

An analysis of some of the questions placed on notice in Federal Parliament by National Party Senator Ron Boswell and their respective responses

On 31 January 2005, Senator Ron Boswell asked the Minister for Health and Ageing, Hon Tony Abbott MP, upon notice, to provide answers to a number of questions related to terminations of pregnancy in Australia. The answers were due for tabling in the Federal Parliament on 2 March 2005, and were publicly available in the Hansard from 10 May 2005.

This paper restates some of the more contentious questions, quotes partially the responses given by Senator Kay Patterson, on behalf of the Minister for Health and Ageing, and provides evidence-based research available to the broader public, which gives more accurate answers and constitutes some of ARHA's input into the public debate. Senator Boswell's questions and Senator Patterson's responses are available at the Parliament's website:

http://parlinfoweb.aph.gov.au/piweb/translatewipilink.ASPX?Folder=HANSARDS&Criteria=DOC DATE:2005-05-10;SEQ_NUM:116

Question 1: How many abortions are carried out each year in Australia in the private and public health sectors in the different states and territories?

Answer to Senator Boswell: "There is no single authoritative or complete data source on terminations of pregnancies in Australia. This means that it is not possible to give a precise number of terminations each year. It is possible however to combine data from a number of sources to provide an estimate of the number of terminations each year. Based on data available to the Department of Health and Ageing, it is estimated that approximately 90,000 terminations of pregnancy procedures were carried out in Australia in 2003-04."

Comment: The figure of 90,000 abortions across Australia in 2003-04 is based in this response on a combination of data: the National Morbidity Data Set (NMDS) and Medicare Benefits Schedule (MBS) claims. Senator Patterson's response outlines the process of data collection for each data set and some of the difficulties associated with them as well as the problems associated with each collection process.

Research published by the Parliamentary Library contains further qualifications that are not given in the response to Senator Boswell. These include:

- Although more accurate than Medicare data, the first set of problems with NMDS data “relates to extrapolating conclusions about numbers of abortion procedures from data about diagnoses”. This means that a patient may be recorded as having a principal diagnosis of ‘medical abortion’ upon admission, but the termination is not carried out. It may also be the case that a patient is readmitted to hospital for follow-up treatment after having an abortion. In these cases, NMDS data may overstate the number of recorded ‘medical abortions’.¹
- The quality of coding for abortion – that is categories of ‘medical abortion’, ‘unspecified abortion’, ‘failed attempted abortion’ and ‘other abortion’ – has never been assessed on a national level, and is provided by the states and territories. This coding is not uniform across the Australian jurisdictions. The parliamentary researchers conclude that “in the absence of such an evaluation, we have no information about how accurately or faithfully the abortion descriptors within the database are used by practitioners”.²
- The number of Medicare claims for the medical procedures which may *result* in an abortion is not the same as the number of ‘Medicare-funded abortions’, commonly cited in the public circles, particularly the media. The Medicare data includes claims for procedures such as those undertaken in the case of miscarriage or fetal death, or other gynaecological conditions that are not necessarily related to pregnancy. Therefore, Medicare claims data for these procedures “includes claims which are not pregnancy terminations per se”. According to estimates given by a number of expert medical practitioners, including Dr Andrew Pearce, the Australian Medical Association’s obstetrics and gynaecology spokesperson, “the number of abortions funded by Medicare each year could range from around 20,000 to around 65,000”.³

South Australia is the only jurisdiction which both collects and routinely publishes comprehensive data on abortions, and this data is sometimes quite sensibly used to calculate national estimates of abortion rates. In 2002 there were approximately 17.2 pregnancy terminations for every 1,000 women between 15 and 44 years of age, performed in South Australia. “If this rate were replicated in the total Australian population of women aged 15-44 (the so-called ‘fertile age range’) for the same period,

¹ Angela Pratt, Amanda Biggs and Luke Buckmaster, *How Many Abortions are there in Australia? A Discussion of Abortion Statistics, Their Limitations, and Options for Improved Statistical Collection*, Research Brief no.9, Parliamentary Library of Australia, February 2005, pp.7-8, emphasis original.

² *How Many Abortions are there in Australia?*, p.8.

³ *How Many Abortions are there in Australia?*, p.5.

there would have been approximately 73,300 abortions in Australia in 2002”.⁴ Complete South Australian data for 2003-04 is still unavailable.

Question 2: (a) Does the department have access to reliable information on the percentage of pregnancies that end in abortion in Australia; and (b) what is the department’s estimate?

Answer to Senator Boswell: “The Department does not have access to reliable information on the percentage of pregnancies that end in abortion in Australia. However, it is possible to construct an estimate of the total number of pregnancies each year and express the estimated number of abortions as a percentage of that total number.”

Comment: Senator Patterson’s response provides two different estimates. The first estimate of 22% of pregnancies that end in termination is derived from academic research published in the journal *Gynaecology*. The second estimate of 19% is calculated using a methodology outlined in the Senator’s response. ARHA cautions against formulating judgments about the abortion rates in the context of unavailable, incomplete and potentially misleading data sets and tenuous (at least for the purposes of providing response to Senator Boswell) collection processes.

South Australian data – perhaps the most reliable in the country – when projected on the rest of Australia, shows that the abortion rate is about 17.2 of terminations for every 1,000 women aged from 15 to 44.

The Public Health Association of Australia (PHAA) quotes the 2003 Australian Study of Health and Relationships: the survey of a large representative sample of Australian women aged between 16 and 59, found that nearly one in six – or 17% – had had an abortion.⁵

The world-wide abortion rate is 35 per 1,000 women aged 15 to 44. International researchers conclude that “abortion rates are no lower overall in areas where abortion is generally restricted by law (and where many abortions are performed under unsafe conditions) than in areas where abortion is legally permitted”.⁶

Question 3: (a) Has the department access to reliable forecasts or predictions of the number of abortions likely in future years; and (b) what is the department’s expectation of Medicare funding allocations required for abortion procedures in the next 10 years?

⁴ *How Many Abortions are there in Australia?*, p. 10.

⁵ Public Health Association of Australia Inc, *Abortion in Australia: Public Health Perspectives*, 2005, p.4;

⁶ Stanley K. Henshaw, Susheela Singh and Taylor Haas, “The Incidence of Abortion Worldwide”, *International Family Planning Perspectives*, vol.25, supplement, 1999, at <http://www.guttmacher.org/pubs/journals/25s3099.html>, accessed on 9 June 2005.

Answer to Senator Boswell: “The Department cannot reliably forecast or predict the number of terminations in future years. Attachment A, which presents the estimated number of terminations each year from 1994-95 to 2003-04, shows an annual count ranging from 84,000 to 94,000. The Department does not prepare estimates of future expenditure on individual MBS items.”

Comment: It is doubtful, for the reasons outlined above, that abortion numbers in Australia currently exceed 80,000 a year. Parliamentary Library research, also cited by the PHAA, shows that the number of Medicare-funded procedures which may result in an abortion has been consistently falling since 2001. The unreliability of data sets, and questions around collection methods, make future forecast of abortion numbers, at best, a highly tenuous exercise.⁷ ARHA believes that public funding used for the purposes of collection data could be better utilized on providing appropriate sex education programs, or improving women’s access to contraception, including emergency contraception. These measures would assist with reducing abortion rates further.

Question 7: Are abortion clinics subject to any form of government accreditation relating to counseling and abortion procedures?

Answer to Senator Boswell: “There is no Australian Government accreditation process for counseling provided in association with termination of pregnancy. The Department is in the process of gathering information from states and territories and professional associations in respect of any accreditation requirements that may apply to counseling and women seeking abortion. However, that information is not available to the Department at this time. Where a procedure is performed in a hospital, the hospital is subject to licensing by individual state and territory governments.”

Comment: Accreditation for counseling provided in association with termination of pregnancy is not and should not be the responsibility of the Federal Government. Abortion provision, legislation, and distribution of funding for health services are all responsibilities of state and territory governments. Abortion-related counseling is provided in some jurisdictions, under the relevant legislation, such as in Western Australia under the *Acts Amendment (Abortion) Act 1998*.

Question 8: (a) How does the department define a ‘late term abortion’; (b) how many late term abortions have been performed in Australia each year for the past 10 years; (c) how many providers of late term abortions are there for the same time period; and (d) what are the statistically significant reasons for late term abortions?

⁷ *How Many Abortions are There in Australia?*, p.7; *Abortion in Australia*, p.3.

Answer to Senator Boswell: “Opinion varies on the definition of ‘late term abortion’. One approach is to define a termination in the third trimester of a pregnancy as a late term abortion. Medicare benefits are not payable for terminations occurring in the third trimester of pregnancy. Another view is that a ‘late term abortion’ is one that occurs after twenty or more completed weeks of pregnancy.”

Comment: The answer to Senator Boswell helpfully gives the number of terminations in hospitals occurring after 20 weeks’ pregnancy and the number of public hospitals providing these termination procedures. ARHA accepts that the data provided is incomplete due to considerable concerns related to the data collection processes, particularly in states like Victoria.

The number of so-named ‘late term abortions’ is comparatively very small. In Western Australia – the state where such procedures are most heavily regulated – there were 107 induced abortions after 20 weeks’ pregnancy between July 1998 and December 2001. This represents 0.37% of the total number of induced abortions performed in the state.⁸

There are reservations related to the use of the term ‘late term abortions’ to identify procedures occurring after 20 weeks’ pregnancy. There is no scientifically approved measure available to suggest that this is an appropriate term. International scientific research suggests that no survival is possible for fetuses born before 22 weeks pregnancy.⁹

Those born at 22 weeks have 1% chance of surviving

- at 23 weeks, 11%
- at 24 weeks 26%.

Severe long-term disability is frequent in premature infants that survive and may be as high as 67% at 23 weeks,

- 38% at 24 weeks, and
- 20% at 25 weeks.¹⁰

Medical practitioners who perform second- or third-trimester abortions are heavily regulated in some Australian jurisdictions. For example, in Western Australia, each woman’s case is considered by a confidential panel of doctors. The only facility allowed

⁸ *Report to the Minister for Health on the Provisions of the Health Act 1911 and the Criminal Code Relating to Abortion as Introduced by the Acts Amendment (Abortion) Act 1998*, Health Department of Western Australia, 2002, p.33, available at <http://www.health.wa.gov.au/publications/documents/ABORTIONREVIEWmaster180602.pdf>, accessed 7 June 2005.

⁹ Dr Ellie Lee, *Late Abortion: A Review of the Evidence*, ProChoice Forum UK, 2004, p.4.

¹⁰ *Late Abortion*, p.4..

to perform these procedures is the King Edward Memorial Hospital. The amended *Health Act 1911* (WA) states, with respect to abortions after 20 weeks of gestation:

If at least 20 weeks of the woman's pregnancy have been completed when the abortion is performed, the performance of the abortion is not justified unless:

- (a) 2 medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgment of those 2 medical practitioners, justifies the procedure; and
- (b) the abortion is performed in a facility approved by the Minister for the purposes of this section.

Question 10: (a) Can the Minister detail the recent history of Commonwealth funding provided to pregnancy counseling services; and (b) can this funding be broken down into services provided by the abortion clinic itself (or affiliated groups) and those provided by 'pro-life' groups and those provided by independent services?

Answer to Senator Boswell: "The Australian Government provides program funding which aims to support a balanced approach to differing family planning service models. These aim to promote responsible sexual behaviour, rather than focusing on one particular strategy or program. This aims to increase choices for women who wish to seek advice from different perspectives."

Comment: There is a large difference between the funding provided to faith-based organizations, such as the Australian Episcopal Conference of the Roman Catholic Church (AECRCC) and funding provided to organizations such as Sexual Health and Family Planning Australia Inc (SHFPA), a national peak body for the Family Planning Organisations. The former will receive \$918,826 in 2004-2005, while the latter will receive only \$100,165 in the same period.

AECRCC promotes only natural family planning to manage fertility, such as the Billings and rhythm methods.¹¹ The SHFPA organisations provide information on natural family planning as well as other methods and have wider community reach.

Question 11: (a) Has there been any research into the impact of mandatory independent pregnancy counseling services on the number of subsequent abortions; and (b) is the Minister

¹¹ 'Top Funding for Natural Family Planning', *Australian*, 8 June 2005.

aware of any Australian institutions where mandatory independent counseling is provided and the impact this has had on the abortion rate.

Answer to Senator Boswell: “There have been some media reports that there has been research in this area. The *Adelaide Sunday Mail* reported (25/7/2004) that the Adelaide Women’s and Children’s Hospital introduced mandatory counseling prior to pregnancy termination in 2003 and that it appeared that the number of terminations was reduced by 25% over a twelve month period. This is the only report that the Department can source in the area of mandatory independent counseling and the impact on the abortion rate.”

Comment: Counseling is one way of ensuring women have a full range of evidence-based information prior to making that decision. Making counseling mandatory may not take into account women’s experiences and knowledge they may already have prior to undergoing termination of pregnancy. Pregnancy counseling in the context of decision-making should commence with respect for women’s capacity to make informed decisions about their health and future. Counseling that is supportive, non-directive and non-judgmental should be available on request by the woman. Mandatory counseling means that the state forces the process on the woman, and may not necessarily be a supportive, non-judgmental move.

Question 15: What would be the cost of including an ultrasound of the foetus as part of the counseling process?

Answer to Senator Boswell: “Based on the number of abortions performed in 2003-04, the average cost to Medicare of including an ultrasound as part of the counseling process would be around \$5 million per annum. This assumes that around 95% of terminations occur in the first trimester with the average cost to Medicare of an ultrasound being \$55.

This does not include women who may currently seek advice in regard to termination but do not proceed. As noted above, this number is unknown.

If the MBS was to be used for this purpose, an amendment to the current items would be necessary to enable the item to be used where there is no clinical indication.

Currently it is not known how many women seek counseling in regard to a pregnancy and consider abortion but then decide to either continue with the pregnancy or miscarry. As many women also have dating ultrasounds as part of the diagnosis of the pregnancy, the number of additional ultrasounds related to counseling may be small and substitute for ultrasounds that are already performed as part of medical management of pregnancy.”

Comment: A decision to view the ultrasound of a fetus as part of making a decision about whether or not to have an abortion should be optional. Ultrasound is already a part of normal medical pregnancy diagnosis, and constitutes an integral part of care in the course of pregnancy.