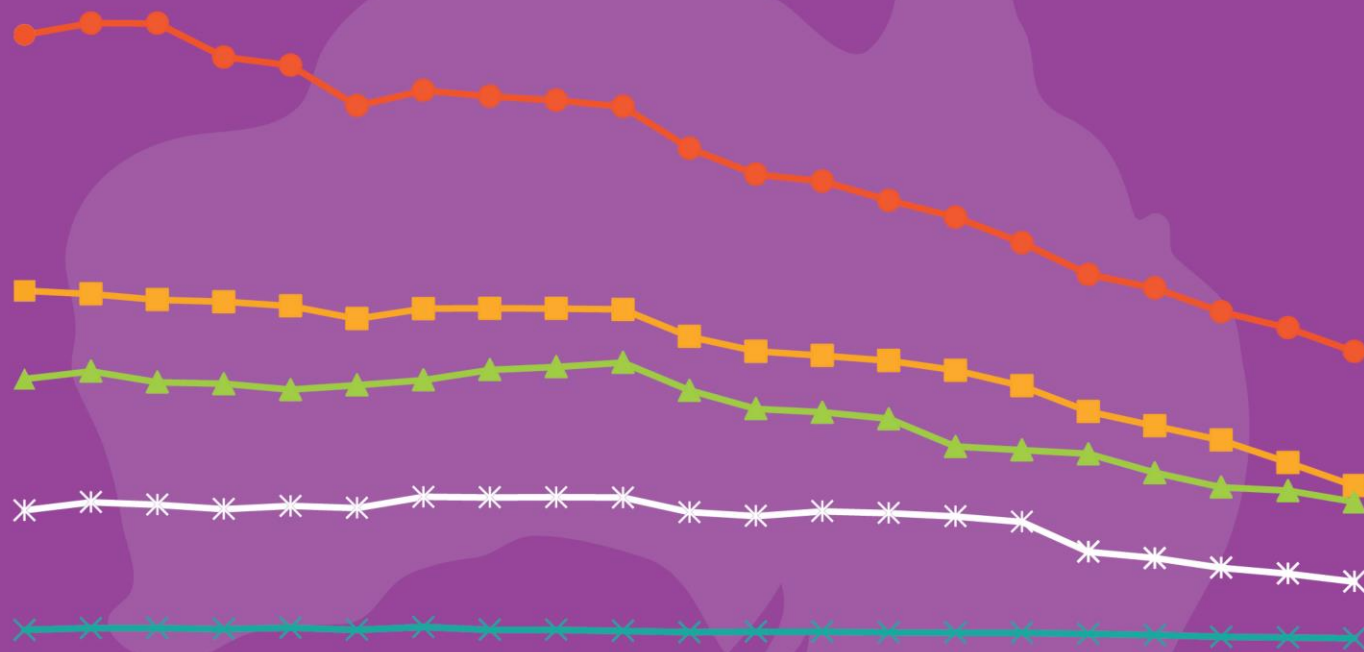


Induced Abortion in Australia: 2000-2020



Publication Information

Induced abortion in Australia: 2000-2020

Published by Family Planning NSW

328-336 Liverpool Road, Ashfield NSW 2131, Australia

Ph. (02) 8752 4300

www.fpnsw.org.au

ABN: 75 000 026 335

© Family Planning NSW 2021

Suggested citation:

Wright, S. M., Bateson, D., & McGeechan, K. (2021). *Induced abortion in Australia: 2000-2020*. Family Planning NSW: Ashfield, Australia.

Acknowledgements:

Authors:

Sarah M. Wright, Research Officer, Family Planning NSW

Deborah Bateson, Medical Director, Family Planning NSW

Kevin McGeechan, Consultant Biostatistician, Family Planning NSW

Internal review:

The production of this document would not have been possible without the contributions of the following members of Family Planning NSW staff:

Dr Yan Cheng, Senior Research Officer, Family Planning NSW

Dr Clare Boerma, Associate Medical Director, Family Planning NSW

Contents

Data used in this report	3
Key indicators	3
Primary data sources	3
Purpose of this report	4
Terms and definitions	4
Data sources and limitations	5
State government abortion notification	5
Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data	5
Estimates and Surveys about abortion access	7
1 Background	10
2 Induced abortion: International comparison	13
3 Induced abortions in Australia	14
3.1 National estimates of induced abortions	14
3.2 MBS and PBS claims for induced abortions	16
4 Induced abortions by state and territory	19
4.1 Induced abortion data from state abortion notification systems	19
4.2 MBS claims for induced abortions by state and territory	20
5 Abortion by gestational age	22
5.1 Abortion at or after 20 weeks' gestation	22
6 Method of abortion	26
7 Induced abortions by age group	27
7.1 MBS claims for induced abortions by age group	27
7.2 Induced abortions by age group in South Australia	29
7.3 Induced abortions by age group in Western Australia	30
8 Induced abortions by area of remoteness	33
9 Induced abortions amongst Aboriginal and Torres Strait Islander people	34
10 Other factors associated with induced abortions	36
11 Discussion	37
11.1 Induced abortions in Australia	37
11.2 Induced abortions by state and territory	37
11.3 Induced abortions by gestational age	37
11.4 Induced abortion by age group	38
11.5 Data development	38
References	39

Data used in this report

Key indicators

- Number of induced abortions
- Rate of induced abortions per 1,000 women aged 15-44 years
- Proportion of induced abortions per known pregnancies (live births plus abortions and miscarriages)
- Rate of induced abortions per 1,000 live births
- Trend in induced abortions

Primary data sources

State government abortion notification data for South Australia, Western Australia, the Northern Territory and Victoria

Government of South Australia. *Pregnancy outcome in South Australia reports (2001-2017)*. Pregnancy Outcome Unit, SA Health.

Government of South Australia (2020). *South Australian Abortion Reporting Committee: Annual Report for the Year 2018*. Pregnancy Outcome Unit, SA Health.

Galrao, M., Hutchinson, M., & Joyce, A. (2019). *Induced Abortions in Western Australia 2016-2018. Sixth Report of the Western Australian Abortion Notification System*. Department of Health, Western Australia.

Hutchinson, M., & Ballestas, T. (2018). *Induced Abortions in Western Australia 2013-2015. Fifth Report of the Western Australian Abortion Notification System*. Department of Health, Western Australia.

Hutchinson, M., Joyce, A., & Cheong, M. (2013). *Induced Abortions in Western Australia. Fourth Report of the Western Australian Abortion Notification System*. Department of Health, Western Australia.

Northern Territory Government (2019). *NT Termination of Pregnancy Law Reform 12 month Interpretive Report*. Department of Health, Northern Territory.

Victoria State Government. *Victoria's Mothers, babies and children reports (2001-2019)*

Online Medicare Benefits Schedule (MBS) data

Online Pharmaceutical Benefits Scheme (PBS) data

Australian Bureau of Statistics:

National, state and territory population.

Population, by age and sex—Australia; Population, by age and sex—States and territories.

<https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release>

Births, Australia.

Fertility, by age, by state [ABS.Stat dataset]

<https://www.abs.gov.au/statistics/people/population/births-australia/latest-release>

Published studies and reports:

Bearak, J. et al. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: Estimates from a comprehensive model for 1990-2019. *The Lancet Global Health*, 9, e1152-e1161. doi: 10.1016/S2214-109X(20)30315-6

Herbert, D., Lucke, J., & Dobson, A. (2009). Pregnancy losses in young Australian women: Findings from the Australian Longitudinal Study of Women's Health. *Women's Health Issues*, 19, 21-29. doi: 10.1016/j.whi.2008.08.007

Rowe, H. et al. (2017). Abortion: Findings from women and men participating in the Understanding Fertility Management in contemporary Australia national survey. *Sexual Health*, 14, 566-573. doi: 10.1071/SH17004

Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E., & de Visser, R. O. (2003b). Sex in Australia: Reproductive experiences and reproductive health among a representative sample of women. *Australian and New Zealand Journal of Public Health*, 27, 204-209. doi: 10.1111/j.1467-842X.2003.tb00809.x

Purpose of this report

- To compare rates of induced abortion between Australia and other countries
- To describe the trends in induced abortion in Australia
- To describe the trends in induced abortion in population subgroups
- To identify areas of data development

Terms and definitions

Abortion	<p>In medical usage, the term <i>abortion</i> refers to the expulsion of the products of conception from the uterus, which includes miscarriage and induced abortion.</p> <p>In this report, the term <i>abortion</i> refers only to induced abortion unless otherwise specified.</p>
Abortion percentage	The number of abortions out of 100 pregnancies (pregnancies include live births, abortions, and miscarriages).
Abortion rate	The number of induced abortions per 1,000 women aged 15-44 years.
Induced abortion	Also referred to as termination of pregnancy, is a medical procedure to end a pregnancy that involves use of medicines or surgery to remove the embryo or fetus from the uterus. Induced abortions exclude spontaneous miscarriages.
Medical abortion	<p>Also referred to as medical termination of pregnancy, refers to the administration of medications for the purpose of ending a pregnancy.</p> <p>RANZCOG guidelines recommend mifepristone (a synthetic anti-progesterone) in combination with misoprostol (a prostaglandin analogue) as the best available regimen for medical abortion.</p> <p>Early medical abortion is approved for use in Australia for pregnancies up to 63 days gestation; until February 2015 it was only approved for pregnancies up to 49 days gestation. Medical abortion is also used in the hospital setting at later gestations.</p>
Miscarriage	Also called spontaneous miscarriage or spontaneous abortion, although the term miscarriage is preferred in clinical settings. Characterised by the loss of a pregnancy before the 20 th week of gestation as a result of abnormalities of the conceptus or maternal environment.
Missed miscarriage	A condition in which an intrauterine death of a fetus is not followed by its immediate expulsion.
Stillbirth	Birth of a fetus at or after 20 weeks gestation, or with a birth weight of 400g or more, with no signs of life at birth. Also called fetal death.
Surgical abortion	Also called surgical termination of pregnancy, is the interruption of a pregnancy by surgical means. In the first trimester, suction curettage is the preferred method and is generally performed as day surgery under sedation. At later gestations surgical termination by dilation and evacuation (D&E) is usually performed.
Women of reproductive age	Women aged 15 to 44 years unless otherwise specified. Rates are calculated using ABS statistics for the total number of women in the age range. This approach means that populations of women that are unlikely to become pregnant are not used, and this is consistent with reporting standards in Australian jurisdictions.

Data sources and limitations

There is no national data collection on the incidence of induced abortion in Australia. The available data on the number of, and indications for, induced abortions are limited. Data on socioeconomic characteristics and the sexual and reproductive health of women who present for abortion are also very limited. This lack of data limits the capacity of governments and local health districts to work toward reducing unwanted pregnancies and to plan and evaluate services for the management of these pregnancies.

State government abortion notification

Legislative requirements in South Australia (SA), Western Australia (WA), Northern Territory (NT), and most recently New South Wales (NSW), require healthcare providers to report details of each abortion performed to each jurisdiction's respective Health Department. However, only South Australia and Western Australia routinely publish data on induced abortions. The most recently reported data is from 2018 for both South Australia (Government of South Australia, 2020) and Western Australia (Galrao et al., 2019). Since significant legislative change regarding abortion in the Northern Territory was enacted in 2017, the Northern Territory Department of Health released a preliminary report providing the first publicly available data on abortion in the Territory (Northern Territory Government, 2019). Similarly, since abortion was decriminalised in New South Wales in 2019, NSW Health requires notification of all abortions, but, as of yet, no data have been made publicly available (NSW Health, 2021).

The reliability of state-level abortion notification data relies on the accurate and timely reporting of abortions from healthcare providers. This may in turn depend on the level of oversight and enforcement of mandatory notification practices at the governmental level, which is likely to differ across jurisdictions. In addition, state-level differences in the type of data collected and the methods for collection may affect the comparability of data between states and territories.

Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data

Surgical abortion

For surgical abortion, the Medicare Benefits Schedule (MBS) data include procedures relating to, but not exclusive to, miscarriage and induced abortion. Until November 2017 these were included under two items:

- Item 35643: Evacuation of the contents of the gravid uterus by curettage or suction curettage.
- Item 16525: Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease.

However, from the 1st of November 2017, item 16525 was removed from the MBS and replaced with the following two items:

- Item 16530: Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation.
- Item 16531: Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation.

The use of MBS data to inform access to surgical abortion services by Australian women presents a number of difficulties. Firstly, the coding of procedures to these items does not provide unique data on induced abortions that are related to unwanted pregnancies as they also count abortive procedures that are performed for other reasons. While the item number 35643 has been used to estimate induced abortions in previous studies (Chan & Sage, 2005; Grayson et al., 2005), this item also applies to missed miscarriage (Bayly, 2005), and trophoblastic diseases such as hydatidiform mole (Commonwealth of Australia, 2005), and may also be used for induced abortions beyond the first trimester. As such, it is possible that differing uses for this MBS item may obscure the data for the purposes of estimating the occurrences of induced abortion. However, this is minimised by the likelihood of the majority of these conditions outside of induced abortion being treated in a hospital setting. These procedures would not attract a Medicare rebate unless treatment is provided in a

private hospital, or as a private patient in a public hospital. Therefore, most of the claims under item 35643 are thought to be for induced abortions (Grayson et al., 2005). The second limitation is that use of this item code to estimate the number of induced abortions may exclude an unknown number of women who receive treatment in private facilities but do not claim a Medicare rebate (Bayly, 2005). There is a similar concern around non-claims for the most recent MBS items 16530 and 16531 (and formerly for 16525), which may be used for surgical abortion beyond 14 weeks gestation. Additionally, these codes are not exclusive to induced abortion procedures, but may be used for uterine procedures performed for a range of reasons, including miscarriage. The third limitation is that solely relying on MBS data presents an even more fragmented view of abortion access in Australia than it did 20 years ago, due to the introduction of medical abortion in 2006, the provision of which has no specific MBS item. This data gap necessitates the use of prescribing data from the Pharmaceutical Benefits Scheme (PBS) to obtain a more complete view of government subsidised abortion care in Australia.

Medical abortion

There is no specific MBS item for the provision of medical abortion. Consultations for the prescribing of medications for induced abortion are coded as non-specific time-based general practitioner attendances (MBS items 3, 23, 36, or 44), non-referred specialist attendances (MBS items 52, 53, 54, or 57), or referred specialist consultations (MBS items 104 or 105).

The WHO endorsed medications used for medical abortion are mifepristone and misoprostol (WHO, 2012). At present in Australia, these medications are dispensed as a composite pack, packaged specifically for medical abortion, known as MS-2 Step, which since 2015 has been subsidised on the PBS under the item code 10211K. Prior to this, mifepristone and misoprostol were listed on the PBS separately. As misoprostol has also been used for other conditions such as gastric ulcers, prescribing rates do not provide unique data on medical abortions. Mifepristone, however, is used exclusively for medical abortion and PBS statistics on the number of prescriptions filled for mifepristone provide a relatively accurate indication of how many induced abortions are carried out using this method. Prescribing data for mifepristone are available from the time it was first added to the PBS in August 2013 under the item code 2710P until 2016, during which time, prescribing codes transitioned to the composite pack. Prior to its approval by the Therapeutic Goods Administration (TGA), mifepristone was available under the Authorised Prescribers Act from 2006, and prescribing statistics up until 2011 are included within the Australian Public Assessment Report (AusPAR) for misoprostol (Therapeutic Goods Administration, 2012b) and the AusPAR for mifepristone (Therapeutic Goods Administration, 2012a). These reports are produced by the TGA to provide information about the evaluation of prescription medications that are approved for inclusion on the Australian Register of Therapeutic Goods (ARTG). AusPARs are static documents that provide information that relates to submissions at the time of assessment. As such, these documents only include mifepristone prescribing data from 2006 up until 2011. Although a further AusPAR was published for the subsequent inclusion of MS-2 Step on the ARTG, this report did not include any further data on mifepristone prescribing (Therapeutic Goods Administration, 2014). As such, where mifepristone prescribing data are used, this is composed of data from the AusPARs between 2006 and 2011, PBS data for mifepristone only (02710P) between 2013 and 2016, and PBS data for MS-2 Step (10211K) from 2015 onwards. This has resulted in a gap in data coverage for 2012, and lower prescribing rates for subsequent years, which may be attributed to continued prescribing through the Authorised Prescriber Scheme, or via private prescriptions which are not captured by the PBS data.

Statistics on current prescribing rates of MS-2 Step at a national level are available from Medicare; however, there are limitations with using PBS data to estimate the number of medical abortions within Australia. Firstly, PBS statistics fail to capture the unknown number of women procuring MS-2 Step using private prescriptions. This is generally the case for those ineligible for rebates under the PBS, such as international students. Secondly, use of PBS statistics may not be useful when looking at the state-based distribution of mifepristone use. In Queensland, for example, the data are artificially inflated because one large pharmacy group supplies

all of the MS-2 Step used by a multi-state provider across its clinics in other states and territories (Children by Choice, 2017). This also results in an underestimation for those states and territories with services delivered by this provider. Finally, there are likely to be irregularities and gaps in the data during time periods where mifepristone transitioned from the Authorised Prescribers scheme onto the PBS, and where there was a changeover period between PBS codes.

Estimates and surveys about abortion access

Several studies have used data from both Medicare and the National Hospital Morbidity Database (NHMD) to estimate the number of induced abortions (Chan & Sage, 2005; Grayson et al., 2005; Laws et al., 2006), as using either dataset alone may result in inaccurate estimates. These studies were conducted before the availability of medical abortion in Australia, therefore the results referred to surgical abortion only. The methods used to combine datasets have varied, and needed to be customised for each jurisdiction to accommodate the varying legislative context in each state, making such estimations time consuming and costly to conduct (Commonwealth of Australia, 2013).

An additional estimate was made more recently as part of a series of global estimates of unintended pregnancy and abortion (Bearak et al., 2020a, 2020c). However, a number of factors may limit the usefulness of this estimate for planning and evaluation purposes. First, this estimate is based on combined data for Australia and New Zealand. Although there is no reason to believe that abortion rates would differ widely between Australia and New Zealand, a combined estimate may present limitations with possible differences, for instance, in abortion access due to variation in rural population across the countries. Second, the Australian data that inform this estimate are indirect estimates available in the scientific literature and official statistics from individual Australian states. When contacted, the government departments who produce the data acknowledged that the data are incomplete. As such, these data were treated as the minimum number of abortions that occurred during the specified time periods, and the true number of abortions was estimated from this. Consequently, the estimation is likely to be less accurate compared to other jurisdictions with more complete data. Third and finally, the estimation of the number of abortions is provided on a scale of millions, which reduces the precision of estimates for countries with small populations including Australia and New Zealand (Bearak et al., 2020b).

As currently available abortion estimates face issues of datedness and methodology that restrict their generalisability to the current trends of abortion access in Australia, data for abortions are generally derived from large sample survey-based studies. These studies include the Australian Longitudinal Study of Women's Health (ALSWH; Herbert et al., 2009; Taft et al., 2019), the Understanding Fertility Management in contemporary Australia national survey (UFM; Rowe et al., 2017), and the Australian Study of Health and Relationships (ASHR; Smith et al., 2003b).

The ALSWH is an Australian longitudinal study that recruits female participants from the Medicare database. The participants are recruited in cohorts (born 1921-1926, 1946-1951, 1973-1978, and 1989-1995), and followed up via postal surveys every three to five years for at least 20 years (Brown et al., 1996; Lee et al., 2005; Loxton et al., 2018). The surveys aim to look at all aspects of women's health, including fertility and induced abortion. The ALSWH is ongoing and data regarding abortion continue to be collected across surveys for cohorts of reproductive age, however, data regarding abortion were last published in 2009.

The UFM was a representative cross-sectional survey investigating how Australians manage their fertility. The survey was distributed to Australian women and men of reproductive age that were registered to vote on the Australian Electoral Roll in 2013. This survey asked how many times they, or them and their partner, had an abortion, as well as additional questions about sociodemographic characteristics and sexual experiences (Rowe et al., 2017).

ASHR is a nationally representative cross-sectional survey initially carried out in 2001/2 to investigate the sexual health of Australian adults by asking questions about a wide range of sexual activity, whether partnered or unpartnered, risky or safe (Smith et al., 2003a). The survey was delivered as a computer-assisted phone survey, with respondents being selected via modified random-digit dialling. Women responding to the survey were asked questions about their fertility, and outcomes of pregnancy for those who had ever been pregnant (Smith et al., 2003b). The ASHR survey was repeated in 2012/13; however, no results on abortion prevalence have been reported. The third ASHR survey will be conducted in 2022.

Limitations and recommendations

Data regarding the number and rate of induced abortions in Australia come from a wide range of sources, each with their own benefits and limitations. Data derived from the MBS and PBS are relatively easy to access and are published every year, providing valuable information about changes in claims over time. These data can also be extracted to compare across demographic variables including age and state or territory of residence. However, these data are neither complete nor comprehensive as they fail to capture subsets of the population who are not eligible for government rebates, and include claims for a number of procedures not related to induced abortion. In addition, the validity of MBS and PBS claim rates as a true measure of abortion rates is affected by a number of factors. For instance, differences in state and territory legislation dictate that abortions may be performed in clinical settings that do not attract healthcare rebates (e.g., public hospitals), and administrative procedures of service providers distort PBS claim rate data at the level of states and territories. Implementation of MBS codes specific for induced abortion may address some of these issues; however, it is likely that some subsets of the Australian population and some clinical settings will continue to be omitted from these data.

Data reports from abortion notification systems tend not to experience the difficulties with completeness and comprehensiveness that MBS and PBS data do. These reports provide data regarding all abortions within their jurisdiction, and tend to include information across a wider range of background variables including clinical setting and method of abortion, gestational age, reason for abortion, indigenous status, parity, and geographic location. However, these data are only collected in some states and territories, and are made publicly available in even fewer. So although the data may be of high quality and are valuable for planning and evaluation purposes, they only provide insights for their respective jurisdictions, which may not generalise to other states and territories. In addition, states such as Western Australia do not publish their reports at regular intervals and produce a single report for multiple time periods, resulting in some data being out-dated by the time of publication. Abortion notification systems represent a valuable opportunity for collecting rich and accurate data about induced abortion in Australia. If timely release of accurate and standardised data can be assured, these data have significant value for planning and evaluation purposes. Coordinated collection and release of similar data for other states and territories would help to present a more complete picture of abortion at a national level.

Estimates and surveys of abortion access can address gaps in existing abortion datasets, particularly at the national level. In general, surveys of abortion access tend to be conducted as part of research projects within universities, which facilitates data collection across geopolitical boundaries created by the regulation and funding of health services at the level of state government. These projects can be tailored specifically to address gaps in the data collected through other means. However, cross-sectional surveys of abortion access tend to provide point prevalence estimates that can date quickly. Ongoing data collection through this method requires ongoing funding, which can be difficult to secure in the long-term. As a result, there are a number of different surveys that evaluate abortion access with varying methodology, which can make it difficult to determine how trends in abortion access change over time. This limitation is addressed by longitudinal studies such as ALSWH, and repeated cross-sectional surveys such as ASHR, which survey participants on a wide variety of health indicators across multiple time points. While this approach can provide information about how abortion access changes over time, the trade-off of collecting data across a multitude of indicators often

results in delays in publication, which reduces the utility of these data for planning and evaluation purposes. Similarly, estimations of abortion rates using pre-existing data such as that conducted by the Australian Institute of Health and Welfare (AIHW) are difficult to undertake as the methodology must be adjusted to account for differences in the data across jurisdictions. Although the AIHW estimate was intended to be conducted on an ongoing basis, it was found to be both a time and resource intensive process, for which federal health funding could not be allocated, and was hampered by difficulties in securing ongoing access to the required datasets (Commonwealth of Australia, 2013).

In summary, although there are a number of data sources for induced abortion in Australia, users must continue to weigh each source's relative strengths and limitations until a comprehensive and accurate national dataset can be developed. Possible pathways towards this end include a coordinated effort to collect and release harmonised abortion data across all states and territories and creation of MBS items specific to induced abortion.

1 Background

Induced abortion is an important health indicator for women of reproductive age. Abortion data inform public health planners about the efficacy of comprehensive sexuality education; the accessibility, uptake, and acceptability of contraception coverage; and potentially also the fertility outcomes of the population (Sifris et al., 2017).

The available data suggest that abortion is a relatively common occurrence, with previous studies indicating that approximately 20-25% of Australian women of reproductive age report having had an abortion in their lifetime (Rowe et al., 2017; Smith et al., 2003b; Taft et al., 2018). Approximately 30% of unintended pregnancies result in abortion. However, induced abortions have also been reported for approximately 15% of intended pregnancies, as induced abortions may also be carried out for medical reasons of the woman and/or fetus including in the case of fetal abnormalities (de Crespigny & Savulescu, 2008; Taft et al., 2018).

Methods of abortion can be broadly divided into two main types: medical abortion, also known as medical termination of pregnancy, and surgical abortion, also known as surgical termination of pregnancy. Medical abortion refers to the administration of medications with the intention of ending a pregnancy. In Australia, this involves the administration of mifepristone (a synthetic anti-progesterone) followed by misoprostol (a prostaglandin analogue) 36-48 hours later. Early medical abortion was approved for use in Australia up to 49 days (7 weeks) gestation until February 2015, after which approval was extended to 63 days gestation (9 weeks). Medical abortion is also used in the hospital setting at later gestations.

Surgical abortion refers to the interruption of a pregnancy via surgical means. In the first trimester, suction curettage is preferred method, and is generally performed as day surgery under sedation. Beyond the first trimester, D&E may be performed, which involves the removal of the products of conception using a curette and forceps. However, many hospitals offer medication abortion at later gestations as skilled surgeons available to perform D&E are scarce.

Provision of abortion in Australia varies across states and territories due to different legislative requirements across jurisdictions. These legislative requirements prescribe what settings abortion can be performed in, under what circumstances, and what information, if any, must be recorded for each abortion performed. Australia has recently undergone a number of important changes, which have affected how abortion is provided, and are likely to further impact provision in the future.

At present in Australia, abortion is available to varying degrees across public hospitals, and the private sector including private clinics, hospitals, and non-government organisations (NGOs). Medical abortion is also available in general practice and other primary care settings, and more recently via telehealth services.

At present, medical abortion is available in general practice and primary care settings across all jurisdictions. However, only doctors who have undertaken the required training through MS Health or who have a specialist qualification can be certified to prescribe MS-2 Step. At the end of 2020 there were 2,841 actively certified prescribers across Australia (MS Health, 2021); however, there is no publicly available list of these doctors, and it is unknown how many doctors have included medical abortion as part of their practice (Children by Choice, 2016).

Up until recently, abortions could only be provided in approved facilities or hospitals in the Northern Territory, Australian Capital Territory and South Australia. These requirements prevented medical abortion from being provided in primary care settings in these jurisdictions. These requirements were first amended in the Northern Territory in 2017 by the Termination of Pregnancy Law Reform Act (Northern Territory Government, 2019). This change allowed certified General Practitioners in the Territory to prescribe MS-2 Step. However, those accessing medical abortion must be within two hours' safe drive of a public hospital, and those living in

rural and remote areas must travel to areas closer to hospitals for the approximately four days required to complete this process (Northern Territory Government, 2018). To facilitate access to abortion services for those in rural and remote areas, the Northern Territory Government operates a Patient Assisted Travel Scheme (PATS) to provide financial support to cover the costs of travel and accommodation for those seeking abortion and their support person (Northern Territory Government, 2018). Despite this initiative, the percentage of Indigenous women accessing surgical abortion in the Northern Territory has increased since 2017, and the gestation at which surgical abortion is provided has also demonstrated a slight increase, which has been attributed to a lack of access in remote communities and/or regulation of access to early medical abortion (Belton et al., 2020). So although PATS increases accessibility of abortion services for many, it is likely that financial barriers are not the only ones faced by those in regional and remote areas.

Similar to the Northern Territory, abortion provision in the Australian Capital Territory was also restricted to 'approved facilities', which limited the number of service providers within the Territory, and restricted the settings in which abortion medications could be prescribed and administered, including via general practice and telehealth. This requirement was removed in 2018 as part of the Health (Improving Abortion Access) Amendment Bill 2018 (Fitzharris, 2018). Lastly, in 2021 South Australia passed the Termination of Pregnancy Bill 2021 which removed the requirement for induced abortions prior to 22+6 weeks to be carried out in approved hospitals, which effectively allowed induced abortions to be provided outside of public hospitals for the first time since it was legalised in 1970.

Decriminalisation of abortion in Queensland in 2018 also resulted in a shift in abortion access. Prior to decriminalisation, there was only very limited access to induced abortion in public hospitals. Since decriminalisation, public hospitals are now required to provide a pathway to access abortion, either through the hospital itself or via partnership with private clinics. However, as yet, not all hospitals have established this pathway (Children by Choice, 2019).

These legislative changes are likely to have affected abortion access up to now, and into the future. For example, increased accessibility of abortion has decreased waiting times in the Northern Territory and resulted in induced abortions occurring at earlier gestations overall, as well shifts towards medical abortions over surgical methods (Belton et al., 2020). While most instances of legislative reform have resulted in increased access to abortion services, there has also been some evidence that legislative change has had little effect on abortion access, or has reduced accessibility. This is the case for Victoria, where abortion was decriminalised in 2008, and while this was seen by clinicians as a positive step, they observed that this had done little to increase access within the state (Keogh et al., 2017). Clinicians identified that, although legislative reform had provided a clear and simple framework for provision of abortions up to 24 weeks' gestation, the lack of supportive policies meant that barriers to abortion access persisted, particularly for abortion beyond 20 weeks (Keogh et al., 2017). In addition, the Victorian reform included a clause regarding conscientious objection of healthcare providers, referred to as Section 8. Section 8 allows clinicians to decline to provide information or perform abortive procedures if doing so contravenes their own moral or religious beliefs. However, the clause requires those exercising this right to refer patients on to another healthcare provider in the same field whom they know does not hold a conscientious objection. This clause may have had the unintended consequence of legitimising the possibility of opting out of providing abortion services, not just for doctors, but for telephone staff in government services, pharmacists, and in some cases, whole institutions (Keogh et al., 2017, 2019). This, combined with reported failures of some clinicians with objections to refer onwards, may have resulted in delays for those trying to access abortion procedures (Keogh et al., 2019). Such delays would likely increase the number of abortions conducted at later gestations, thus also resulting in differences in methods of abortion used, and may also prevent some from accessing abortions entirely (Keogh et al., 2019). However, without access to comprehensive quantitative abortion data, it is difficult to substantiate the effects of these legislative changes beyond the anecdotal evidence provided by frontline healthcare workers participating in these qualitative studies.

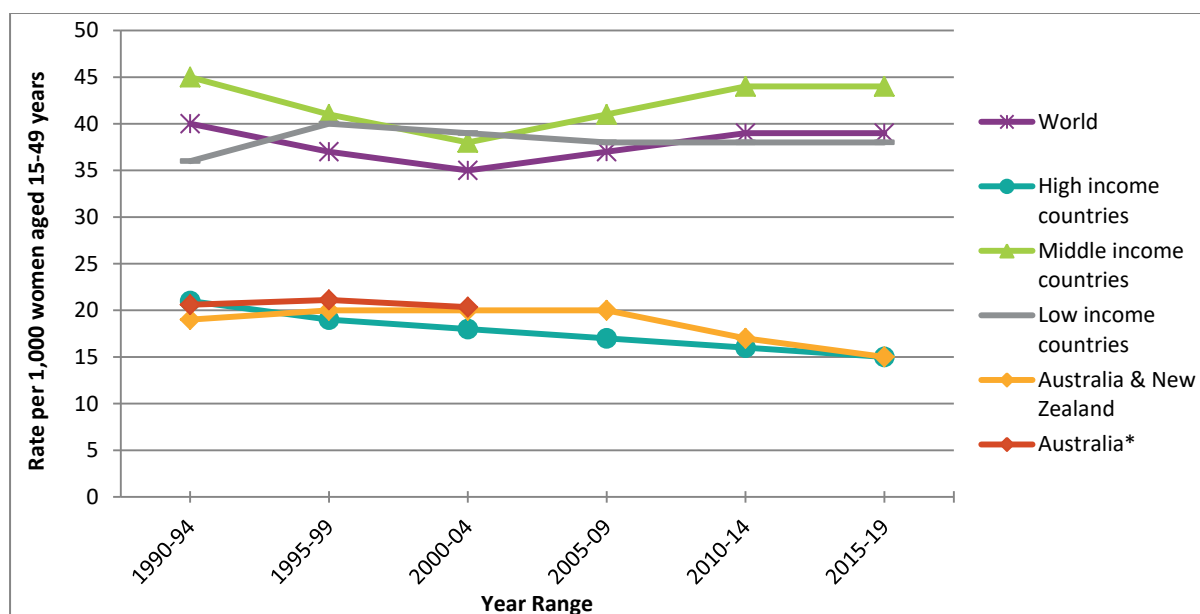
Provision of abortion services in Australia is also affected by access to service providers. For example, while medical abortion is accessible in Tasmania, there is limited availability of surgical abortion through either public hospitals or private gynaecologists, and it is only available up to 14-16 weeks. After this time, induced abortions must be carried out interstate, with clinicians generally referring their patients to services in Victoria (Family Planning Tasmania, 2018; Women's Health Tasmania, 2021). Similarly, there is limited availability of abortions in public hospitals in Western Australia, with less than 7% of all abortions in 2018 occurring in this setting, and almost exclusively in rural areas (Galrao et al., 2019).

2 Induced abortion: International comparison

It is estimated that 73.3 million abortions occurred annually worldwide between 2015 and 2019 (Bearak et al., 2020a). This equates to a rate of 39 abortions per 1,000 women aged 15-49 years, and indicates that approximately 61% of all unintended pregnancies worldwide ended in abortion. The global abortion rate for the period 2015-19 was similar to the rate in 1990-94 (40 per 1,000 women aged 15-49). However, the global abortion rate decreased to 35 per 1,000 women in the period 2000-04 before increasing for each period until 2015-19 (Bearak et al., 2020a).

In the period between 2015 and 2019, the abortion rate was lowest in high income countries (15 abortions per 1,000 women aged 15-49), and highest in middle income countries (44 abortions per 1,000 women). The abortion rate for low income countries was 38 per 1,000 women, which is comparable to the abortion rate worldwide. Abortion rate estimates were calculated for Australia and New Zealand combined, and indicated an abortion rate of 15 per 1,000 women in 2015-19. This rate is consistent with that reported for other high income countries and is less than the worldwide abortion rate. It is estimated that 41% of unintended pregnancies ended in abortion in Australia and New Zealand for the 2015-19 period. This is comparable to 43% of unintended pregnancies in high income countries, and lower than the proportion of unintended pregnancies ending in abortion in middle income countries (66%). Abortion rate estimates specifically for Australia are only available up to 2003 (Chan & Sage, 2005). However, these estimates are very similar to those more recent estimates for Australia and New Zealand and for those of high income countries for the same periods (Bearak et al., 2020a). International abortion rates compared to those for Australia and New Zealand are presented in Figure 1.

Figure 1 International comparison of abortion rates 1990-2019



* For this figure, the average abortion rate for each five-year period was used, with the exception of 2000-04, where only four years were used, as Chan & Sage (2005) did not make abortion rate estimates for 2004.

Sources: International Data – Bearak, J., Popinchalk, A., Ganatra, B., Moller, A.-B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkerna, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: Estimates from a comprehensive model for 1990-2019. *Lancet Global Health*, 8, e1152-e1161. doi: 10.1016/S2214-109X(20)30315-6
 Australian Data – Chan, A. & Sage, L. C., (2005). Estimating Australia's abortion rates 1983–2003. *Medical Journal of Australia*, 182, 447-452. doi: 10.5694/j.1326-5377.2005.tb06783.x

3 Induced abortions in Australia

3.1 National estimates of induced abortions

At present there is no national data collection on the incidence of induced abortion in Australia. As such, the most up to date and comprehensive data available regarding induced abortion at the national level come from survey-based studies including the ALSWH, UFM, and ASHR. However, these data are becoming rapidly out-dated, with the most recent (UFM) being from 2013.

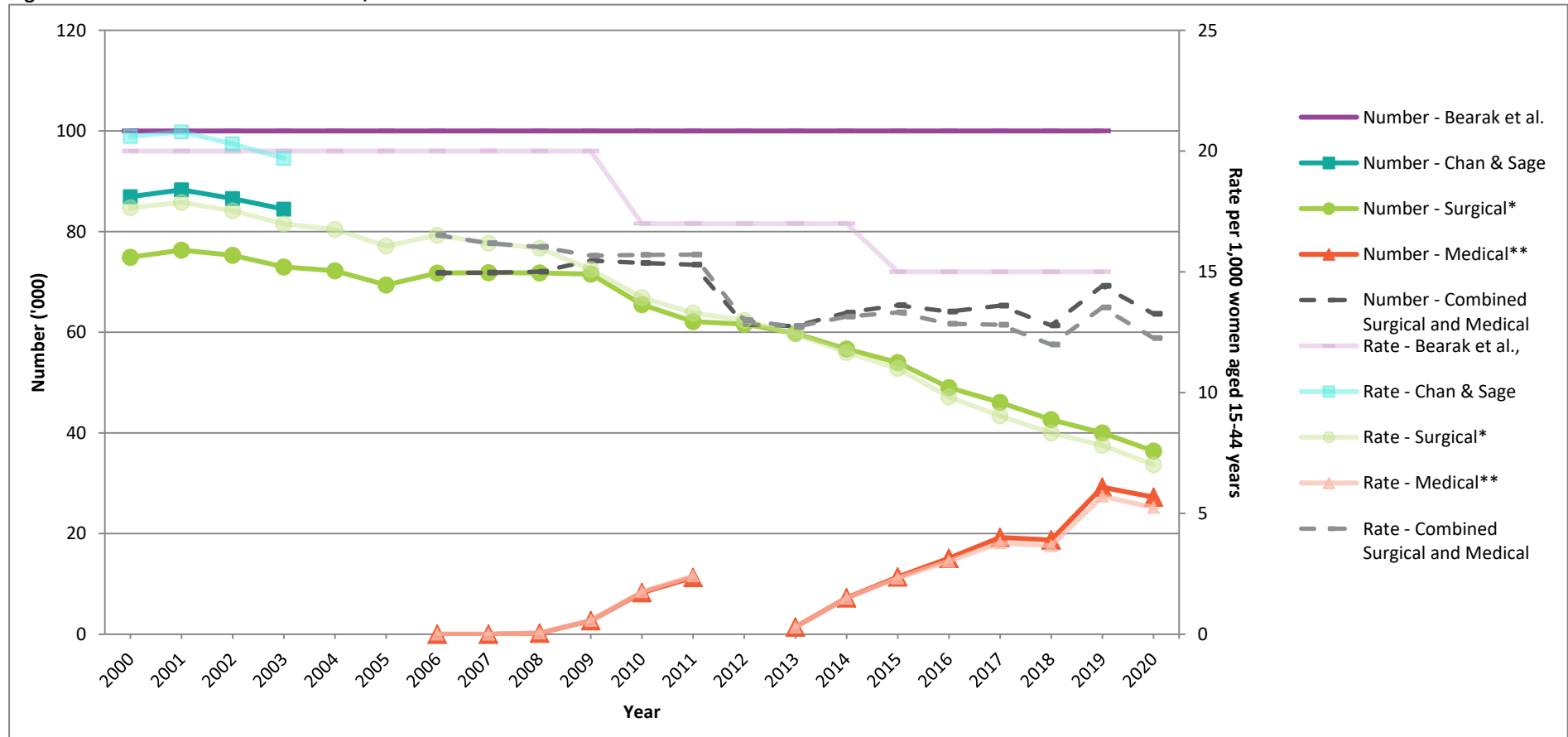
The ALSWH study collected longitudinal survey data from women about their health. Within the cohort of women born between 1973 and 1978, the proportion of respondents who had ever had an abortion increased from 7% at age 18-23 (in 1996) to 16% by the time the women were aged 28-33 years (in 2006; Herbert et al., 2009). The ASHR survey conducted in 2001/2002 reported a higher lifetime proportion of 23% across the wider age range of 16-59 years (Smith et al., 2003b), while the UFM survey, conducted in 2013, indicated that 15.3% of women and 10.1% of men aged 18-50 reported having had, or been a partner in, an abortion (Rowe et al., 2017).

In comparison, Bearak et al., (2020c) report an abortion rate of 19 per 1,000 aged 15-49 for the period 1990-94, followed by an increase to 20 per 1,000 women which was sustained across the two periods 1995-99 and 2000-04 and somewhat comparable to the now out-dated estimation of Chan and Sage (2005). Bearak et al. (2020c) report that the rate remained stable at 20 abortions per 1,000 women for the additional period 2005-09, after which it declined to 17 abortions per 1,000 women for the period 2010-14, and declined further to 15 abortions per 1,000 women for the period 2015-19.

This decreasing trend is somewhat mirrored by the available MBS and PBS claims data for abortion-related procedures (see *Figure 2*). However, the Medicare data demonstrate more variability for each year as compared to the estimation of Bearak et al., (2020c) who made estimates combined for five-year periods. These trends in the MBS and PBS data suggest that claim rates for abortion have somewhat plateaued since 2012, while the estimation of Bearak et al., (2020c) presents a decreasing trend for the two comparable five-year periods covering 2012 to 2019. In addition, Bearak et al., (2020c) estimated the number and rate of abortions for all people in Australia and New Zealand combined, whereas MBS and PBS data only include claims for abortion-related procedures or medications for those in Australia who are eligible for government rebates. As such, MBS and PBS claims data likely represent the lower bound of the number and rate of abortions, and therefore underestimate the true number of abortions in Australia.

Two comprehensive estimates of the number of abortions in Australia were conducted in 2004 (Chan & Sage, 2005; Laws et al., 2006). At this time, the estimated number of induced abortions was over 83,000 (19.3 per 1,000 women aged 15-44; Laws et al., 2006). The number of live births from the same year was over 254,000 (Australian Bureau of Statistics, 2015). This equates to approximately one abortion for every four known pregnancies and was similar to the result from an estimate in 2003 (Chan & Sage, 2005). These data are now of limited use as they fail to reflect recent significant changes in abortion access, including changes to state legislation and the availability of medical abortion, thus highlighting the need for an updated estimate of the number and rate of abortions in Australia. However, when these estimates are viewed in relation to other available data, they provide some insight as to the changing trends in Australians' access of abortion services (see *Figure 2*).

Figure 2 Induced abortions in Australia, 2000 to 2020



Note: *Item 35643 Evacuation of the contents of the gravid uterus by curettage or suction curettage.

** Combined mifepristone prescribing numbers derived from TGA (2012) *Australian Public Assessment Report for Misoprostol*, Table 15. <https://www.tga.gov.au/sites/default/files/auspar-misoprostol-121002.pdf> (2006-2011); PBS item 2710P (mifepristone; 2013-2016); PBS item 10211K (MS-2 Step; 2015-2020).

Sources: Bearak et al., (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: Estimates from a comprehensive model for 1990-2019. *The Lancet Global Health*, 8, e1152-e1161. doi:10.1016/S2214-109X(20)30315-6

Chan, A. & Sage, L. C., (2005). Estimating Australia's abortion rates 1983—2003. *Medical Journal of Australia*, 182, 447-452. doi: 10.5694/j.1326-5377.2005.tb06783.x

Medicare Australia, http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp, accessed May 2021.

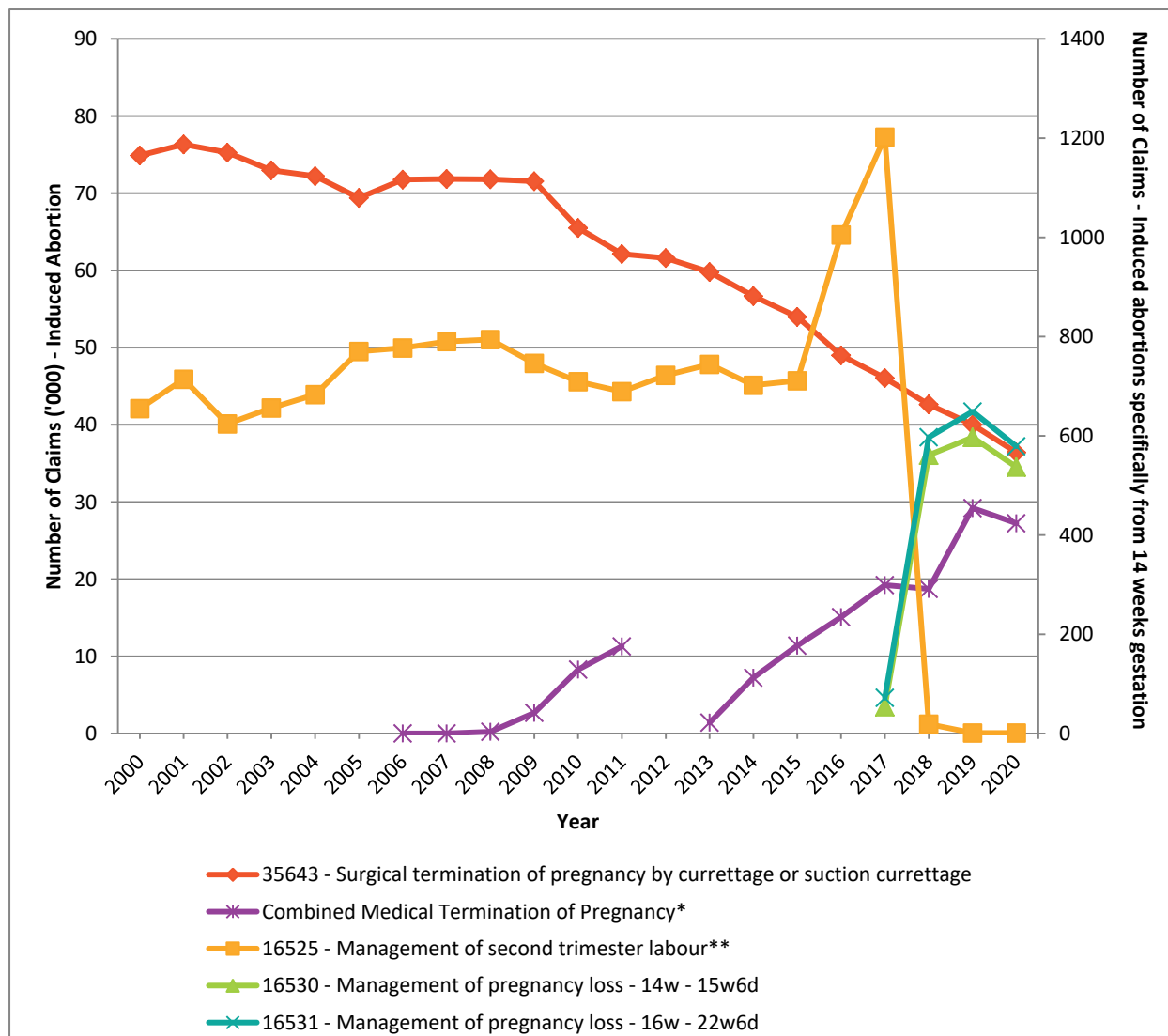
Medicare Australia, http://medicarestatistics.humanservices.gov.au/statistics/pbs_item.jsp, accessed May 2021.

Number of women aged 15-44 years as denominator was downloaded from Australian Bureau of Statistics website: <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release>, accessed May 2021.

3.2 MBS and PBS claims for induced abortions

MBS claims for surgical induced abortions prior to 14 weeks gestation are coded using item 35643. Claims under this MBS code decreased gradually from over 76,000 in 2001 to approximately 71,500 claims in 2009. After this time, claims reduced sharply to approximately 65,000 in 2010 to just over 36,000 claims in 2020 (see *Figure 3*). This represents a decrease of approximately 50% since 2001. This decrease in claims for the MBS item for surgical abortion may be at least partly due to the introduction of medical abortion to Australia in 2006 and its subsequent listing on the PBS in August 2013. Claims for MS-2 Step, used in medical abortion, (PBS code 10211K) increased from just over 1,400 claims in 2014 to over 29,000 claims in 2019, which then reduced to approximately 27,000 claims in 2020.

Figure 3 Number of MBS and PBS claims for induced abortion (primary axis) and abortion specifically from 14 weeks' gestation (secondary axis)



Note: * Combined mifepristone prescribing numbers derived from TGA (2012) *Australian Public Assessment Report for Misoprostol*, Table 15. <https://www.tga.gov.au/sites/default/files/auspar-misoprostol-121002.pdf> (2006-2011); PBS item 2710P (mifepristone; 2013-2016); PBS item 10211K (MS-2 Step; 2015-2020).

** 16525 was discontinued in November 2017 and replaced by items 16530 and 16531

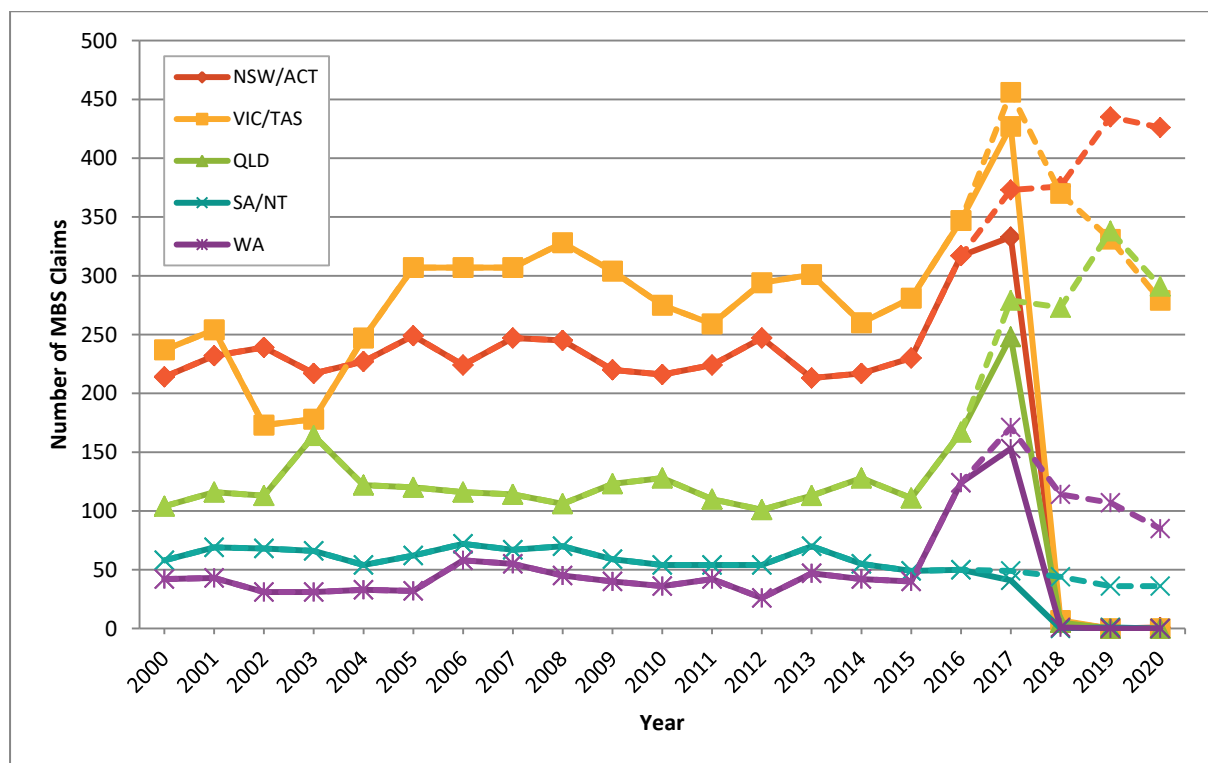
Abortions carried out beyond the first trimester were coded under 16525 until 1st November 2017, after which those abortions occurring between 14 weeks and 15 week 6 days gestation are coded under 16530, and those occurring from 16 weeks to 22 weeks 6 days gestation are coded under 16531. Despite the 2017 cut-off date for 16525, very small numbers of procedures continue to be conducted under this code into 2020 (see *Figure*

3). This change in MBS codes resulted in a significant drop in claims for 16525 from 2017 to 2018, after which claims were then distributed between the two new item codes (16530 and 16531), based on gestational age.

Between 2000 and 2015, the number of claims for the management of second trimester labour remained relatively steady, ranging between 624 claims in 2002 to 794 claims in 2008. However, there was a sharp increase in claims under this code, from 711 claims in 2015 up to 1,005 in 2016, increasing again to 1,202 claims in 2017. Increased numbers of claims were seen for all jurisdictions except for South Australia/Northern Territory (see Figure 4). Of the additional 491 procedures carried out under this code in 2017 compared to 2015, the largest increase was 146 procedures in Victoria/Tasmania followed by 137 in Queensland, and 113 in Western Australia. The reason for this spike in claims is not readily apparent. However, given that these increases are not mirrored in the available data from South Australia, Western Australia, and Victoria regarding abortions at later gestations (see Section 5), this increase is likely to be an artefact of changes in claiming behaviour rather than a true increase in abortions at later gestations. Since claims peaked in 2017 the number of claims at the national level have remained relatively steady, with combined claims for all three codes (16525, 16530, and 16531) ranging between 1,117 and 1,247 in the period 2018-2020. Across states in this same period, claim trends for these codes have decreased in Victoria/Tasmania and Western Australia, and increased in New South Wales/Australian Capital Territory and Queensland.

Figure 4 Number of MBS claims for management of second trimester labour (16525) by state, 2000-2020

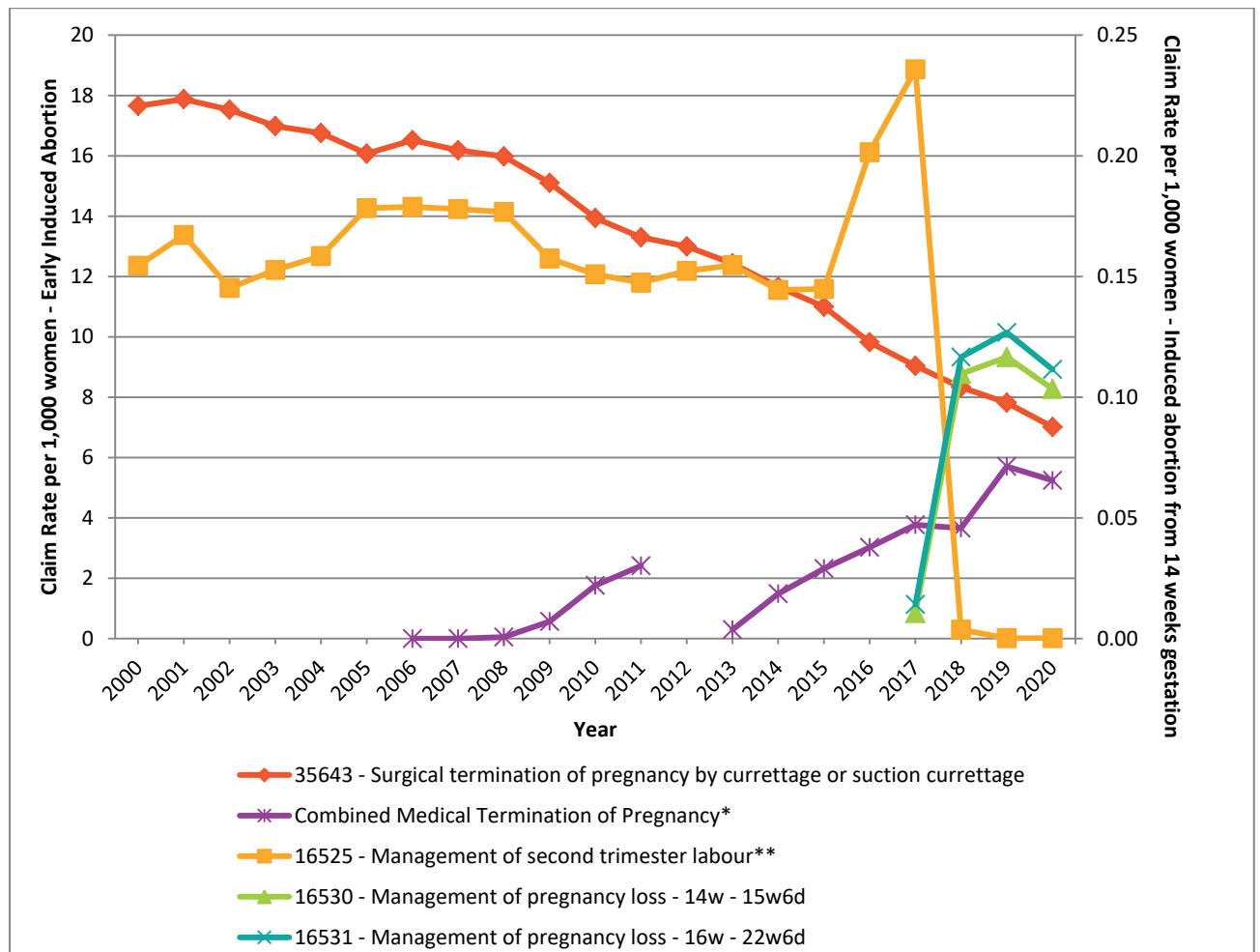
Note: Solid lines represent claims for 16525 only; dashed lines represent combined claims for 16525, 16530, and 16531 from 2017 onwards.



The claim rates for MBS and PBS items associated with induced abortion follow similar trends to that of the number of claims. Claim rates for MBS code 35643 decreased gradually from 17.9 claims per 1,000 women in 2001 to 15.1 in 2009. After this time, the claim rate reduced sharply from 13.9 in 2010 to 7 claims per 1,000 women in 2020 (see Figure 5). Similarly, PBS claims for MS-2 Step under code 10211K increased from 0.29 claims per 1,000 women when it was first listed in 2013 to 5.7 claims per 1,000 women in 2019 and then decreasing to 5.2 in 2020.

Trends in claim rates for procedures associated with abortions from 14 weeks gestation onwards also mirrored that of the number of claims. Claim rates for management of second trimester labour (16525) remained relatively stable between 2000 and 2015, ranging between 0.14 and 0.18 claims per 1,000 women, before rising to 0.20 and 0.24 claims per 1,000 women in 2016 and 2017 respectively. From 2018 to 2020, claim rates for the MBS codes the newly introduced codes were all approximately 0.10 claims per 1,000 women.

Figure 5 MBS and PBS claim rate for induced abortion per 1,000 women aged 15-44



Note: * Combined mifepristone prescribing numbers derived from TGA (2012) *Australian Public Assessment Report for Misoprostol, Table 15*. <https://www.tga.gov.au/sites/default/files/auspar-misoprostol-121002.pdf> (2006-2011); PBS item 2710P (mifepristone; 2013-2016); PBS item 10211K (MS-2 Step; 2015-2020).
 ** 16525 was discontinued in November 2017 and replaced by items 16530 and 16531

4 Induced abortions by state and territory

There are very few empirical studies or estimations available that provide comparisons of the number and rate of induced abortions across states and territories, with the most recent estimation being conducted in 2003 and 2004, prior to medical abortion being introduced into Australia (Grayson et al., 2005; Laws et al., 2006). As such, this section focuses on the available data from the state mandatory notification systems in South Australia and Western Australia, as well as preliminary reporting on abortion from the Northern Territory. This section also reports MBS data for abortion-related procedures by state. However, some variability between states is likely to be due to state-level differences in provision of abortions in the private sector, which utilise MBS claims, and the public hospital system, which does not generally use MBS claiming. Further, although PBS prescribing data for MS-2 Step are available by state, these data are misleading as one large pharmacy group in Queensland supplies MS-2 Step for a multi-state provider across all of its clinics, while processing their prescriptions in Queensland. This results in the number of prescriptions being artificially inflated in Queensland, and underrepresenting prescribing in other states and territories serviced by this provider.

4.1 Induced abortion data from state abortion notification systems

At present, South Australia, Western Australia and the Northern Territory have abortion notification systems which collect information about abortion in their respective states. Data from South Australia are generally produced in a publicly available report each year, whereas data from Western Australia are reported less frequently. At present, the Northern Territory does not routinely produce publicly available reports from their notification system; however, a small amount of information has been released by the Northern Territory government since legislative change was implemented in the Territory in 2017. The available data regarding number of abortions and abortion rates for South Australia and Western Australia are presented in *Figure 6*.

Induced abortion data for South Australia are available from 1970. Here we present the data available for the period from 2000 to 2018. There were 4,415 induced abortions in South Australia in 2018, which equates to 13.4 abortions per 1,000 women aged 15-44 compared to 4,349 abortions in 2017 (13.2 abortions per 1,000 women). The abortion rate in South Australia has been steadily decreasing since 2009 but plateaued in the five years to 2018.

There were 7,816 abortions in Western Australia in 2018. This equates to 14.3 abortions per 1,000 women aged 15-44 years. Although the number of abortions in Western Australia was relatively stable between 2000 and 2018, the rate of abortions has steadily declined since 2006 with a rate of 19.2 abortions per 1,000 women down to 14.3 reported in 2018.

Legislative reform in the Northern Territory in 2017 now requires routine collection of abortion data. While a full report from the Northern Territory government is yet to be released, preliminary data shows that in the financial year ending 30th June 2018, there were 742 induced abortions in the Territory. Of those, 541 (73%) were early medical abortions at or before 9 weeks gestation occurring in a primary healthcare setting. The remaining 201 abortions, comprising 27% of all abortions in the Northern Territory, were carried out in hospitals. In this period, 99% of abortions were conducted at or before 14 weeks gestation, and 73% were at 9 weeks gestation or less (Belton, 2019; Northern Territory Government, 2019).

Figure 6 Induced abortions in South Australia and Western Australia, 2000-2018



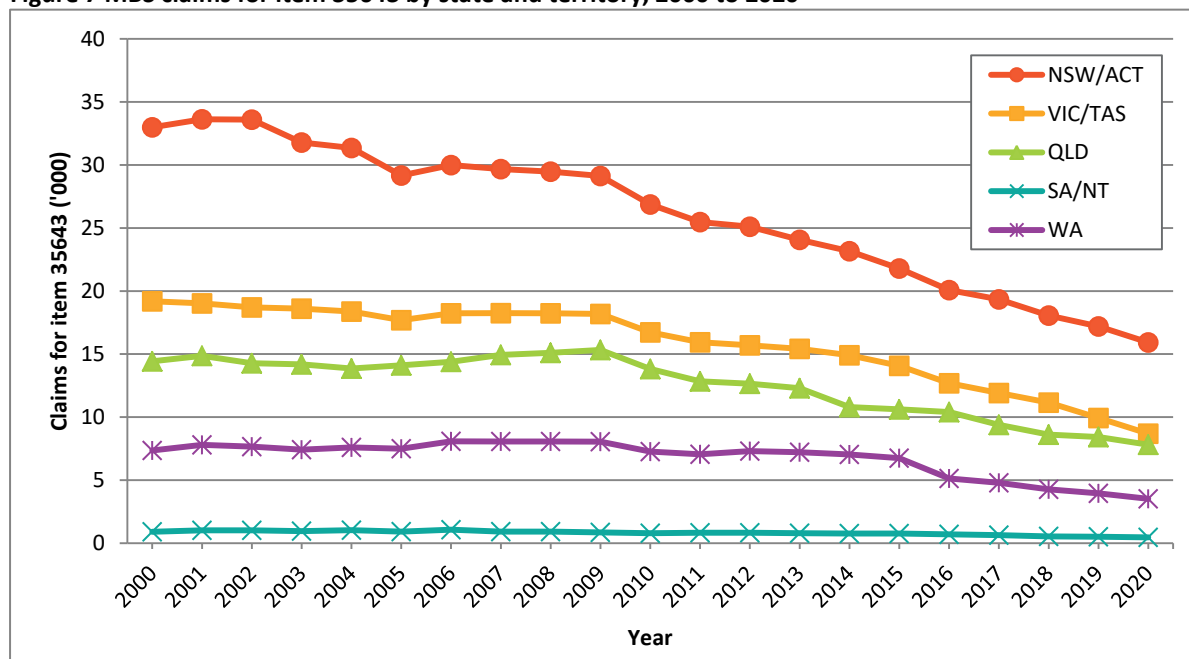
Sources: Government of South Australia (2020). *South Australian Abortion Reporting Committee: Annual Report for the Year 2018*. Adelaide: Pregnancy Outcome Unit, Wellbeing SA.
Galrao, M., Hutchinson, M., & Joyce, A. (2019). *Induced abortions in Western Australia 2016-2018. Sixth Report of the Western Australian Abortion Notification System*. Department of Health, Western Australia.

4.2 MBS claims for induced abortions by state and territory

The number and rate of MBS claims between 2000 and 2020 demonstrates a generally decreasing trend for all states and territories. This trend is least pronounced for South Australia/the Northern Territory decreasing from 910 claims in 2000 to 466 claims in 2020 (see *Figure 7*). The low number of claims in these jurisdictions is because abortions over this period were only permitted in hospitals. As such, surgical abortions would only attract an MBS rebate in a small number of circumstances, such as private patients being treated in public hospitals. This restriction was eased by legislative change in 2017 in the Northern Territory and in 2020 in South Australia.

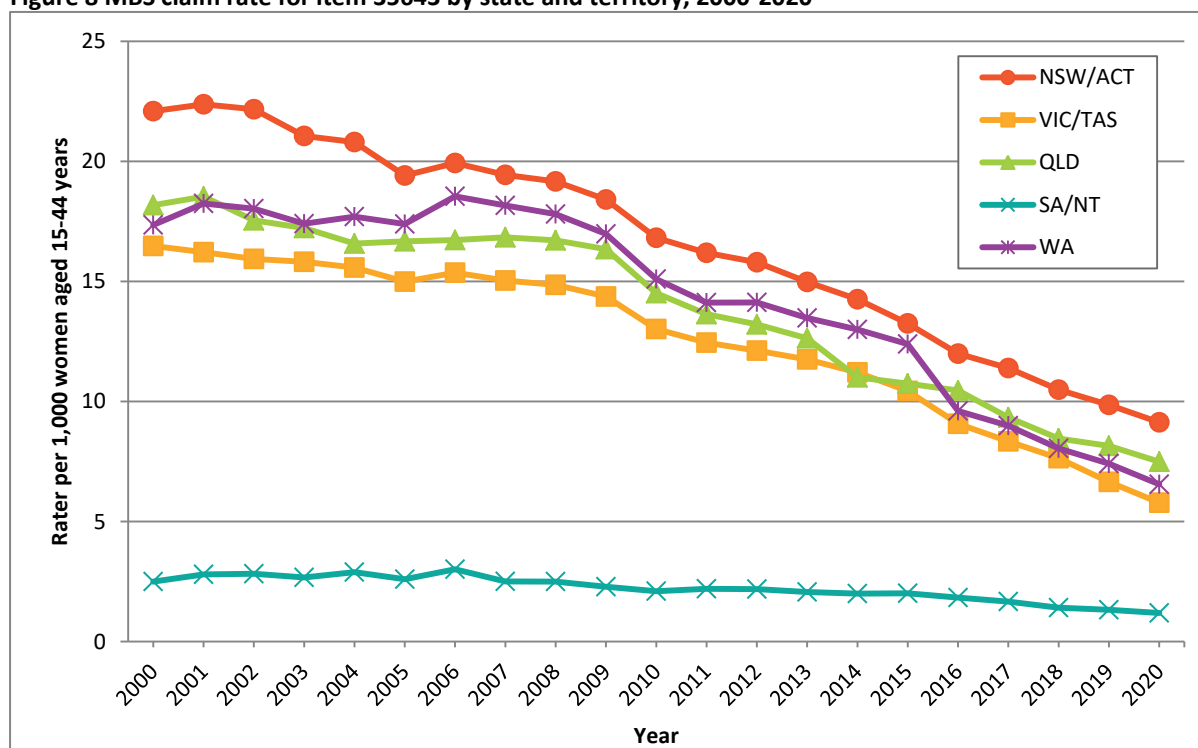
For 2020, the claim rate was highest for New South Wales/the Australian Capital Territory, with 9.1 claims per 1,000 women of reproductive age (see *Figure 8*). This is a decrease from 22 claims per 1,000 women for the years 2000-2002. This represents a reduction from approximately 33,000 claims per year in 2003 to 16,000 in 2020. The lowest claim rate outside of South Australia/the Northern Territory is for Victoria/Tasmania at 5.8 claims per 1,000 women in 2020, followed by 6.5 claims in Western Australia, and 7.5 claims in Queensland. The absolute number of claims demonstrate a similar decreasing pattern; however, the smallest number of claims for 2020 was in Western Australia (3,520 claims), followed by 7,812 in Queensland and 8,692 claims in Queensland. This difference between the absolute number of claims and the claim rate is due to between state differences in the population of women of reproductive age.

Figure 7 MBS claims for item 35643 by state and territory, 2000 to 2020



Note: Item 35643 is evacuation of the contents of gravid uterus by curettage or suction curettage and relates to surgical abortion.
 Source: Medicare Australia: www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp, accessed May 2021

Figure 8 MBS claim rate for item 35643 by state and territory, 2000-2020



Note: Item 35643 is evacuation of the contents of gravid uterus by curettage or suction curettage and relates to surgical abortion.
 Sources: Medicare Australia: www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp, accessed May 2021
 Australian Bureau of Statistics: Number of women aged 15-44 years was used as the denominator and was downloaded from: <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release>, accessed November 2020

5 Abortion by gestational age

Only South Australia and Western Australia routinely report comprehensive data regarding the gestational age at which abortions are sought. There is, however, more data available from additional jurisdictions regarding abortion specifically at or after 20 weeks gestation. Abortions carried out at this gestation tend to be collected by states as part of their respective perinatal data collections and through death registrations. Data regarding the number and rate of induced abortions at or beyond 20 weeks' gestation and the reason for these abortions are published for South Australia, Western Australia, and Victoria. The Australian Capital Territory has published the number of abortions only. For New South Wales, Queensland, Tasmania, and the Northern Territory, publicly available reports of perinatal mortality include abortions at or after 20 weeks' gestation combined with statistics for fetal deaths (stillbirths).

In South Australia in 2018, 91.1% of abortions were conducted at less than 14 weeks gestation (Government of South Australia, 2020). There were 300 abortions conducted at 14-19 weeks' gestation, representing 6.8% of all abortions in South Australia, and 92 abortions at 20+ weeks' gestation (2.1% of all abortions).

In Western Australia in 2018, 93.9% ($n = 7,342$) of abortions were conducted at less than 14 weeks gestation, with 82.1% ($n = 6,417$) occurring at 9 weeks' or less (Galrao et al., 2019). There were 391 abortions conducted at 14-19 weeks' gestation (5% of all abortions), and 83 at 20+ weeks' gestation (1.1% of all abortions).

5.1 Abortion at or after 20 weeks' gestation

Data regarding abortions occurring at or after 20 weeks of pregnancy are collected in all states and territories, and all available reports indicate that this data collection is somewhat uniform across jurisdictions. Despite this, comprehensive publicly available data are lacking. The most comprehensive, publicly available data come from routine reporting of the South Australian and Western Australian abortion reporting systems. These reports include detailed information regarding the number and rate of induced abortions at this gestation, as well as some information regarding reasons for these procedures (Galrao et al., 2019; Government of South Australia, 2020). Victoria also publish the number of abortions performed at 20+ weeks' gestation, and whether these were performed due to congenital abnormalities or maternal psychosocial indications (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2021). Data regarding the number of abortions at 20+ weeks' gestation and the proportion of all abortions (if available) are reported in *Table 1*.

Table 1 Number of abortions at 20 or more weeks' gestation, and proportion of all abortions, for South Australia, Western Australia, and Victoria

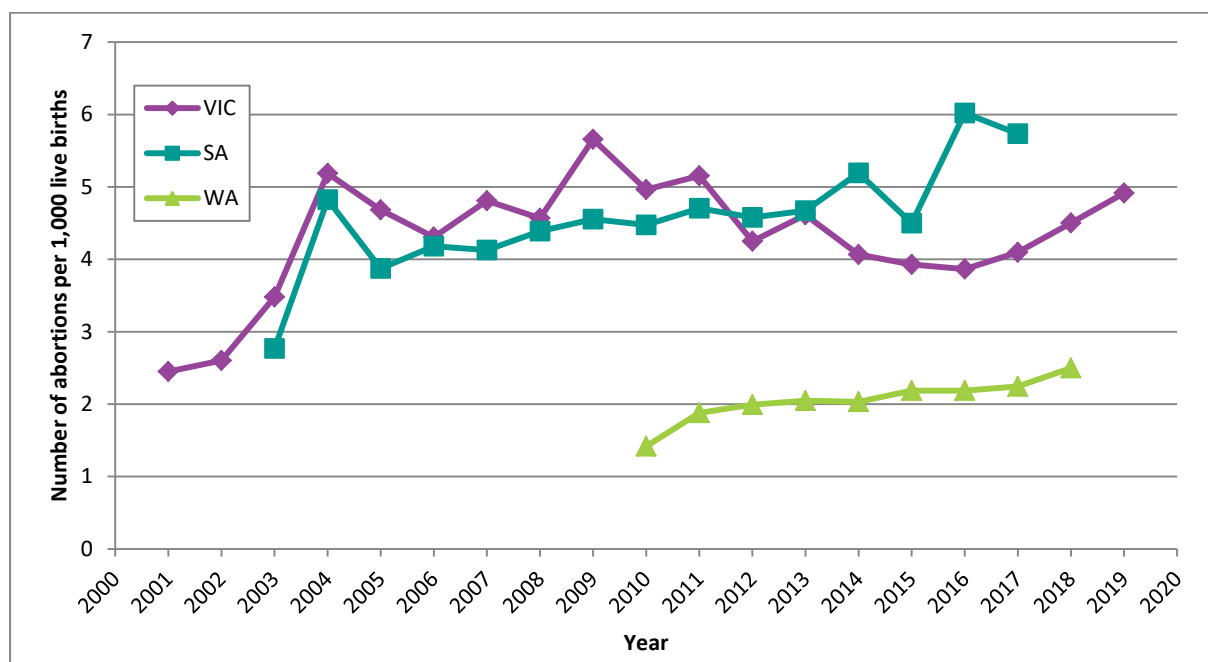
Year	South Australia		Western Australia		Victoria	
	N	%	N	%	N	%*
2010	89	1.8	44	0.5	366	-
2011	95	1.9	60	0.7	378	-
2012	94	2.0	67	0.8	330	-
2013	94	2.0	70	0.8	358	-
2014	107	2.3	71	0.8	319	-
2015	90	2.0	76	0.9	309	-
2016	120	2.8	78	1.0	310	-
2017	111	2.6	77	1.0	324	-
2018	92	2.1	83	1.1	352	-
2019	-	-	-	-	388	-

**Proportion cannot be calculated as Victoria does not publish total number of induced abortions*

The rate of induced abortions at 20+ weeks' gestation per 1,000 live births adjusts for differences in population size and fertility rates between states and over time, and may be more informative than raw numbers of abortions alone. In 2017, the most recent year for which data are available across all three states, South Australia had the highest rate of abortions at this gestation at 5.7 abortions per 1,000 live births. This is compared to 4.1 abortions per 1,000 live births in Victoria, and 2.2 abortions in Western Australia (see *Figure 9*).

The number of abortions at this gestation indicates a generally increasing trend between the most recent data point and the first available data point for each respective state. However, these rates are characterised by a considerable level of variability in Victoria and South Australia, which may reflect changes in service delivery or accessibility, legislative changes, or other variables that may not be accounted for.

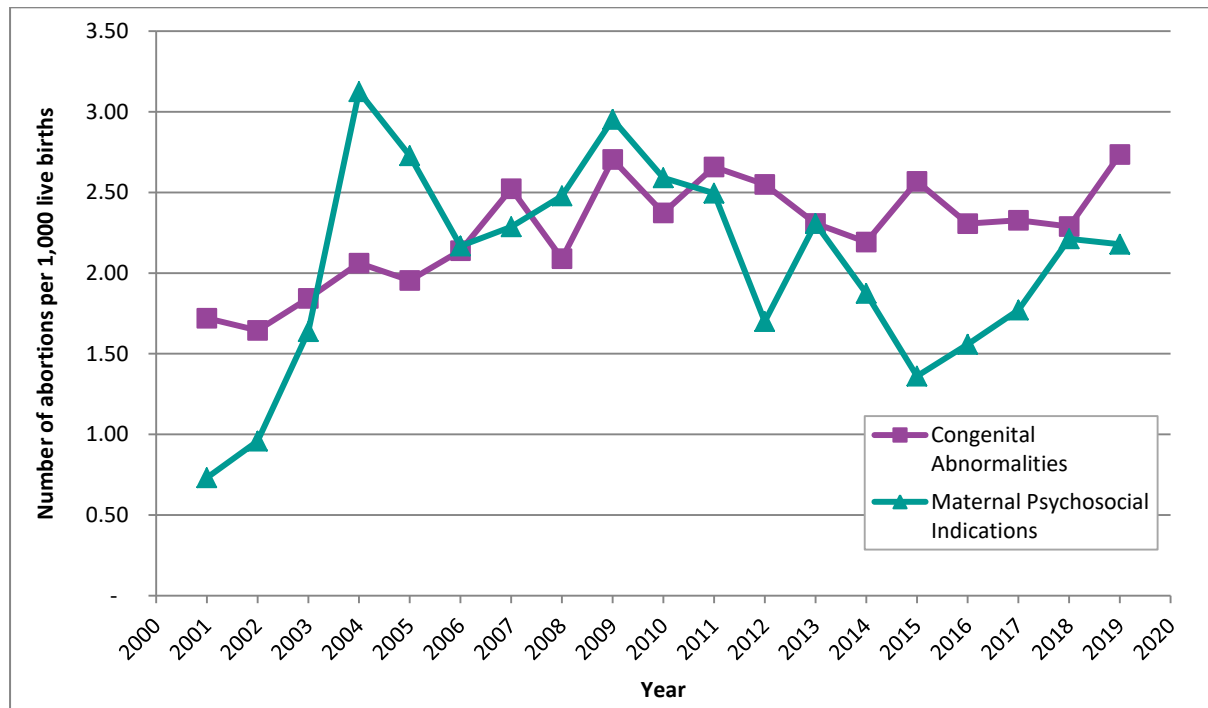
Figure 9 Number of abortions at 20+ weeks' gestation per 1,000 live births for Victoria, South Australia, and Western Australia



Sources: Galrao, M., Hutchinson, M., & Joyce, A. (2019). *Induced abortions in Western Australia 2016-2018. Sixth Report of the Western Australian Abortion Notification System*. Perth: Department of Health, Western Australia.
 Hutchinson, M., & Ballestas, T. (2018). *Induced abortions in Western Australia 2013-2015. Fifth Report of the Western Australian Abortion Notification System*. Perth: Department of Health, Western Australia.
 Hutchinson, M., Joyce, A., & Cheong, M. (2013). *Induced abortions in Western Australia 2010-2012. Fourth Report of the Western Australian Abortion Notification System*. Perth: Department of Health, Western Australia.
 Government of South Australia (2003-2017). *Pregnancy Outcome in South Australia*. Adelaide: Pregnancy Outcome Unit, Wellbeing SA
 Consultative Council on Obstetric and Paediatric Mortality and Morbidity (2001-2019). *Victoria's Mothers, Babies and Children*. Melbourne: Health and Human Services, Victoria State Government.

One reason for increases in the number of abortions being carried out at 20+ weeks' gestation is due to increased testing for congenital abnormalities. This general trend can be observed in the Victorian data, with abortions for this reason occurring at a rate of 1.72 abortions per 1,000 live births in 2001 and increasing to 2.74 abortions per 1,000 live births in 2019 (see *Figure 10*). Abortions for maternal psychosocial indications tend to be more variable by comparison, with the lowest rate in 2001 at 0.73 abortions per 1,000 live births. This increased rapidly to 3.12 in 2004 and was then followed by a period of relative stability ranging between 2.95 and 1.67 for the period 2005 to 2013. Abortions rates for these indications have been gradually increasing between 2014 (1.36) to 2018 (2.29).

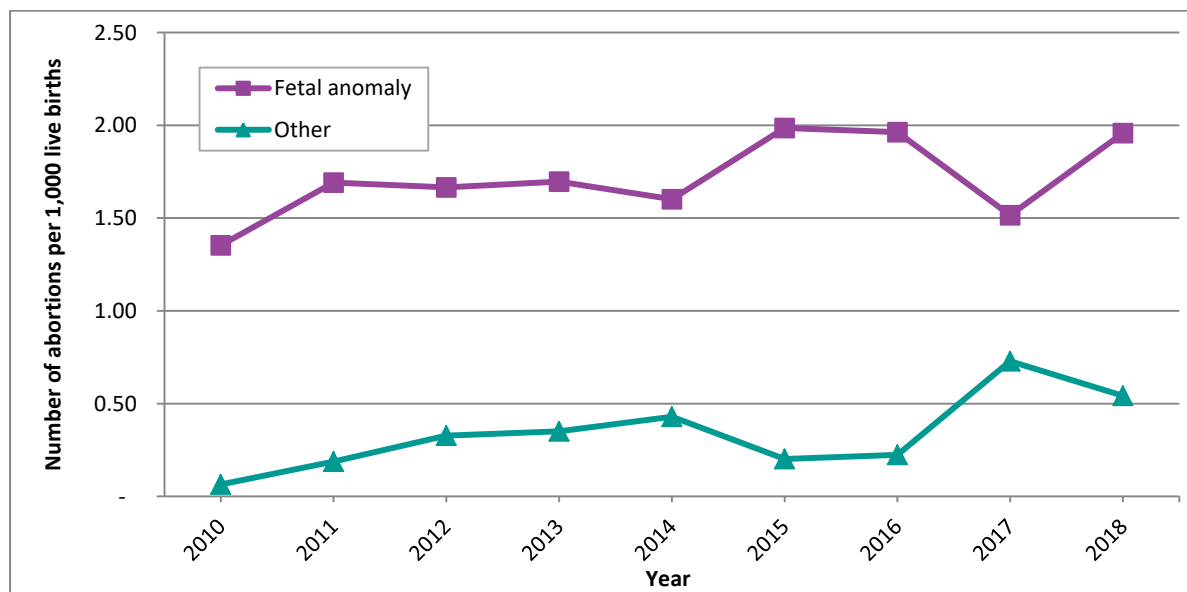
Figure 10 Abortions at 20+ weeks' gestation per 1,000 live births in Victoria by reason for abortion



Source: Consultative Council on Obstetric and Paediatric Mortality and Morbidity (2003-2021). *Victoria's Mothers, Babies and Children Report 2001-2019*. Melbourne: Health and Human Services, Victoria State Government.

In Western Australia, reasons for abortion at 20+ weeks' gestation are categorised as being for fetal abnormalities or 'other' reasons. Abortions at this gestation are more frequent for fetal abnormalities than other reasons at all time points (see *Figure 11*). Trends in abortions for each reason tend to be relatively stable over time, ranging between 1.35 and 1.99 abortions per 1,000 live births for fetal abnormalities and between 0.06 and 0.73 abortions per 1,000 live births for other reasons.

Figure 11 Abortions at 20+ weeks' gestation per 1,000 live births in Western Australia by reason for abortion



Sources: Galrao, Hutchinson, & Joyce (2019). *Induced abortions in Western Australia 2016-2018. Sixth Report of the Western Australian Abortion Notification System*. Perth: Department of Health, Western Australia.
 Hutchinson & Ballestas (2018). *Induced abortions in Western Australia 2013-2015. Fifth Report of the Western Australian Abortion Notification System*. Perth: Department of Health, Western Australia.
 Hutchinson, Joyce, & Cheong (2013). *Induced abortions in Western Australia 2010-2012. Fourth Report of the Western Australian Abortion Notification System*. Perth: Department of Health, Western Australia.

In South Australia, the format in which the reason for abortions at 20+ weeks' gestation changed in 2016. At present, reasons for abortion are categorised as for *mental health of the woman*, *congenital abnormalities*, or *specified medical condition of the woman*. Prior to 2016, only the proportion of abortions at 20+ weeks' gestation that were for *fetal reasons* is reported. The number of abortions in each category, the proportion of all abortions at 20+ weeks' gestation, and the rate per 1,000 live births are reported in *Table 2*.

Table 2 Reported reasons for abortions at 20+ weeks' gestation in South Australia, 2003-2018

Raw numbers are reported first, followed by proportion of all abortions at 20+ weeks' gestation in parentheses, and the rate per 1,000 live births in bold.

Year	Mental health of woman	Congenital abnormalities	Specified medical condition of women	Fetal reasons	Other
2003	-	-	-	21 (42.9) 1.19	28 (57.1) 1.58
2004	-	-	-	41 (48.8) 2.36	43 (51.2) 2.47
2005	-	-	-	34 (48.6) 1.88	36 (51.4) 1.99
2006	-	-	-	40 (51.3) 2.14	38 (48.7) 2.04
2007	-	-	-	44 (54.3) 2.24	37 (45.7) 1.89
2008	-	-	-	49 (56.3) 2.47	38 (43.7) 1.92
2009	-	-	-	49 (54.4) 2.48	41 (45.6) 2.07
2010	-	-	-	48 (53.9) 2.41	41 (46.1) 2.06
2011	-	-	-	49 (52.1) 2.43	45 (47.9) 2.23
2012	-	-	-	53 (56.4) 2.58	41 (43.6) 2.00
2013	-	-	-	47 (50.0) 2.34	47 (50.0) 2.34
2014	-	-	-	52 (48.6) 2.52	55 (51.4) 2.67
2015	-	-	-	50 (55.6) 2.50	40 (44.4) 2.00
2016	58 (48.3) 2.91	52 (43.3) 2.61	10 (8.3) 0.50	-	-
2017	55 (49.5) 2.84	53 (47.7) 2.74	3 (2.7) 0.15	-	-
2018	37 (40.2) -	47 (51.1) -	8 (8.7) -	-	-

Note: Rates cannot be calculated for 2018 as the number of live births has not yet been reported.
Sources: Government of South Australia (2005-2019). *Pregnancy Outcome in South Australia Reports 2003-2017*. Adelaide: Pregnancy Outcome Unit, Wellbeing SA
Government of South Australia (2020). *South Australian Abortion Reporting Committee: Annual Report for the Year 2018*. Adelaide: Pregnancy Outcome Unit, Wellbeing SA

6 Method of abortion

Data regarding the method of abortion used are collected by some state abortion notification systems. The data available from South Australia and Western Australia are as follows:

- In South Australia in 2018, the majority of abortions at less than 14 weeks' gestation were conducted via vacuum aspiration/dilatation and curettage (51.6%), and 42 percent were medical abortions. Abortions in the second trimester were primarily via dilation and evacuation ($n = 270$, 68.9% of all abortions after 14 weeks' gestation), followed by medical abortions using mifepristone and/or misoprostol ($n = 84$, 21.4%).
- For abortions of 9 weeks' gestation or less, the most common method in Western Australia in 2018 was vacuum aspiration (54.8%, $n = 3,514$), having decreased from 81.3% ($n = 5,525$) in 2014. The use of medical abortion increased from 12.3% ($n = 862$) in 2010 to 37.3% ($n = 2,396$) in 2018.

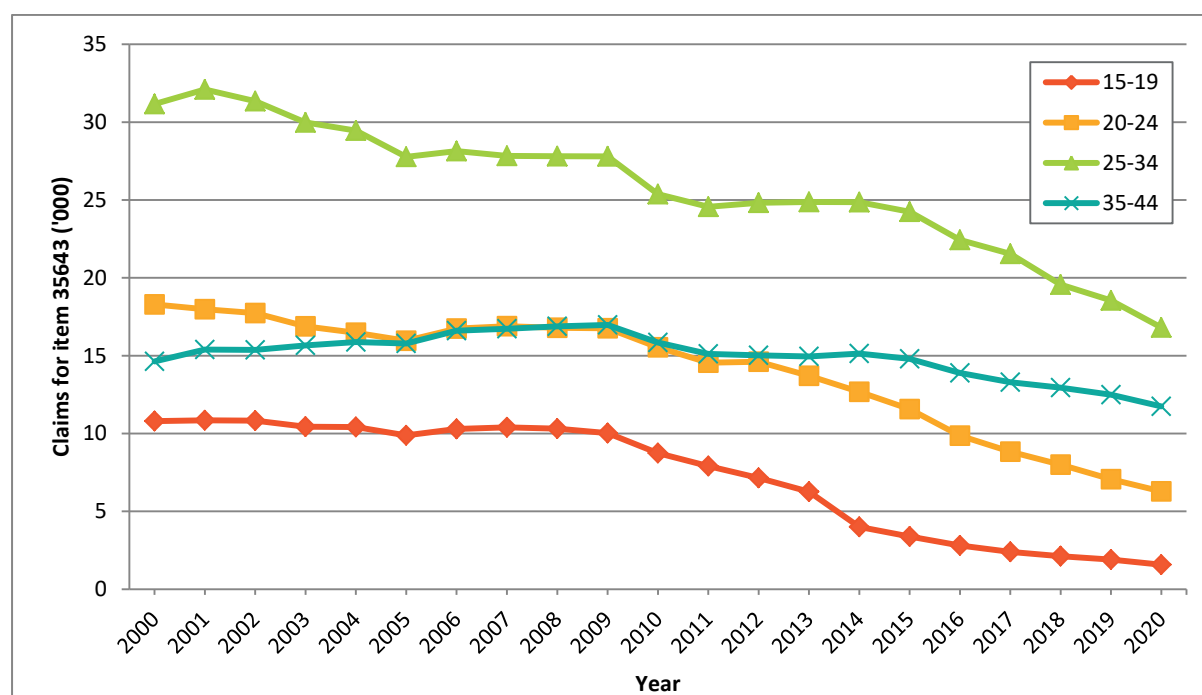
7 Induced abortions by age group

MBS data presented below are for four age groups, collapsed for all geographic regions. The 15-19 year age group may also include claims by people less than 15 years old. Similarly, the 35-44 year age group may include claims by people older than 44 years.

7.1 MBS claims for induced abortions by age group

The number and rate of claims for surgical abortion (MBS item 35643) has been steadily decreasing since 2000 for all age groups. See *Figure 12* for number of claims and *Figure 13* for claim rates. However, the reductions in claims for this item have been more marked for the 15-19, 20-24, and 25-34 age groups, and more gradual for the older 35-44 age group. Claims for all age groups have demonstrated greater decreases since 2009, perhaps owing to increasing use of medical abortion since it was made available in 2006.

Figure 12 MBS claims for item 35643 by age group aggregated across states/territories, 2000 to 2020



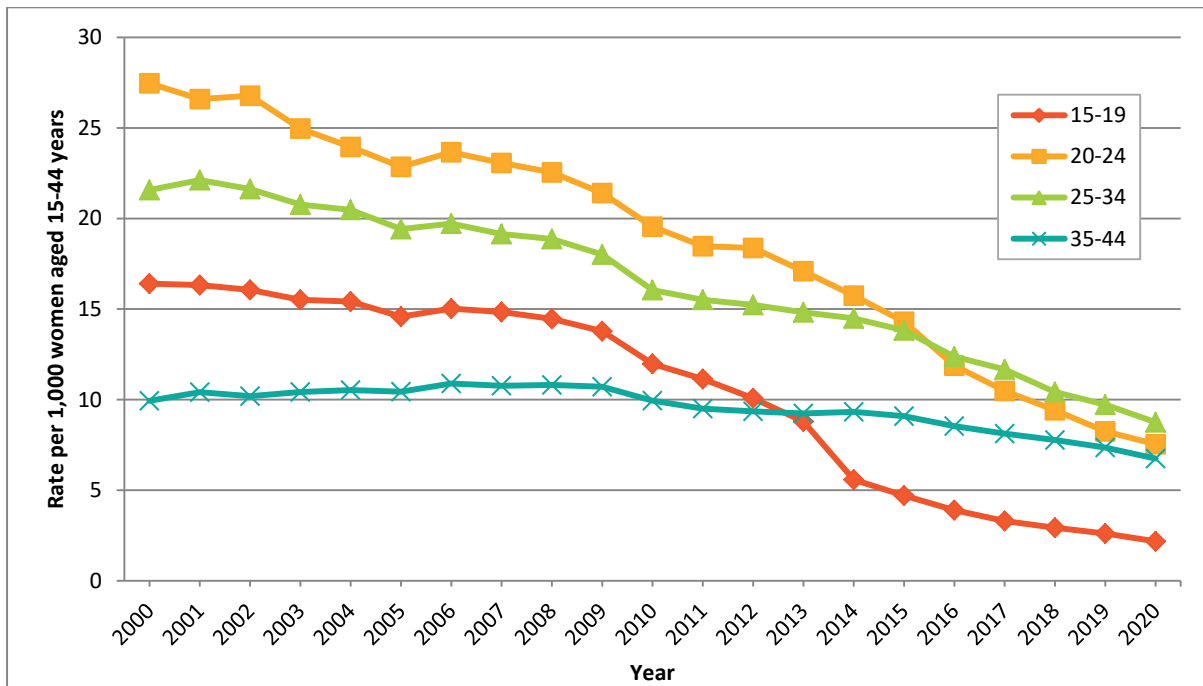
Note: Item 35643 is evacuation of the contents of gravid uterus by curettage or suction curettage.

Age group 15-19 years may also include people younger than 15 years. Age group 35-44 years may also include people older than 44 years.

Sources: Medicare Australia: www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp, accessed November 2020

The 25-34 year age group has consistently had the highest number of claims for 35643, decreasing from 31,167 claims in 2000 (21.6 claims per 1,000 women in that age group) to 16,814 claims in 2020 (8.8 claims per 1,000 women in that age group). However, claim rates are highest for the 20-24 year age group with 27.5 claims per 1,000 women within that age group in 2000 (18,288 claims), decreasing to a rate of 7.5 claims per 1,000 women (6,278 claims) in 2020.

Figure 13 MBS claim rate for item 35643 by age group aggregated across states/territories, 2000 to 2020

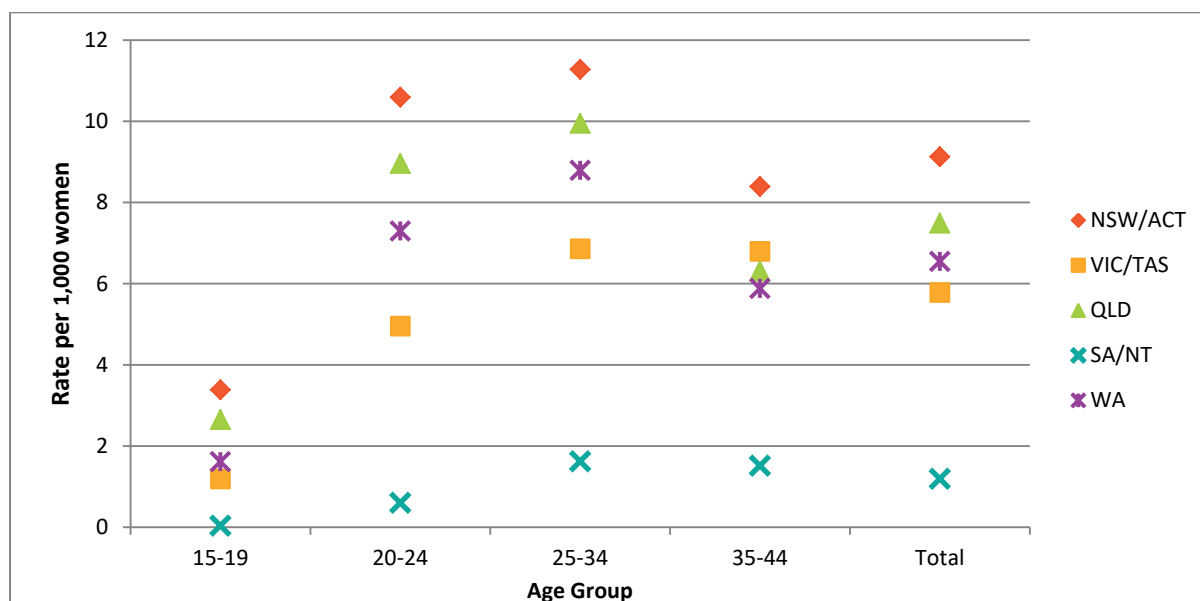


Notes: Item 35643 is evacuation of the contents of gravid uterus by curettage or suction curettage.
 Age group 15-19 years may also include people younger than 15 years. Age group 35-44 years may also include people older than 44 years.

Sources: Medicare Australia: www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp, accessed November 2020
 Australian Bureau of Statistics: Number of women aged 15-44 years was used as the denominator and was downloaded from: <https://www.abs.gov.au/statistics/people/national-state-and-territory-population/latest-release>, accessed November 2020

MBS claim rates differ slightly by age group and state and territory (see Figure 14). Claim rates are lowest for South Australia/the Northern Territory for all age groups in 2020, likely because abortions could only be performed in hospitals in South Australia, and thus would not attract a Medicare rebate. Similarly, claim rates for New South Wales/the Australian Capital Territory are highest across all age groups, as abortions are primarily available in clinical settings that attract Medicare rebates such as private clinics and NGOs, with limited abortion services available through the public hospital system. Beyond this, the trends for each age group tend to reflect similar differences across states as seen at the national level, particularly with the lowest claim rates for those aged 15-19, followed by those aged 20-24 and then those aged 25-34.

Figure 14 MBS claim rate for item 35643 by age group, and state and territory, 2020



Notes: Item 35643 is evacuation of the contents of gravid uterus by curettage or suction curettage.
 Age group 15-19 years may also include people younger than 15 years. Age group 35-44 years may also include people older than 44 years.

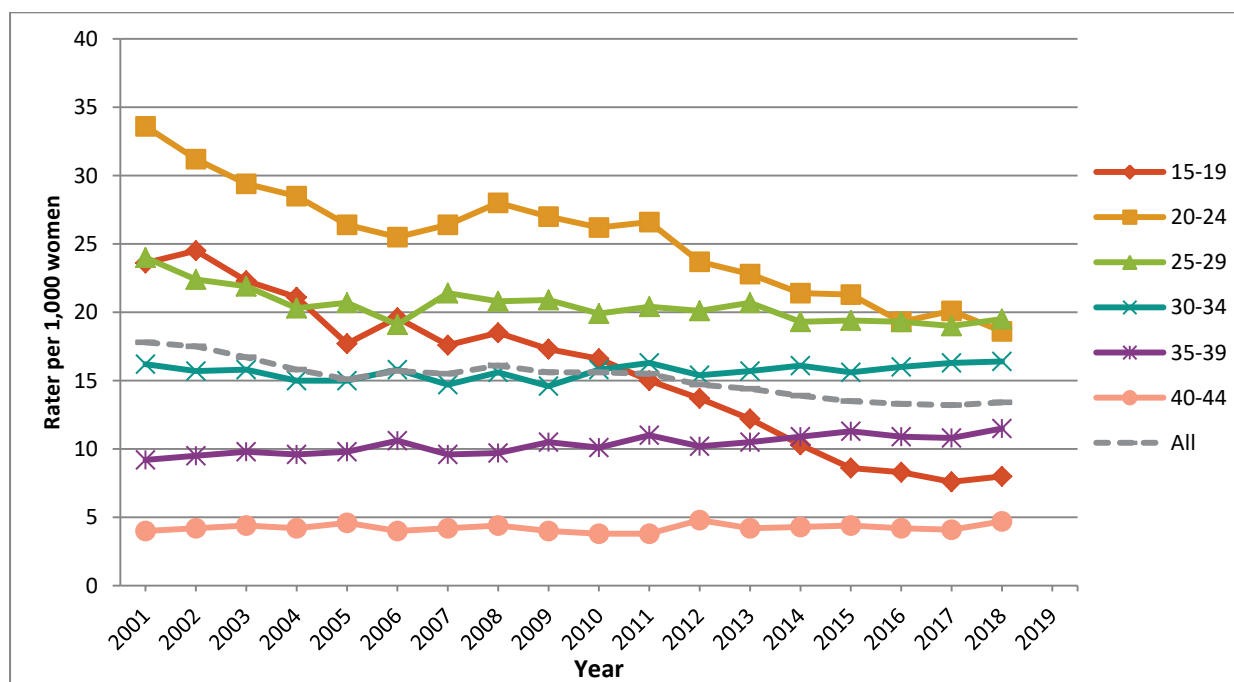
Sources: Medicare Australia: www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp, accessed November 2020
 Australian Bureau of Statistics: Number of women aged 15-44 years was used as the denominator and was downloaded from: <https://www.abs.gov.au/statistics/people/national-state-and-territory-population/latest-release>, accessed November 2020

7.2 Induced abortions by age group in South Australia

Data for all abortions, both surgical and medical, are available from the South Australian Abortion Notification system, and rates demonstrate similar trends as are seen for MBS claims nationally (see Figure 15). Induced abortion rates were highest for the 20-24 age group at all time points between 2001 (33.6 abortions per 1,000 women within the age group) and 2017 (20.1 abortions per 1,000). In 2018, the 25-29 year age group had the higher rate of abortions at 19.5 per 1,000 women, compared to 18.6 abortions per 1,000 women for those aged 20-24.

While rates of abortions have been steadily declining between 2001 and 2018 for the two youngest age groups (15-19 years and 20-24 years), abortion rates have remained relatively stable across the same period for those aged 25-29 and 40-44, while slight increases have been observed for those aged 30-34 and 35-39.

Figure 15 Induced abortion rate by age group in South Australia, 2001 to 2018

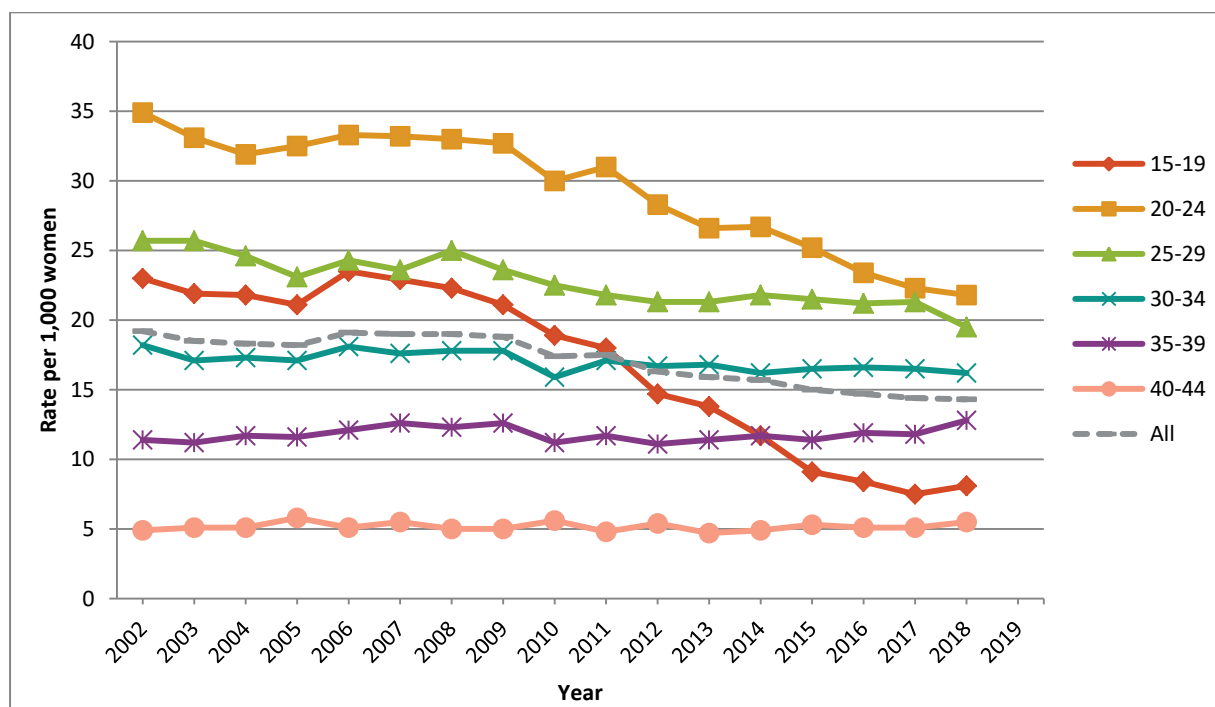


Sources: Government of South Australia (2002-2019). *Pregnancy Outcome in South Australia Reports 2001-2017*. Adelaide: Pregnancy Outcome Unit, Wellbeing SA.
 Government of South Australia (2020). *South Australian Abortion Reporting Committee: Annual Report for the Year 2018*. Adelaide: Pregnancy Outcome Unit, Wellbeing SA.

7.3 Induced abortions by age group in Western Australia

Data from the Western Australian Abortion Notification System demonstrate similar age trends as that of South Australia and MBS claims at the national level (see *Figure 16*). Induced abortion rates were highest for the 20-24 year age group at all time points between 2002 and 2018. Over this period they decreased steadily from 34.9 abortions per 1,000 women within the age group, down to 21.8 abortions per 1,000. A similar decrease was seen for the 15-19 year age group, decreasing from 23 abortions per 1,000 women to 8.1 abortions per 1,000. The 25-29 year age group demonstrated a more gradual reduction across the same period, from 25.7 abortions per 1,000 women in 2002 to 19.5 abortions per 1,000 women in 2018. The abortion rate for the remaining age groups (30-34, 35-39, and 40-44) remained relatively stable between 2002 and 2018.

Figure 16 Induced abortion rate by age group in Western Australia, 2002 to 2018

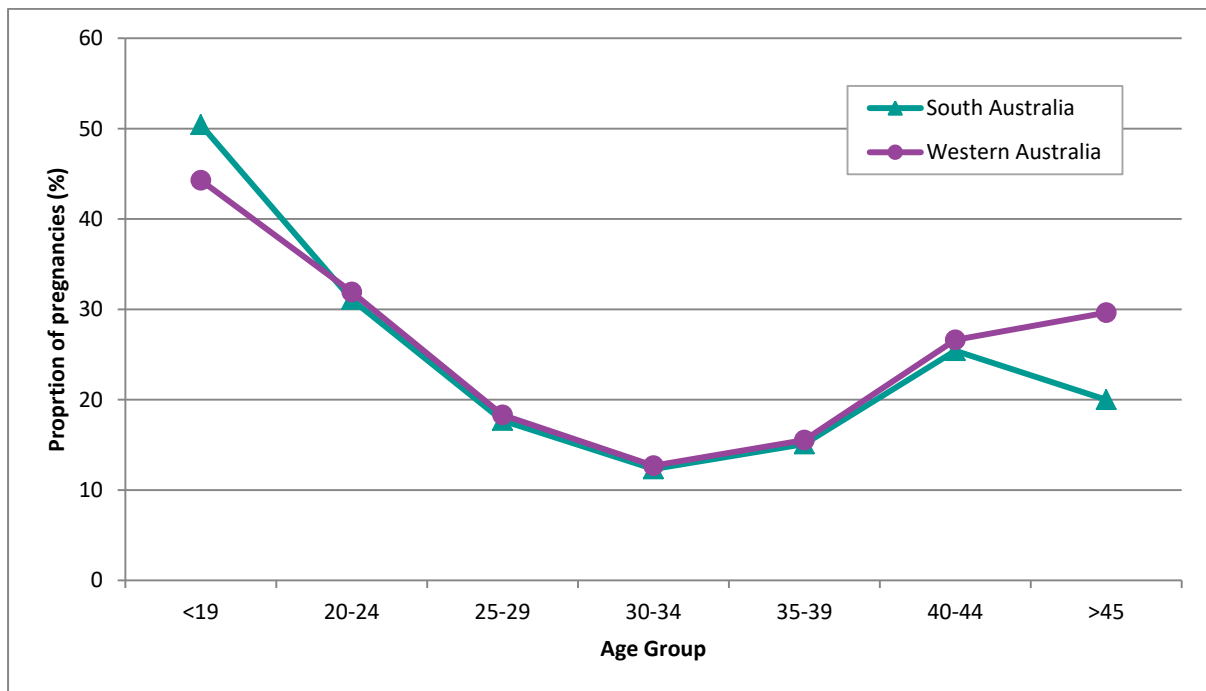


Sources: Galrao, Hutchinson & Joyce (2019). Induced abortions in Western Australia 2016-2018. Sixth report of the Western Australian Abortion Notification System. Perth: Department of Health, Government of Western Australia.

The abortion notification systems in South Australia and Western Australia also provide sufficient data to calculate the proportion of known pregnancies in 2018 that resulted in induced abortion for each age group (see Figure 17). These proportions are similar across the states for all age groups except for the youngest (<19 years) and oldest (>45 years) age groups.

The proportion of pregnancies ending in abortion was highest in both states for those under 19 years of age. In South Australia, half of all known pregnancies within this age group resulted in abortion, compared to 44 percent in Western Australia. This decreased to 31 and 32 percent for South Australia and Western Australia, respectively for the 20-24 year group. The proportion of pregnancies resulting in abortions continued to decrease for each subsequent age group to the lowest proportion within the 30-34 age group, 12 and 13 percent of all pregnancies for South Australia and Western Australia, respectively. The proportion then increased for the two subsequent age groups (35-39 and 40-44). For the oldest age group (>45 years) the proportions diverged for states with Western Australia continuing to increase compared to the 40-44 year age group, to 30 percent of all pregnancies. For those in South Australia, the proportion was 20 percent of pregnancies, which is less than that of the 40-44 age group (25%).

Figure 17 Proportion of pregnancies resulting in induced abortion in South Australia and Western Australia, 2018



Sources: Galrao, Hutchinson & Joyce (2019). *Induced abortions in Western Australia 2016-2018. Sixth report of the Western Australian Abortion Notification System*. Perth: Department of Health, Government of Western Australia.
 Government of South Australia (2020). *South Australian Abortion Reporting Committee: Annual report for the year 2018*. Adelaide: Pregnancy Outcome Unit, SA Health.
 Australian Bureau of Statistics (2021). *Fertility by age, by state (ABS.Stat Dataset)*.

8 Induced abortions by area of remoteness

Data regarding the number and rate of induced abortions by area of remoteness are available within the reports from the Western Australian and South Australian abortion notification systems. At present, there are no data available regarding the number or rate of induced abortions in rural and remote areas for any other Australian jurisdictions. In addition, South Australia is the only Australian jurisdiction to publish data comparing place of residence with abortion facility location, giving an indication of the proportion of women travelling significant distances to access abortion services.

In Western Australia, the abortion rate was higher in metropolitan areas compared to country regions for the years 2016-2018. In metropolitan areas, the abortion rate decreased from 18.4 per 1,000 women in 2010 to 14.9 per 1,000 in 2018. Abortion rates were more stable in country areas across the same period ranging from a low of 11.2 per 1,000 in 2018 to a high of 13.6 in 2011.

In South Australia, 81 percent of all abortions in 2018 were provided to those residing in metropolitan areas and 18 percent to those in country areas, with a small number with unknown location. The vast majority of those residing in metropolitan Adelaide had their abortion at a facility within the metropolitan area (99.1%). However, of those living in country areas of South Australia, only 17.4% had their abortion at a country facility, with the remaining 82.6% travelling to facilities in metropolitan areas. These data suggest that there may be a lack of access to abortion services in country areas, which necessitates travel to major cities for those in regional areas seeking abortion.

9 Induced abortions amongst Aboriginal and Torres Strait Islander people

Data on induced abortion specifically for Aboriginal and Torres Strait Islander people is limited to the Western Australian abortion report. Within the Western Australian report, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander in recognition that Aboriginal people are the original inhabitants of Western Australia. However, abortion cases are reported as Aboriginal if the status of the woman was reported as Aboriginal and/or Torres Strait Islander. For consistency, this report uses the term Aboriginal, with the acknowledgement that this likely includes cases of Torres Strait Islanders.

The abortion rate for Aboriginal women in Western Australia was relatively stable between 2010 and 2016, ranging between 10 and 11.4 abortions per 1,000 women. The abortion rate for Aboriginal women increased in 2017 to 12.9 per 1,000 women, and again in 2018 to 14.1 per 1,000 women. Despite increases in the abortion rate for Aboriginal women, the abortion rate remained lower than that of non-Aboriginal women at all time -points (see *Figure 18* and *Table 3*).

Figure 18 Abortion rates per 1,000 women by Aboriginal status in Western Australia, 2010-2018



Sources: Galrao, Hutchinson, & Joyce (2019). *Induced abortions in Western Australia 2016-2018. Sixth report of the Western Australian Abortion Notification System*. Perth: Department of Health, Government of Western Australia.
 Hutchinson & Ballestas (2018). *Induced abortions in Western Australia 2013-2015. Fifth report of the Western Australian Abortion Notification System*. Perth: Department of Health, Government of Western Australia.
 Hutchinson, Joyce, & Cheong (2013). *Induced abortions in Western Australia 2010-2012. Fourth report of the Western Australian Abortion Notification System*.

Table 3 Abortion number and rate by Aboriginal status in Western Australia, 2010-2018

Year	Aboriginal		Non-Aboriginal	
	N	Rate per 1,000	N	Rate per 1,000
2010	216	10.6	8,222	17.7
2011	236	11.4	8,487	17.7
2012	225	10.6	8,240	16.6
2013	220	10.2	8,288	16.2
2014	219	10.0	8,297	16.0
2015	223	10.0	7,956	15.3
2016	230	10.1	7,625	14.9
2017	295	12.9	7,533	14.5
2018	325	14.1	7,491	14.3

Sources: Galrao, Hutchinson, & Joyce (2019). *Induced abortions in Western Australia 2016-2018. Sixth report of the Western Australian Abortion Notification System*. Perth: Department of Health, Government of Western Australia.
Hutchinson & Ballestas (2018). *Induced abortions in Western Australia 2013-2015. Fifth report of the Western Australian Abortion Notification System*. Perth: Department of Health, Government of Western Australia.
Hutchinson, Joyce, & Cheong (2013). *Induced abortions in Western Australia 2010-2012. Fourth report of the Western Australian Abortion Notification System*.

10 Other factors associated with induced abortions

In 2013, a cross sectional survey of men and women of reproductive age who were registered to vote in Australia found that women with socioeconomic disadvantage, those who experience discomfort negotiating contraceptive use with partners, and those who have experienced sexual coercion were more likely to have had an abortion (Rowe et al., 2017). In this same study, women who indicated that religion played an important role in fertility choices were less likely to have had an abortion.

Within a cohort of women born between 1973 and 1978, a trend analysis of longitudinal data showed that socio-demographic and behavioural factors were associated with abortion, and that strength of the relationship varied with age (Taft et al., 2019). Women in their twenties were twice as likely to end a pregnancy if they were using less effective methods of contraception (i.e., condoms or natural family planning and withdrawal methods), and 1.7 times as likely if their alcohol use had recently become more risky. Women reporting illicit drug use in the past 12 months were three times more likely to have had a previous abortion than those reporting non-use in their twenties, and 2.7 times as likely in their thirties. In addition, women who reported experiencing any kind of violence were significantly more likely to end a pregnancy. This was particularly the case for those in their twenties reporting recent partner violence who were more than twice as likely to end a pregnancy as women reporting no violence. This is compared to 1.5 times more likely for those in their thirties (Taft et al., 2019).

11 Discussion

At present there is no national data collection on the incidence of induced abortion in Australia. Available data regarding abortion at both the national and state level come with a variety of unique limitations, but can provide some information, albeit incomplete, about the incidence of induced abortion within Australia, and across states and territories.

11.1 Induced abortions in Australia

All available data suggests that the rates of induced abortion have been decreasing at the national level since 2000. The most recent estimate for Australia and New Zealand suggests that the rate of abortion is approximately 15 abortions per 1,000 women of reproductive age for the period 2015-2019 and that this has been steadily decreasing from 17 abortions per 1,000 in 2010-14, and from 20 abortions per 1,000 in 2005-09. Similarly, claims for the MBS item that covers surgical abortion (35643) have also been decreasing between 2000 and 2020, with decreases becoming more marked since the introduction of medical abortion in 2006. However, these decreases in surgical abortion, estimated via MBS claims, have in part been compensated by a corresponding rise in medical abortion, estimated via PBS claims. When these data are combined, it appears that the rate of abortion may have plateaued in recent years. This trend is consistent with abortion rates in both South Australia and Western Australia. In contrast, claims for MBS items covering induced abortion in the second trimester (16525, 16530 and 16531) increased consistently since 2015, which may be a result of delays in accessing abortion services at earlier gestations, or increases in genetic testing of conditions that cannot be detected until the second trimester of pregnancy.

11.2 Induced abortions by state and territory

MBS claims for surgical abortions have been decreasing across all states and territories between 2000 and 2020. In 2020, claim rates were highest in New South Wales/the Australian Capital Territory (9.1 claims per 1,000 women of reproductive age) and lowest in South Australia/the Northern Territory (5.8 claims per 1,000 women). Variation in claim rates across jurisdictions are likely due to differences in the clinical settings of abortion services, with states such as South Australia which provide services through public hospitals making fewer claims as procedures in public hospitals are ineligible for Medicare rebates. PBS claim rates provide limited information about differences in medical abortion across jurisdictions due to anomalies in the data relating to the processing of PBS scripts by a large interstate abortion provider.

Abortion rates from notification systems in Western Australia and South Australia present the most accurate data of abortion access in those states. These reports indicate that abortion rates in both states have been gradually declining between 2000 and 2018, but these trends have started to plateau in the five years to 2018, with 13.4 and 14.3 abortions per 1,000 women in South Australia and Western Australia respectively for 2018. Although these data are likely to be the most accurate within Australia, these cannot be generalised to other jurisdictions due to a range of differences between these and other states including population density, differences in abortion legislation, and differences in the clinical settings in which abortion is provided.

11.3 Induced abortions by gestational age

The vast majority of abortions continue to be carried out prior to 14 weeks' gestation, with 91% and 94% of abortions being completed by this stage in South Australia and Western Australia, respectively. While the number of induced abortions carried out at 20+ weeks' gestation remain low in all jurisdictions where data are available (Western Australia, South Australia, and Victoria), rates of abortions at this stage of pregnancy are following a generally increasing trend, with those in Victoria increasing from 1.72 to 2.74 abortions per 1,000 live births between 2001 and 2019.

In Victoria, abortions at 20+ weeks' gestation due to confirmed or suspected congenital abnormalities have demonstrated modest increases between 2001 and 2019, while those for psychosocial indications are more

variable. Similar increases have also been identified for fetal anomalies in Western Australia. These trends may be due to increased incidence of testing for congenital conditions, or improvements to the sensitivity of such tests. It may also be possible that the incidence of some abnormalities, such as chromosomal abnormalities, is increasing in cases where women are having children in later life.

11.4 Induced abortion by age group

MBS claim rates for induced abortion have experienced moderate decreases for 15-19 and 20-24 year age groups since 2000, while claim rates tend to be more stable for older age groups. These trends are mirrored in the data from both Western Australia and South Australia; however, reports from these states tend to show slight increases in abortion rates recently for those in older age groups (30-34, 35-39 and 40-44 for South Australia, and 30-34 in Western Australia).

The proportion of pregnancies resulting in induced abortion across age ranges displays a U-shape trend, with higher proportions of pregnancies ending in abortion for the younger and older age groups, and the lowest proportion for those in the middle age group (30-34).

11.5 Data development

A lack of complete and comprehensive data about abortion creates barriers for the planning, delivery, and evaluation of healthcare services, the assessment of effects resulting from changes in legislation and policy, and the evaluation of school-based comprehensive sexuality education. While the data presented in this report provide some information about abortion access and how it has changed over time at both the national and state level, these data also have a number of limitations that restrict their utility and accuracy for this purpose. A strong need remains for comprehensive and complete data on abortion access in Australia. While implementation of MBS and PBS codes specific to induced abortion may somewhat assist with this, these data will still be incomplete for people not eligible for Medicare rebates such as international students, and will omit procedures performed in clinical settings where Medicare claiming does not apply, such as public hospitals.

Abortion notification systems that are already established in many states and territories represent the best opportunity for collecting rich and accurate data about induced abortion in Australia. If collection and release of this data can be coordinated and harmonised across all states and territories, these data could provide a more complete picture of abortion access in Australia. Until such time as this is achieved, those seeking to use the available data must continue to weigh the relative strengths and weaknesses of each source for their intended purposes.

References

- Australian Bureau of Statistics. (2015). *Births, Australia, 2014* (ABS Cat. No. 3301.0).
<https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3301.0Main+Features12014?OpenDocument=>
- Bayly, C. (2005). Informing the abortion debate. *O&G Magazine*, 7(1), 50–51.
- Bearak, J., Popinchalk, A., Ganatra, B., Moller, A.-B. B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020a). Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *The Lancet Global Health*, 8(9), e1152–e1161.
[https://doi.org/10.1016/S2214-109X\(20\)30315-6](https://doi.org/10.1016/S2214-109X(20)30315-6)
- Bearak, J., Popinchalk, A., Ganatra, B., Moller, A.-B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020b). *Global estimation of unintended pregnancy and abortion using a Bayesian hierarchical random walk model*. 1–26. <http://arxiv.org/abs/2007.09246>
- Bearak, J., Popinchalk, A., Ganatra, B., Moller, A.-B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020c). Supplementary appendix. *The Lancet Global Health*, 8(9), e1152–e1161. [https://doi.org/10.1016/S2214-109X\(20\)30315-6](https://doi.org/10.1016/S2214-109X(20)30315-6)
- Belton, S. (2019). Northern Territory should be included in discussions on sexual reproductive health. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 59(3), E12.
<https://doi.org/10.1111/ajo.12992>
- Belton, S., McQueen, G., & Ali, E. (2020). Impact of legislative change on waiting time for women accessing surgical abortion services in a rural hospital in the Northern Territory. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 60(3), 459–464. <https://doi.org/10.1111/ajo.13117>
- Brown, W., Bryson, L., Byles, J., Dobson, A., Manderson, L., Schofield, M., & Williams, G. (1996). Women's health Australia: Establishment of the Australian longitudinal study on women's health. *Journal of Women's Health*, 5(5), 467–472. <https://doi.org/10.1089/jwh.1996.5.467>
- Chan, A., & Sage, L. C. (2005). Estimating Australia's abortion rates 1985–2003. *Medical Journal of Australia*, 182(9), 447–452. <https://doi.org/10.5694/j.1326-5377.2005.tb06783.x>
- Children by Choice. (2016). *Medical abortion in Australia*.
<https://www.childrenbychoice.org.au/factsandfigures/medicalabortioninaustralia>
- Children by Choice. (2017). *Australian abortion statistics*.
<https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics>
- Children by Choice. (2019). *Abortion in Queensland FAQ*.
<https://www.childrenbychoice.org.au/factsandfigures/abortioninquenslandfaq>
- Commonwealth of Australia. (2005). *The Senate: Questions on notice - Abortion. Question 325*.
- Commonwealth of Australia. (2013). *Answers to estimates questions on notice: Health and Ageing portfolio*. Commonwealth of Australia.
- de Crespigny, L. J., & Savulescu, J. (2008). Pregnant women with fetal abnormalities: the forgotten people in the abortion debate. *Medical Journal of Australia*, 188(2), 100–103. <https://doi.org/10.5694/j.1326-5377.2008.tb01531.x>
- Family Planning Tasmania. (2018). *Personal Communication*.
- Fitzharris, M. (2018). *Government amendments to the Health (Improving Abortion Access) Legislation Amendment Bill 2018 - Supplementary explanatory statement*.
https://www.legislation.act.gov.au/b/db_57801/default.asp

- Galrao, M., Hutchinson, M., & Joyce, A. (2019). *Induced abortions in Western Australia 2016-2018. Sixth report of the Western Australian Abortion Notification System.*
- Government of South Australia. (2020). South Australian Abortion Reporting Committee: Annual Report for the year 2018. In *Authority for Electricity Regulation-Oman* (Vol. 64, Issue 1).
<https://doi.org/10.1179/peq.1932.64.1.1>
- Grayson, N., Hargreaves, J., & Sullivan, E. A. (2005). *Use of routinely collected national data sets for reporting on induced abortion in Australia* (No. 17; Perinatal Statistics Series).
- Herbert, D., Lucke, J., & Dobson, A. (2009). Pregnancy losses in young Australian women: Findings from the Australian Longitudinal Study on Women's Health. *Women's Health Issues, 19*(1), 21–29.
<https://doi.org/10.1016/j.whi.2008.08.007>
- Hutchinson, M., Arthur, J., & Cheong, M. (2013). *Induced Abortions in Western Australia 2010-2012. Fourth report of the Western Australian Abortion Notification System.*
- Hutchinson, M., & Ballestas, T. (2018). *Induced abortions in Western Australia 2013-2015. Fifth report of the Western Australian Abortion Notification System.*
- Keogh, L. A., Gillam, L., Bismark, M., McNamee, K., Webster, A., Bayly, C., & Newton, D. (2019). Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers. *BMC Medical Ethics, 20*(1), 11. <https://doi.org/10.1186/s12910-019-0346-1>
- Keogh, L. A., Newton, D., Bayly, C., McNamee, K., Hardiman, A., Webster, A., & Bismark, M. (2017). Intended and unintended consequences of abortion law reform: Perspectives of abortion experts in Victoria, Australia. *Journal of Family Planning and Reproductive Health Care, 43*(1), 18–24.
<https://doi.org/10.1136/jfprhc-2016-101541>
- Laws, P. J., Grayson, N., & Sullivan, E. A. (2006). *Australia's mothers and babies 2004* (No. 18; Perinatal Statistics Series).
- Lee, C., Dobson, A. J., Brown, W. J., Bryson, L., Byles, J., Warner-Smith, P., & Young, A. F. (2005). Cohort Profile: The Australian Longitudinal Study on Women's Health. *International Journal of Epidemiology, 34*(5), 987–991. <https://doi.org/10.1093/ije/dyi098>
- Loxton, D., Tooth, L., Harris, M. L., Forder, P. M., Dobson, A., Powers, J., Brown, W., Byles, J., & Mishra, G. (2018). Cohort Profile: The Australian Longitudinal Study on Women's Health (ALSWH) 1989–95 cohort. *International Journal of Epidemiology, 47*(2), 391–392e. <https://doi.org/10.1093/ije/dyx133>
- MS Health. (2021). *Impact Report 2020.*
- Northern Territory Government. (2018). *Having a termination of pregnancy (abortion) in the Northern Territory.* <https://hdl.handle.net/10137/1313>
- Northern Territory Government. (2019). *NT Termination of Pregnancy Law Reform 12 month Interpretive Report.* <https://hdl.handle.net/10137/7327>
- NSW Health. (2021). *Pregnancy Options - For health professionals.*
<https://www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-health-professionals.aspx>
- Rowe, H., Holton, S., Kirkman, M., Bayly, C., Jordan, L., McNamee, K., McBain, J., Sinnott, V., & Fisher, J. (2017). Abortion: Findings from women and men participating in the Understanding Fertility Management in contemporary Australia national survey. *Sexual Health, 14*(6), 566–573.
<https://doi.org/10.1071/SH17004>
- Sifris, R., Belton, S., & Journal, H. R. (2017). Australia: Abortion and Human Rights. *Health and Human Rights Journal, 19*(1), 209–220.
- Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E., & de Visser, R. O. (2003a). The rationale and methods of

- the Australian Study of health and relationships. *Australian and New Zealand Journal of Public Health*, 27(2), 106–117. <https://doi.org/10.1111/j.1467-842X.2003.tb00797.x>
- Smith, A. M. A., Rissel, C. E., Richters, J., Grulich, A. E., & de Visser, R. O. (2003b). Sex in Australia: Reproductive experiences and reproductive health among a representative sample of women. *Australian and New Zealand Journal of Public Health*, 27(2), 204–209. <https://doi.org/10.1111/j.1467-842X.2003.tb00809.x>
- Taft, A. J., Powell, R. L., Watson, L. F., Lucke, J. C., Mazza, D., & McNamee, K. (2019). Factors associated with induced abortion over time: secondary data analysis of five waves of the Australian Longitudinal Study on Women's Health. *Australian and New Zealand Journal of Public Health*, 43(2), 137–142. <https://doi.org/10.1111/1753-6405.12874>
- Taft, A. J., Shankar, M., Black, K. I., Mazza, D., Hussainy, S., & Lucke, J. C. (2018). Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes. *The Medical Journal of Australia*, 209(9), 407–408. <https://doi.org/10.5694/mja17.01094>
- The Consultative Council on Obstetric and Paediatric Mortality and Morbidity. (2021). *Victoria's Mothers, Babies and Children 2019*.
- Therapeutic Goods Administration. (2012a). *Australian Public Assessment Report for Mifepristone* (Issue October). <https://www.tga.gov.au/node/869>
- Therapeutic Goods Administration. (2012b). *Australian Public Assessment Report for Misoprostol*. <https://www.tga.gov.au/node/873>
- Therapeutic Goods Administration. (2014). *Australian Public Assessment Report for mifepristone/misoprostol* (Issue October). <https://www.tga.gov.au/node/283537>
- WHO. (2012). *Safe abortion: Technical and policy guidance for health systems (2nd ed.)*. <https://www.who.int/publications/i/item/clinical-practice-handbook-for-safe-abortion>
- Women's Health Tasmania. (2021). *Pregnancy Choices Information*. <https://www.womenshealthtas.org.au/pregnancy-choices-information>

