Tradition," *Australian Journal of Politics & History* 57/4 (2011), pp. 562-579.

18. H. Pringle, "Urban mythology: The question of abortion in parliament," *Australasian Parliamentary Review* 22/2 (2007), pp. 5-22.

19. See 3101.0 - Australian Demographic Statistics, Sep 20. Available at <http://www.abs.gov.au/ausstats/abs@nsf/mf/3101.0>; Area of Australia - States and Territories. Available at <http://www.ga.gov.au/scientific-topics/national-location-information/dimensions/area-of-australia-states-and-territories>.

20. L. Cannold and C. Calcutt, "The Australian Pro-Choice Movement and the struggle for legal clarity, liberal laws and liberal access: Two case studies," in B. Klugman and D. Budlender (eds), *Advocating for abortion access: Eleven country studies* (Johannesburg: School of Public Health, Women's Health Project, University of Witwatersrand, 2001), pp. 46-57.

21. Ibid., p. 57.

22. Interview with Julie conducted by the author in Melbourne, July 2015, p. 9.

23. Cannold and Calcutt (see note 20), p. 57.

24. Petersen (see note 1), p. 240.

25. Australian Capital Territory Acts, *Health Act 19* Part Abortions. Available at <http://www.austlii.edu.au/au/legis/>

[act/consol_act/ha199369/](http://www.austlii.edu.au/au/legis/act/consol_act/ha199369/).

26. Interview with Julie (see note 22), p. 8.

27. Ibid., p. 8; see also G. Gray, *Reaching for health: The Australian women's health movement and public policy* (Canberra: ANU E Press, 2012), p. 204.

28. HIH Insurance Group Collapses. Available at http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/hihinsurance.

29. Interview with Julie (see note 22), pp. 6-7.

30. Ibid., p. 10

31. S. Allanson, *Murder on his mind: The untold story of Australia's abortion clinic murder* (Melbourne: Wilkinson Publishing, 2006).

32. See the Annual Reports of FPA ACT (from 2002 Sexual Health and Family Planning ACT (SHFPACT)). Available on application from SHFPACT. <http://www.shfpact.org.au/>.

33. Interview with Julie (see note 22), p. 13, p. 7.

34. The Tabbott Foundation. Available at <http://www.tabbot.com.au>.

35. Hospitals in Canberra. Available at [https://www.accesscanberra.act.gov.au/app/answers/detail/a_id/1859/~hospitals-in-canberra](https://www.accesscanberra.act.gov.au/app/answers/detail/a_id/1859/~/hospitals-in-canberra)

36. J. Morgan, "Abortion law reform: The importance of democratic change," *UNSWLJ* 35 (2012), pp. 146-147.

37. NHMRC (see note 8); Victorian Law Reform Commission, *Law of Abortion. Final Report* (2008), pp. 34-

38. Gray (see note 27), p. 205.

39. Morgan (see note 36), p. 158.

40. Victorian Current Acts. *Abortion Law Reform Act 20* Available at http://www.austlii.edu.au/au/legis/vic/consol_act/alra2008209/.

41. Morgan (see note 36), p. 161.

42. Ibid., pp. 161-1

43. Keogh et al (see note 10), pp. 18-24.

44. Interview with June and Bree conducted by the author, April 2013, pp. 9-10.

45. Ibid., p. 17.

46. Keogh et al (see note 10).

47. Interview with Phyl conducted by the author in Melbourne, July 2015, p. 28.

48. Keogh et al (see note 10), p. 21.

49. Interview with Phyl (see note 47), p. 29; see also Keogh et al (see note 10).

50. Keogh et al (see note 10), pp. 21-22.

51. J. Stark, "Hospitals clamp down on abortions," *Age* (March 24, 2013). Available at <http://www.theage.com.au/action/printArticle?id=4135388>.

52. Interview with Phyl (note 47), p.

53. Keogh et al (see note 10), p. 21.

54. Women's Health Association of Victoria (WHAV), Proposal for: Victorian Sexual and Reproductive Health Strategy (nd). Available at <http://www.cersh.com.au/>

wp-content/uploads/2014/09/WHAV-proposal-for-Victorian-Sexual-and-Reproductive-Health-Strategy.pdf.

55. Interview with Evie conducted by the author in Melbourne, April 2013, p. 20, p. 4.

56. Keogh et al (see note 10), p. 22.

57. W. Rogers, "What should we do about sex selective abortion," *The Conversation* (29 October 2013). Available at <https://theconversation.com/what-should-we-do-about-sex-selective-abortion-19292>; J. Woodhead, "Tell him he's dreaming: Geoff Shaw and abortion," *Overland* (May 9, 2014). Available at <https://overland.org.au/2014/05/tell-him-hes-dreaming-geoff-shaw-and-abortion/>.

58. Baird (see note 12), p. 173.

59. Keogh et al (see note 10), p. 21.

60. State of Victoria, Department of Health and Human Services, *Women's Sexual and Reproductive Health. Key Priorities 2017-20* (Melbourne: Victorian Government, 2017). Available at <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/womens-sexual-health-key-priorities>.

61. B. Baird, "The futures of abortion," in E. McMahon and B. Olubas (eds) *Women making time: Contemporary feminist critique and cultural analysis* (Perth: UWA Press, 2006), pp. 128-129.

62. Interview with Louella conducted by the author in Melbourne, April 2013, p. 9.

63. Interview with Hilda conducted by the author in Hobart, April 2013, p. 20.

64. Interview with Louella (see note 62), p. 15.

65. *Ibid.*, p. 15.

66. Interview with Rosalie conducted by the author in Melbourne, April 2013, p. 30, p. 29.

67. Interview with Louella (see note 62), pp. 19-24.

68. Tasmanian Numbered Acts. *Reproductive Health (Access to Terminations) Act 2013 (No. 72 of 2013)*. Available at http://www.austlii.edu.au/au/legis/tas/num_act/rhhta20137202013481/; R. Sifris, "Tasmania's Reproductive Health (Access to Terminations) Act 2013: An analysis of conscientious object to abortion and the 'obligation to refer,'" *Journal of Law and Medicine* 22 (2015), pp. 900-914.

69. Interview with Petra conducted by the author in Hobart, January 2017, p. 20, p. 3.

70. M. Smith, "Fears raised as one of Hobart's two abortion clinic [sic] closes," *Mercury* (July 18, 2014). Available at <http://www.themercury.com.au/news/tasmania/fears-raised-as-one-of-hobarts-two-abortion-clinic-closes/news-story/34dd8bfdcoe23bc8dfd44ee5f399e077>; E. Baker, 'Launceston abortion centre to close,' *Examiner* (May 10, 2016). Available at <http://www.examiner.com.au/story/3899702/abortion-centre-to-close/>; The Tabbott Foundation (see note 34).

71. Smith (see note 70).

72. Interview with Petra (see note 69), p. 4.

73. *Ibid.*, p. 6.

74. Australian Capital Territory Acts (see note 26); Victorian Current Acts, Public Health and Wellbeing Act 20 Available at http://www.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/.

75. S. Belton, "Decriminalisation in the NT signals abortion is part of normal health care," *The Conversation* (24 March 2017). Available at <https://theconversation.com/decriminalisation-in-the-nt-signals-abortion-is-part-of-normal-health-care-74992>.

76. S. Belton, C. De Costa, and A. Whittaker, "Termination of pregnancy: A long way to go in the Northern Territory," *MJA* 202/3 (February 16, 2015).

77. Northern Territory of Australia. *Termination of Pregnancy Law Reform Act 20* Available at <http://www.austlii.edu.au/au/legis/nt/bill/toplr2017373/>.

78. Belton (see note 75).

79. Keogh et al (see note 10), p. 23.

80. Baird (see note 12).

81. Baum and Dwyer (see note 5), p. 1

82. Albury (see note 9), pp. 10-11.

83. Rebouché (see note 6), p. 117.