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Legal abortion in South Australia: a review of the first 30 years

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ABSTRACT

Objectives

To review the first 30 years' experience of legal abortion in South Australia and its demographic implications.

Data and methods

Information was obtained from official abortion statistics and demographic publications of the Australian Bureau of Statistics. Standard demographic and statistical techniques of analysis were used.

Results

After an initial rise during the 1970s, abortion rates remained fairly constant for the next decade but have increased since 1990. The Pregnancy Advisory Centre opened in 1992, to reduce waiting times and to cater for late abortions. This resulted in an increase in abortions earlier in pregnancy and also an increase in late abortions. With the adoption of vacuum aspiration techniques and improved services, abortion is now a day-only procedure, performed by specially trained doctors. Morbidity and mortality have been greatly reduced. Concurrent sterilisation has also declined. The increase in abortion has affected all age groups, but particularly women under 30, consistent with the national trend towards the postponement of births. After an initial rapid decline, the total pregnancy rate has risen slightly since 1990, showing changes in patterns of contraceptive use. However, this is not reflected in an increase in the total confinement rate.

Conclusion

Overall, contraception has had a greater effect than abortion in reducing births in South Australia. The abortion rate is still lower than in the rest of Australia as calculated from Medicare data, even though this is an underestimate because it includes only fee-paying patients. There remains a need for continuing emphasis on better contraceptive use, including emergency contraception.

INTRODUCTION

This paper reviews the first 30 years' experience of legal abortion in South Australia, its incidence, the characteristics of abortion patients and the possible demographic implications. During this period, the laws concerning abortion in Australia were liberalised in all States and Territories except Tasmania, either by the expansion of case law or by amendments to existing legislation.[1] The South Australian legislation requires all abortions to be notified, and a special Committee has the responsibility to examine and report annually to the Parliament.[2] South Australia is the only State that publishes abortion statistics.

The legislation requires that abortions be carried out in approved hospitals provided that two medical practitioners certify that continuation of the pregnancy would constitute a greater physical or mental risk to the patient's health than would an abortion, or there is a substantial risk of serious handicap to the child. The patient's actual or reasonably foreseeable environment may be taken into account. To discourage women from other states travelling to South Australia for abortion, a minimum of two months residency is required, although it was foreseen that this would be hard to enforce. Medical practitioners are not obliged to perform an abortion against their conscience.

By the late 1970s, free standing day-only abortion clinics had been established in Victoria and New South Wales and some women travelled to these states to avoid long waiting times in South Australia. Medibank data for 1976 showed that 7.5% more South Australian women travelled interstate for abortions than women coming to South Australia.[3] The 1988

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report states that 31 women were subsidised to travel interstate for late terminations in that year.

In 1985 a special committee, set up to examine abortion services in South Australia, found that the provision of services was 'quantitatively and qualitatively inadequate'.[4] As a result, the Pregnancy Advisory Centre was established in 1992, attached to the Queen Elizabeth Hospital, to reduce waiting times and to cater for late abortions. There are no privately operated free standing abortion clinics in South Australia.

Data

This paper draws on data from the Annual Reports of the Committee, and from two overview reports prepared by the South Australian Health Commission,[5,6] which contain additional information. Over the years, the types of information recorded and published have changed. The Annual Reports are based on calendar years, and since 1982, totals corrected for late reporting have been listed. The differences are small in number and are not available for all categories such as age and marital status. In these categories calculations are based on the annual reports.

Data on confinements and on estimated resident populations were taken from publications of the Australian Bureau of Statistics.[7,8] For statistical purposes, the Bureau defines a confinement as 'a pregnancy resulting in at least one live birth'. This excludes pregnancies resulting in stillbirths.

In this paper the terms abortion and termination of pregnancy are used synonymously. Pregnancies and abortions occurring in women under age 15 and over age 45 have been included in the figures for women aged 15–19 and 40–44 years. Total known pregnancies have been calculated from the sum of confinements and recorded abortions. This assumes a constant level of stillbirths and spontaneous abortion. Other papers[5,9–11] have used births instead of confinements in estimating pregnancy rates and abortion ratios, which include multiple births. Use of livebirths or confinements does not change the overall conclusions.

While data on the incidence of abortion and the characteristics of patients appear to be accurate, reporting of complications may be less so, particularly in the early years as mentioned in the 1976 Annual Report. Given that it has been comparatively easy to obtain an abortion in Victoria and New South Wales, it is unlikely that the official abortion statistics are greatly influenced by patients coming from other states.

RESULTS

Incidence

The 1999 Annual Report shows that the number of abortions in South Australia increased from 1440 in 1970 to 5660 in 1999. Aggregating the data over the six quinquennial periods indicates that the incidence of abortion increased from 9.8 per 1000 women aged 15–44 in 1970–74 to 17.3 per 1000 in 1995–99: an increase of 76% (Table 1). The dramatic increase during the early years can be attributed mainly to the shift from the clandestine sector and to better reporting of abortions. After the initial rise, the abortion rate reached a plateau until the early 1990s and has risen since, reflecting the increase in the proportion of pregnancies that end in abortion.

Table 1 Age-specific abortion rate per 1000 women per year, South Australia, 1970–99

Age	1970–74	1975–79	1980–84	1985–89	1990–94	1995–99
<20	12.3	18.7	21.1	18.7	19.6	24.5
20–24	12.7	17.9	21.9	23.1	26.4	32.2
25–29	9.4	12.1	14.2	15.4	17.8	22.6
30–34	8.9	8.6	9.3	10.8	12.7	14.5
35–39	7.7	6.8	5.8	6.1	7.6	9.3
40+	4.8	4.2	2.9	1.9	2.7	3.5
All ages	9.8	12.4	13.5	12.8	14.5	17.3
Average annual number of abortions	**2451**	**3512**	**4073**	**4248**	**4795**	**5555**

The teenage abortion rate rose rapidly in the first 15 years and after a decline in 1985–89 has been increasing again (Table 1). Among women aged 20–24 the abortion rate has increased in each time period and since 1980–84 has been the highest for all age groups. Rates have also increased for women aged 30–34 and 35–39. Women aged 40 and over are the only group where abortion rates have declined overall but even here there has been a slight rise since 1990.

Characteristics of abortion patients

The changing characteristics of women undergoing abortion in South Australia are summarised in Table 2.

Age of woman

About half of the women who had an abortion were aged 25 years or younger. The mean age declined in the first 15 years and has been increasing ever since.

Marital status

The analysis of marital status depends much on the definition of nuptiality that the Australian Bureau of Statistics relates to a registered marriage. In the official reports, de facto unions have been identified only since the 1980–84 period, reflecting the general trend of an increase in such relationships. The percentage of abortions to unmarried women in each quinquennial period increased up to 1985–89 and has declined since. The largest proportional increase has been among those in de facto relationships.

Place of residence

Because of changes in classification, country and other have been combined. The proportion of women from country areas increased over the first 15 years but has declined since to the original level around 17% of the total.

Table 2 Percentage distributions of characteristics of women undergoing abortion in South Australia, 1970–99

Characteristic	1970–74	1975–79	1980–84	1985–89	1990–94	1995–99
Age						
< 20	27.2	31.7	29.3	24.6	21.0	21.3
20–24	26.0	27.8	30.9	30.4	30.7	29.3
25–29	16.7	18.1	18.8	21.0	20.7	21.7
30–34	12.8	11.2	12.0	14.0	15.7	14.4
35–39	10.4	7.2	6.5	7.6	8.9	9.8
40+	6.8	4.0	2.6	2.4	3.0	3.5
Mean age	26.1	24.7	24.6	25.3	26.0	26.1
Marital status*						
Unmarried	57.7	65.4	71.7	71.8	68.3	61.2
Married	42.3	33.5	26.1	23.6	22.6	24.2
De facto	n/a	n /a	1.9	3.8	6.6	10.6
Place of residence						
City	83.3	81.3	80.3	81.4	83.0	83.4
Country	16.7	18.7	19.7	18.6	17.0	16.6
Previous abortions						
None	87.9	85.9	79.3	78.7	72.9	64.7
1 or more	12.1	14.1	20.7	21.3	27.1	35.3
1 or more under SA Act	3.1	3.8	12.8	17.6	21.4	27.4
Period of gestation						
First trimester	86.8	90.1	92.3	96.0	95.1	93.2
Second trimester	13.2	9.9	7.7	4.0	4.9	6.8
Reasons for termination						
Psychiatric disorders	88.9	96.4	97.7	97.6	96.9	97.6
Medical disorder	6.7	1.6	0.8	0.6	0.5	0.3
Potential fetal damage/abnormality	4.0	1.9	1.4	1.7	2.5	2.0
Others	0.4	0.1	0.1	0.1	0.1	0.1

n/a = data not available; *excludes cases when marital status was not stated

The 1999 Annual Report comments that while 18% of women in South Australia were from country areas, only 7% of abortions were performed in country hospitals, reflecting the capacity of country hospitals to carry out abortions, as well as the accessibility of metropolitan hospitals.

Previous abortions

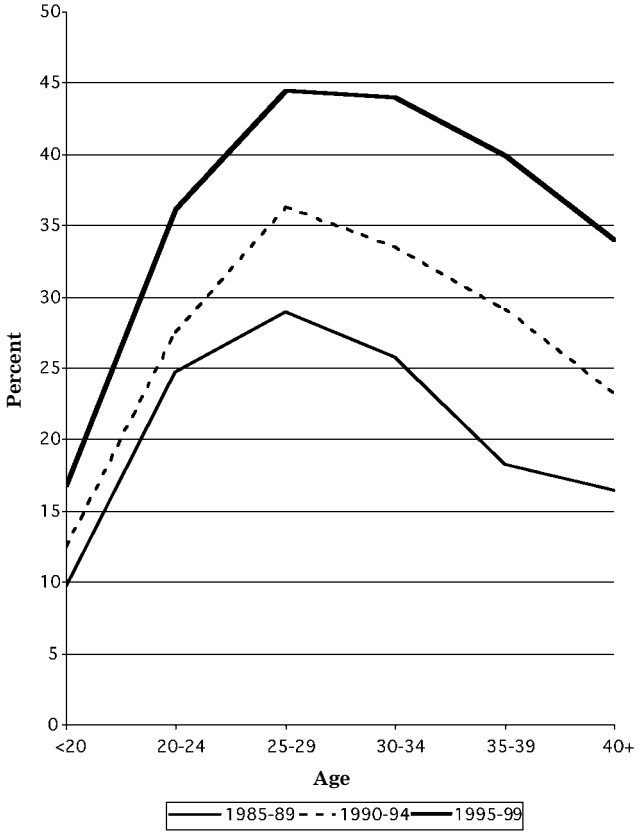
The proportion of women reporting one or more previous abortions has trebled over the 30-year period, including an increase in those performed under the South Australian Abortion Act. The disparity represents women who have had abortions elsewhere. In early years a detailed history of previous terminations was not collected and no distinction was made between spontaneous and induced abortions.[5]

Figure 1 shows that during the three most recent quinquennial periods, the percentage of women who had previous abortions had increased over all age groups and particularly over the past decade. The increase, particularly among teenage women, should be a matter of concern.

Period of gestation

The proportion of terminations performed in the first trimester, rose from 87% in 1970–74 to 96% in 1985–89, and has declined since. More detailed figures available since 1985–89 indicate that the proportion of terminations at 5–8 weeks actually increased, with a decline in terminations at 9–12 weeks and a rise in second

Figure 1 Age specific percentage of women reporting previous abortions, South Australia, selected periods



trimester abortions. In 1999, these included 213 abortions over 20 weeks gestation in the last five-year period and 91 in 1999 alone, of which only 41 were for abnormality of the fetus.

Reason for termination

The main reason for termination has been the mental health of the woman, which increased from 89% of cases in 1970–74 to around 97% since 1980–84. According to the 1999 Report, 6% of women stating a mental health reason had their abortion during the second trimester and were responsible for 71% of second trimester abortions, including 49 of the 91 performed after 20 weeks. Medical conditions in the woman have declined from 7% of terminations in 1970–74, to less than 1% from 1980–84, and in 1999 only 18 cases were recorded for this reason, of which 13 were performed in the first trimester.

The proportion of abortions due to the risk of fetal damage has also declined, largely due to the decline in maternal rubella. In the first five years, 229 cases of maternal rubella were recorded, declining to 13 in 1985–89, five in 1990–94 and none since 1996. Recording of fetal indications has also changed over the years. In 1970–74, 4% of terminations were for 'potential damage to the fetus', declining to 2% for 'abnormality of the fetus' in 1995–99. In 1999, of 118 terminations performed for this indication, 105 were for identified fetal abnormality and eight for possible damage from drugs, including three for exposure to isotretinoin, used for the treatment of severe acne. Ninety-six of the 118 cases were performed in the second trimester, including 41 after 20 weeks. The 1990 Annual Report noted that an increase in terminations for potential fetal damage was likely, due to improvements in prenatal diagnostic methods, but such an upsurge is not yet apparent.

Parity

Information about parity is not included in the Annual Reports, but was obtained from the two consolidated reports.[5,6] Over the period 1970–74 to 1985–89, abortions among nulliparous women increased from 48% to 58%, and from 10 to 16% among para 1 women. Abortions among para 2 women remained constant around 16–17% and there was a marked decline among women with three or more children from 25% to 9%. These figures reflect the postponement of first births and the general decline in family size, which has also occurred nationally. The percentage of women reporting four or more children ever born declined from 26 in 1981 to 12 in 1996.[7] No consistent relationship between age, parity and reported termination has been found.[5]

Procedure and related Issues

Information about the procedures used for termination of pregnancy and related issues is summarised in Table 3.

Table 3 Percentage distributions of procedures, complications, type of doctor, hospital type and length of stay for abortions, South Australia, 1970–99

Characteristic	1970–74	1975–79	1980–84	1985–89	1990–94	1995–99
Procedure						
Dilatation and curettage	41.5	11.9	4.5	1.3	0.9	1.5
Hysterotomy/hysterectomy	8.0	1.1	0.4	0.2	0.1	0.0†
Vacuum aspiration	48.8	82.5	91.4	96.6	95.2	92.3
Chemical methods*	n /a	0.7	3.3	1.8	2.0	1.7
Cervical prostaglandin instillation followed by dilatation and evacuation	n /a	n /a	n /a	n /a	1.9	4.5
Others including not stated	1.7	3.7	0.5	0.1	0.0	0.0†
Concurrent sterilisation	16.9	13.0	8.9	7.1	4.2	2.2
Complications						
None	94.6	97.2	97.6	98.9	99.1	99.2
Complication type (percentages based on those who had complications)						
Sepsis	23.7	28.3	11.5	13.5	14.7	13.6
Haemorrhage	27.1	19.5	24.1	48.8	37.6	44.1
Perforation /trauma of uterus	n /a	5.1	10.9	14.7	13.3	9.5
Anaesthetic complication	n /a	n /a	1.1	1.6	0.9	0.5
Others	49.2	47.1	52.5	21.4	33.5	32.3
Type of doctor						
Specialist/trainee in obstetrics and gynaecology	67.8	87.7	84.3	85.3	62.7	37.2
Other medical practitioners	32.2	12.3	15.7	14.7	37.3	62.8
Hospital type						
Metropolitan – public	46.4	72.5	73.2	68.6	76.8	88.5
Metropolitan – private	46.9	19.9	19.2	24.0	14.3	5.1
Country	6.6	7.6	7.7	7.4	8.9	6.4

*Includes intra-uterine injection (including prostaglandin), intra-uterine/intravenous infusion, extra-amniotic or cervical prostaglandin instillation; †< 0.1per cent; n/a = data not available

Procedure

One of the earliest changes was the improvement in abortion techniques. Vacuum aspiration as a day-only procedure has replaced dilatation and curettage as the most common method used and hysterotomy/hysterectomy have almost disappeared. The increase in second trimester abortions over the last decade is reflected in the use of chemical methods (intrauterine injection, intrauterine or intravenous prostaglandin infusion, extra-amniotic or cervical prostaglandin instillation) with or without dilatation and evacuation.

Concurrent sterilisation

Another major change has been the decline in concurrent sterilisation across all age groups (Table 4). This is associated with changes in technology and length of stay. While it is not known how many women go on to be sterilised later, a study of women in New South Wales has shown a marked decline in female sterilisation and a postponement to older age groups.[12] When the median age of childbirth is rising,[7] abortion facilitates the postponement of childbirth and gives women a choice of a further birth at a later date.

Of more concern is the use of concurrent sterilisation among young women. Although no sterilisations have been reported in the past 10 years among teenagers, a few are still occurring in women aged 20–24.

Table 4 Age-specific percentage of women undergoing abortion who had concurrent sterilisation, South Australia, 1970–99

Age	1970–74	1975–79	1980–84	1985–89	1990–94	1995–99
< 20	0.5	0.5	0.2	0.2	0.0	0.0
20–24	3.9	2.7	1.5	1.2	0.4	0.3
25–29	19.7	14.8	9.3	6.5	3.2	1.8
30–34	36.2	32.9	22.8	15.5	8.8	3.6
35–39	44.6	48.4	41.1	28.0	14.7	7.7
40+	46.5	55.7	49.2	41.3	23.4	12.6

Note: Data for 1970–1989 were taken from Chan et al[5]

Complications

Complication rates have improved dramatically since the adoption of vacuum aspiration. Haemorrhage during the abortion or postoperatively remains the major complication followed by sepsis. Complication rates are higher for abortions induced by extra-amniotic or cervical prostaglandin instillation. According to the 1999 Annual Report, these procedures had a complication rate of 12%, compared with less than 1% overall. There may have been serious deficiencies in the reporting of complications in the early years. With short stay procedures, complications occurring after discharge may also not be reported.

In Australia prior to 1969, abortion complications were the commonest single cause of maternal death.[3] Since the new legislation there has been a marked decline in maternal deaths and only two deaths have been recorded in South Australia – both in the first five years.

Type of doctor

The changes in technology are also reflected in the type of doctor performing the termination. The trend towards obstetric specialists in the first 20 years has been reversed. With the opening of the Pregnancy Advisory Centre, which also acts as a training centre, nearly two-thirds of operations are now performed by trained general practitioners. This relieves the load on general hospitals and specialists, especially given the rise of other specialties. It is generally recognised that the most important factors in reducing morbidity associated with abortion are the skill of the operator, the duration of pregnancy and the method used.[13]

Type of hospital

The proportion of terminations performed in country hospitals has been fairly constant. In 1970, 115 or 8% of the 1440 abortions were performed in country hospitals. In 1999, while the proportion had declined to 7% the number had increased to 411 cases.

Hospital details have been recorded since 1980–84. The proportion of abortions performed in the two major public hospitals, Queen Elizabeth and Queen Victoria (since 1995 the Women's and Children's Hospital) declined from 55% in 1991, to less than 20% in 1999, and now more than half are performed in the Pregnancy Advisory Centre. There has been a marked shift from private to public hospitals in metropolitan areas. In 1995–99, only 5% of the abortions were carried out in private hospitals.

Length of stay

Length of stay was not included in the Annual Reports but was available in the 20- year report.[6] The adoption of the newer techniques and the decline in complication rates has resulted in a significant change in the utilisation of hospital beds. Day-only procedures have increased from 3% in 1970–74 to 79% in 1985–89, while the percentage of women who stayed for two or more days declined from 79% to only 8%.

Demographic implications of abortions

An estimate of total known pregnancies was obtained by adding abortions to confinements as recorded by the Australian Bureau of Statistics. Based on age-specific abortion and confinement rates two other indices – total abortion rate and total confinement rate – were estimated by summing the annual rates over the reproductive period. These rates are defined as the expected number of abortions/confinements 1000 women will have in their lifetime if they were subjected to the underlying age-specific abortion/confinement rates.

In 1970–74, the total confinement rate was 2383 and the total abortion rate was 279, with an estimated total pregnancy rate of 2662 (Figure 2). The total pregnancy

Figure 2 Estimated total pregnancy rate and its components, South Australia, 1970–1999

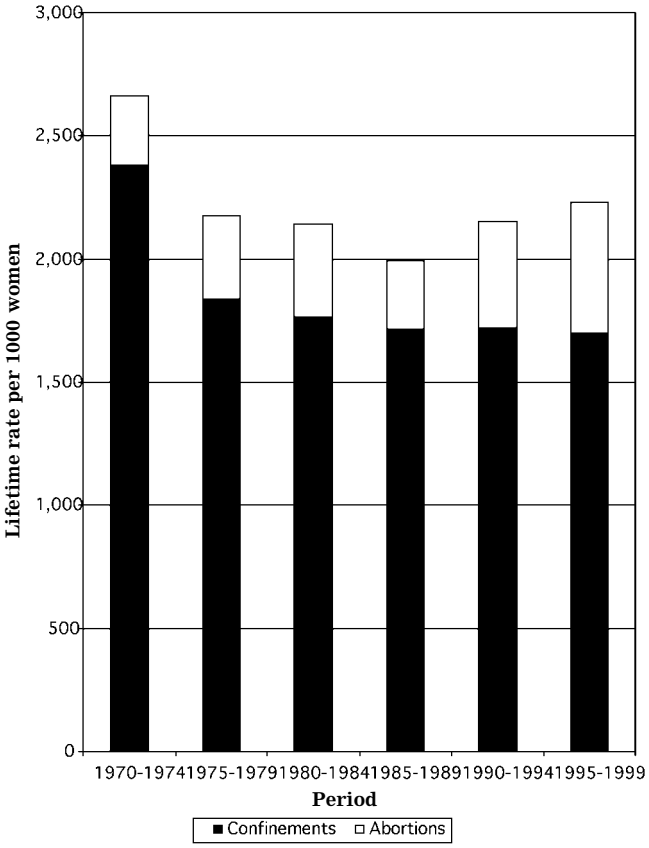
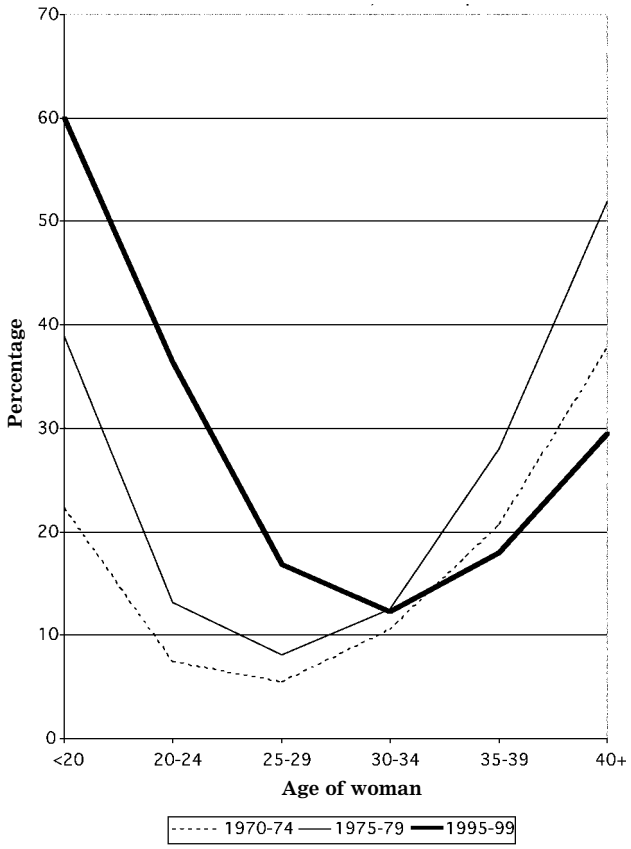


Figure 3 Abortions as a percentage of known pregnancies per year by age of woman, South Australia, selected periods



rate showed a dramatic initial decline, but has been increasing since 1985 reflecting changing patterns of contraceptive use. The total confinement rate after a sharp initial drop has continued to decline at a slower pace, indicating the increase in abortion over the same period.

The proportion of pregnancies ending in abortion has more than doubled over the 30-year period from 10.3% to 23.3%. Changes have varied across different age and marital status groups. The highest proportion occurs among unmarried women, fluctuating between 43.4% and 54.5%, while for married women this has increased from 5.1% in 1970–74 to 9.5% in 1995–99. Figure 3 shows the marked increase in this proportion among teenagers, and to a lesser extent among those aged 25–29. After that age the proportion declined substantially due to the shift towards older age at childbearing which reflects the postponement of motherhood.

DISCUSSION

South Australia remains the only state where notification of abortion is required and an annual report is published. In the other states, in the absence of routine reporting and publication, the availability of data is more complicated. One source of information is the data from Medicare, which covers only those women for whom a rebate has been paid. Information on abortions performed on public patients is not included in the Medicare data and has to be obtained separately.

Medicare data are generally considered to be an under-estimate of the total number of abortions by about 10–20%.[14] Data obtained by the authors indicate that in 1985, 41% of South Australian cases were reported under Medicare, and this declined to 28% by 1992, the year the Pregnancy Advisory Centre was opened, and in 1999 declined further to 13%, reflecting the small proportion of terminations carried out on fee-paying patients in South Australia.

The Annual Reports show that the abortion rate in South Australia has nearly doubled since 1970. The abortion rate in 1999 was 17.9 per 1000 women aged 15–44, still well below the rate of 18.6 calculated using Medicare data for the remainder of Australia.

The federal Royal Commission on Human Relationships commented on the higher rates of concurrent sterilisation in the early stages of legal abortion that was often seen as a condition for performing the operation.[13] The Commission quoted from the Lane Report in the United Kingdom that found that concurrent sterilisation increased the morbidity and

mortality rates of abortion. They recommended that women should not be pressured into making two serious decisions at the one time: termination and sterilisation. The indications for concurrent sterilisation in South Australia were not stated, but some intellectually handicapped young women may have been sterilised as a means of avoiding further pregnancies.

Over time it might be expected that the proportion of women reporting previous abortions would show an increase, both because the population at risk increases, and because circumstances may make some women more liable to repeated unplanned pregnancy. The improvement in access and reduction in morbidity, stigma and stress associated with abortion and the attitude that full control of pregnancy is now possible, all reduce the social and psychological barriers which might have prevented women from seeking termination. In the early years many women might not have been prepared to report previous, often illegal, abortion. While it had been anticipated that the proportion of repeat abortions would reach a plateau,[5] this is not yet obvious.

CONCLUSION

Since the amendments to the abortion legislation dramatic changes have occurred in South Australia. The introduction of better surgical techniques, special training, and improved facilities and access, have meant that abortion has become a safer, day-only procedure. Abortion deaths have virtually disappeared. The opening of the Pregnancy Advisory Centre has relieved the burden on general hospital beds. To some extent this has made abortion a more accessible and acceptable solution to an unplanned pregnancy.

The decision to proceed with an unplanned pregnancy is influenced by many social, economic and demographic factors, including the increasing participation of women in education and the workforce, the necessity for a second family income, and increasing age at marriage. The choice between abortion and continuing the pregnancy has a major impact on the rest of a woman's life. A young unmarried woman, raising a child alone, faces serious financial and social disadvantages. There is still stigma and criticism surrounding such women going on supporting mother's benefits.

Concern has been expressed by opponents to legalising abortion that its availability would result in women using abortion rather than contraception for birth control. Earlier studies indicated that more births are prevented by contraception than by abortion.[15] In the past 15 years, in South Australia the emphasis seems to be shifting from contraception to abortion. However, overall, for the 30-year period, the decline in total pregnancies well exceeded the increase in abortion rates.

No state governments and political parties have abortion law reform in their policies. Experience in other states suggests that further attempts to liberalise abortion could result in legislation imposing stricter requirements than under the common law rulings. However, it should still be possible for all states to obtain and publish abortion data similar to that in South Australia.

Finally, the Commonwealth Government should consider the removal of restrictions on the import and availability of better methods of post-coital contraception that could reduce the need for abortions.

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