ABORTION CARE IN THE 21ST CENTURY

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The past two decades have seen major changes in both abortion law and abortion provision across Australia. Safe legal abortion is now available to all Australian women, and accessible to many. Decriminalisation across states and territories, and reforms in all to mandate safety zones around abortion services, have led to wider discussion about abortion in Australian society, and lessening of the stigma associated with abortion practice.[1] Progress has come in increments. Surgical abortion was the sole option for Australian women until 2006 when the restrictive Harradine amendment was overturned in parliament allowing the slow introduction of mifepristone. In 2011 Marie Stopes Australia published the first large trial of outpatient early medical abortion (EMA) using mifepristone and misoprostol;[2] in 2012 mifepristone was fully licensed by the Therapeutic Goods Administration and in 2013 it was put on the PBS as the combined package MS-2 Step® containing mifepristone and misoprostol, for use in the first 63 days of pregnancy.[3] However the drug can only be prescribed by registered medical practitioners who have undertaken an online course, still requires an authority script, and must be supplied by registered pharmacies. Mifepristone used in hospitals for abortion later in pregnancy is not covered by the PBS.

There is no readily-available Australian national data on abortion rates, medical or surgical, and there is no Medicare item number for EMA consultations. Hence it has not been possible to reliably estimate the overall extent of induced abortions, nor assess the socio-demographic characteristics of women presenting for abortion. Such data is useful in tracking public health measures such as occurred with the United Kingdom's teenage pregnancy strategy. Progress in this complex multisectorial intervention in England monitored conception, abortions, and maternities in individuals under 18 years of age and directed resources to the areas of highest need, documenting a 51% fall in teenage conceptions between 1998 and 2014.[4] In the United States the Centre for Disease Control Prevention captures routine abortion data noting its importance in documenting progress towards the national goal of reducing unintended pregnancy.[5]

In this issue of the Journal two papers shed welcome new light on how many abortions are being performed, where in Australia women can access them easily, and where obtaining abortion remains geographically and financially challenging. *Author/s' names* [6] used the National Hospital Morbidity Database and Diagnosis Related Groups (DRGs) to determine the number of surgical abortions performed across Australia using aggregated data, 2014-2015 and 2017-2018. They also obtained data from the Pharmaceutical Benefits Scheme (PBS) showing how many prescriptions were written for MS 2 Step in the timeframe studied. They then added the two figures.

This total does not though include all abortion procedures in Australia. There are freestanding clinics in parts of the country that do not report DRGs. There is a small failure/complication rate for EMAs (<5%) and some of these women will be admitted to hospital for curettage, possibly leading to them being counted twice. Some surgical abortions may be misclassified as miscarriages. Nevertheless, we believe their conclusion, that surgical abortion rates have dropped, and EMA rates risen, over the past seven years, is accurate.

More information comes from *Authors' names* [7] who also examined the MS-2 Step® prescription data from the PBS from 2015 to 2019, against standard geographical areas: urban, regional and remote. These authors identify areas where no general practitioner (GP) prescribed, and no pharmacy dispensed, MS-2 Step®. Dispensing rates of the drug combination increased over the time period and in the last year of data (2019) rates were greatest for women living in outer regional and remote Australia despite 30% of Australian women living in regions where no GP prescribed and no pharmacy dispensed the medication.

The authors call, rightly, for more support for telehealth provision, which has increased over recent years, particularly during the COVID-19 pandemic. Continuation of the recent Medicare telehealth item numbers is required to ensure women in areas underserved by

prescribing general practitioners and dispensing pharmacies have access to medical abortion. The authors also call for easier access to training and education for regional practitioners and greater support from their local services. Normalising abortion care would be facilitated by the removal of the mandate for prescribers to register on a special program and by making mifepristone available like any other drug. These measures, along with greater abortion education in medical schools and training in postgraduate programs would reduce the stigma of abortion care.

The key issue highlighted in both these papers is that without systematic national abortion data collection it is difficult to identify areas of inequity of access to services and assess the effectiveness of interventions. Telehealth providing EMA is certainly reducing inequalities but women living in regional and remote areas seeking surgical abortion still face travelling long distances and incurring great expense.[8] As *authors of both papers* show, more than 80,000 Australian women make the choice for abortion each year, and a significant proportion of them live in regional and remote areas. The National Women's Health Strategy[9] has equity of care as one of its core principles, including timely, appropriate and affordable care for women and girls in their own communities. It's time this is applied to abortion care.

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