

Medical abortion in Australia: a short history

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Abstract: *Surgical abortion has been provided liberally in Australia since the early 1970s, mainly in privately owned specialist clinics. The introduction of medical abortion, however, was deliberately obstructed and consequently significantly delayed when compared to similar countries. Mifepristone was approved for commercial import only in 2012 and listed as a government subsidised medicine in 2013. Despite optimism from those who seek to improve women's access to abortion, the increased availability of medical abortion has not yet addressed the disadvantage experienced by poor and non-metropolitan women. After telling the story of medical abortion in Australia, this paper considers the context through which it has become available since 2013. It argues that the integration of medical abortion into primary health care, which would locate abortion provision in new settings and expand women's access, has been constrained by the stigma attached to abortion, overly cautious institutionalised frameworks, and the lack of public health responsibility for abortion services. The paper draws on documentary sources and oral history interviews conducted in 2013 and 2015. © 2015 Reproductive Health Matters. Published by Elsevier BV. All rights reserved.*

Keywords: medical abortion, mifepristone, Australia, abortion regulation

Introduction

Australia has lagged behind other developed countries in making medical abortion widely available. Surgical abortion became liberally accessible in Australia from the early 1970s. But when medical abortion was becoming available in comparable countries elsewhere, its introduction to Australia was obstructed legislatively by the federal government through its jurisdiction over the import of pharmaceutical drugs. Since the removal of this obstructive legislation in 2006, an array of forces have both enabled and constrained the availability of medical abortion. This article provides a brief history of medical abortion in Australia and offers an account of the context in which medical abortion is currently being made available. It argues that while medical abortion is becoming increasingly available, its potential to solve problems of access for women who are poor and/or outside metropolitan centres is yet to be realised. It adds to national and international literature on both the availability of medical abortion and the challenges of creating adequate access to abortion services for all women.

The article is based primarily in historical analysis of documentary sources and secondary literature.

This is complemented by expert opinions from health professionals and managers who have worked in abortion services in both the public and private sectors and researchers, educators, public servants, advocates and activists, obtained through interviews conducted by the author in 2013 and 2015.*

Abortion in Australia

Australia has a federal system of government. Abortion has been defined in the criminal law, separately in each state and territory. Liberalisation

*The Flinders University Social and Behavioural Research Ethics Committee approved the oral history project (no 5958) which produced these interviews, as part of a bigger investigation of the provision of abortion services in Australia from 1990 until the present. Interviewees were selected from the author's networks based on their professional background and long experience. At the instigation of the author all are anonymous. Nevertheless, given the high public profile of many, their comments may identify them to others in the abortion and/or sexual and reproductive health fields in Australia and this was understood by all the interviewees when they consented to participate in the interview.

proceeded in the 1970s, state by state, not by removing abortion from the criminal law, but by liberal court ruling or legislative reform which delivered a medicalised framework. Despite a generally robust public health system in Australia, albeit one subject to the pressures of neoliberal economic policy,¹ there has been very little public health responsibility taken for the provision of abortion in the period since liberalisation. In 1990, 13% of abortions were provided in the public health system free of charge.² The proportion of public provision has declined since 1990.³ Service provision has been dominated by general practitioners in private specialist clinics concentrated in the capital cities.² In 2000, a subsidiary of Marie Stopes International, the UK-based global reproductive health NGO, entered the Australian abortion provision market. In 2015, Marie Stopes International Australia (henceforth Marie Stopes) clinics provide upwards of one third of all abortions in Australia and do so with the expressed intention of generating surplus funds to support their activities in developing countries.⁴

Whilst public provision has been minimal, Medicare, the federal government health insurance scheme, has provided a rebate for the cost of a privately provided surgical abortion procedure since its inception in 1974. This rebate, on average, halves the cost of a surgical procedure.^{2,5} Prices vary from clinic to clinic and increase sharply for pregnancies over twelve weeks. For a surgical abortion under twelve weeks the cost is, *on average*, between AU \$400 and AU \$500 after the rebate. For many poor women and those in non-metropolitan locations even this rebated cost is prohibitive, especially when travel costs are also involved. This disadvantage is compounded if women are also young, disabled, racially marginalised or without citizenship entitlements.²

Australians, including doctors, have been increasingly pro-choice in their views about abortion since the 1970s.^{6–8} But since the 1990s, a melange of moral judgement, liberal feminism and neoliberal forces has constituted a dominant “hybrid discourse” that is both pro-choice and anti-abortion.⁹ Abortion has a historically accumulated status which makes it marginalised and stigmatised as a health service and as a woman’s reproductive experience. The inclusion of abortion in training for doctors is haphazard. The small number of doctors willing to perform abortions is a constant challenge to the adequate provision of services and is explained in part by this marginalisation.¹⁰

The arrival of medical abortion is just one aspect of the dynamic nature of abortion in Australia in the early twenty-first century. There have been significant political contests over abortion in nearly every jurisdiction since the mid-1990s. Since 2002 abortion has been completely removed from the criminal law in three jurisdictions,^{9,11,12} but this achievement has not solved the problems of access for women in these jurisdictions.

The history of mifepristone and medical abortion in Australia

In the early 1990s, internationally coordinated trials sponsored by WHO were initiated in New South Wales and Victoria to investigate the use of mifepristone as an emergency contraceptive and as an abortifacient.¹³ At the same time, the Australian National Health and Medical Research Council had established an Expert Panel to investigate abortion services. This multidisciplinary, generally feminist group of experts on abortion recommended research and evaluation of mifepristone and misoprostol.² Both initiatives drew anti-abortion responses and their promise of a move towards the availability of medical abortion in Australia was cut short in 1996 when the newly elected conservative government, led by Prime Minister John Howard, passed legislation that created special conditions for the import of mifepristone into Australia, thus effectively banning it.⁹ The obstruction of the development of medical abortion was only one of several anti-abortion measures introduced by the Howard government during their time in office. But the Medicare rebate remained in place and all but one contest in state and territory parliaments resulted in pro-choice victories.⁹

Moves to lift the ban on mifepristone took a few years to materialise. In 2000, the president of the Abortion Providers Federation of Australia was quoted in the media as saying that the federation was planning to lobby for the drug’s availability.¹⁴ A College Statement by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, issued first in 2001, and then amended in 2005, stated that mifepristone’s entry into Australia should be assessed like other drugs and so, implicitly, not through the obstructive framework in place.¹⁵ Some individual obstetricians and gynaecologists published articles in the medical press calling for Australian women to have access to mifepristone.¹⁶

Against this backdrop, a cross-party group of female federal parliamentarians introduced a bill

to remove the special conditions that applied to the import of mifepristone. After a parliamentary inquiry and significant lobbying the bill passed through the parliament in 2006, a victory over the conservative Christian lobby which included several senior ministers of the then federal government.¹³

This legislative change did not necessarily mean that mifepristone would be imported. It did, however, allow doctors to undergo a time-consuming process to become Authorised Prescribers of mifepristone, a Therapeutic Goods Administration process which enables individuals “to import and use drugs that are recognised and used overseas but are unavailable in Australia”.¹⁷ Misoprostol was already available. Once authorised, doctors were able to import the drug from a not-for-profit company in New Zealand, which had been importing the drug from France since 2001.^{18,19} After a slow start, by 2012 about 200 doctors had been authorised in Australia, nearly all located in the larger capital cities.¹⁷ It is almost certain that most of these were already offering surgical abortions in existing private clinics or public hospitals.

Several doctors who had led the way in gaining Authorised Prescriber status published commentaries and research articles in a variety of health and medical journals about their initial use of mifepristone, showing that its use was effective, safe, consistent with international experience and well-accepted by women.^{20,21} De Costa et al called for a proactive approach by “individual doctors, professional bodies and Health Departments” to make mifepristone more widely available.²² They also called for reform in jurisdictions where the law restricted the places where abortions could be performed.²³

The possibility of increased accessibility of mifepristone depended on a costly application process to the Therapeutic Goods Administration by a drug company or a sponsor willing to import it. Ultimately, Marie Stopes set up MS Health as a subsidiary company explicitly for this purpose.²⁴ In August 2012, after a process of about three years, they successfully obtained registration from the Therapeutic Goods Administration for mifepristone Linepharma (200mg) and misoprostol GyMiso® (four tablets of 200mcg) for medical abortion up to 49 days gestation. While misoprostol had already been used widely “off-label”, this registration was a landmark in formal recognition of its usefulness for abortion purposes.²⁵ MS Health received approval from the Therapeutic Goods Administration to import and distribute the drug on the condition that, as one

abortion-providing doctor described it to me, a huge and expensive risk management scheme was put in place. This included mandatory training for prescribers, registration for doctors and pharmacists, 24-hour access to an information service and to emergency medical care for a 14-day period, and a follow-up visit. Ultrasound to confirm pregnancy was recommended. The infrastructure for training and registration that MS Health was required to provide contributed to a six-fold higher price of mifepristone when compared to that charged by the company in New Zealand. Twelve months after the approval by the Therapeutic Goods Administration, the two drugs were registered by the Pharmaceutical Benefits Advisory Committee as subsidised drugs on the Pharmaceutical Benefits Scheme, reducing their cost significantly.²⁶ In 2015, mifepristone and misoprostol were approved for use up to 63 days of gestation.²⁷

Desires, Hopes and Fears

While the political process described above was unfolding, Australian women’s knowledge of and desire for medical abortion was growing. As early as 2000, doctors reported that women’s demand was a key reason for their offering medical abortion with methotrexate (an inferior alternative to mifepristone) and/or misoprostol “off label”.¹⁴ A public sexual health clinic in Far North Queensland started offering methotrexate medical abortion in 2006.²² Some of the doctors who sought Authorised Prescriber status after 2006 referred to women’s desire for medical abortion as their motivation.²² In 2013, the media coverage given to mifepristone’s newly subsidised availability immediately raised expectations among women that medical abortion would become a cheap option beyond existing clinic provision.²⁸

Women were also obtaining the drugs for medical abortion outside formal channels in the years before they became more easily available. The most notable case concerned a 19-year-old woman and her boyfriend, who were arrested in Cairns, where, ironically, medical abortion was available at the time, under a never previously applied law that criminalised the practice of a woman inducing her own abortion. The woman had used mifepristone sent to her from the Ukraine.²⁹ She and her boyfriend were eventually acquitted by a jury and it is likely that the interpretation of the law in relation to mifepristone in this case will set a significant precedent.³⁰ Media at the time claimed that, according to doctors, mifepristone and misoprostol were “widely available on

the black market”.⁶ One doctor I interviewed in 2013 recounted the case of a young Indian woman attending a public hospital after an incomplete medical abortion induced with drugs purchased over the counter in India.^{30,31} That is, even since becoming available legitimately, mifepristone is being accessed outside regulated channels, demonstrating not only the porosity of Australian regulations and borders but also women’s ingenuity in obtaining abortifacient drugs.

Given women’s demand for medical abortion, the response from the pro-choice constituency to the Pharmaceutical Benefits Scheme listing of mifepristone was celebratory. “Medical abortions will finally be easily available to Australian women” wrote one group of public health academics, envisioning cheaper and wider access to medical abortion for women, including those in rural areas.²⁶ A clinic manager I interviewed in 2013 imagined the possibility of nurse practitioners providing medical abortions, something not currently lawful in any jurisdiction, and telemedicine as a way to provide access for women in rural and remote locations.

Some interviewees however, counsellors, a women’s health worker and a doctor, expressed reservations about medical abortion *per se*. Concerns were expressed about the possible isolation of women who abort at home and the situation of women who are poor and/or homeless. These reservations reprised issues about Marie Stopes’ then current practice of medical abortion, which were raised in an editorial in the *Medical Journal of Australia* written by two obstetricians and gynaecologists in 2012.¹⁷ The telephone hotline which constituted Marie Stopes’ arrangements for emergency aftercare at that time was, the authors stated, not always appropriate, ‘especially for women in rural areas’. The authors noted that while the clinical supports needed for complications after a medical abortion are the same as those for a spontaneous miscarriage, the personal and social circumstances surrounding abortion, including some women’s desire for confidentiality, are different. Some interviewees also expressed the concern that as, (if), doctors and clinics, and governments, see medical abortion as the preferable option, the number of doctors with the skill to perform surgical abortions would diminish even further.

What has happened in recent years?

The potential for medical abortion to deliver greater access lies in its integration into primary

health care. In Australia, this mostly means general practitioners in private practice.

Given the absence of national data regarding abortion, and the confidentiality of MS Health’s registration information, the exact situation regarding the availability of medical abortion is unknown. Presentations at conferences in 2014 and 2015 as well as interviews conducted in 2015 suggest that the uptake of medical abortion by general practitioners has been disappointingly slow.^{28,32,33}

Some of the earliest reports in the popular media after mifepristone and misoprostol were subsidised complained that medical abortion was not costing less than surgical abortion. In some cases, it was costing more.^{34,35} The CEO of Marie Stopes was reported on a feminist blog explaining that in addition to the cost of the drugs, there were “medical practitioner consultation fees, ultrasound costs, blood tests or other tests, if required”. She expected that over time the price would come down.³⁵ For the time being, this has not yet been realised in abortion clinics, although a very small number of general practitioners offer medical abortion at a significantly cheaper cost, and it is free in the public sector.

Some early impediments to the uptake of medical abortion have been resolved. Insurance companies who provide medical indemnity cover initially considered the risks of providing medical abortions to be the same as providing surgical abortions. Doctors who may have been considering incorporating medical abortion into their general practice were thus faced with a prohibitive annual increase in their medical indemnity insurance.^{34,35} After lobbying by the relevant medical Colleges, the major medical insurer of general practitioners in Australia, Avant, remedied the disparity at the end of 2014, thus removing this financial disincentive.³⁹ One doctor who I interviewed hoped that the extension of the authorised use of mifepristone to 63 days from the beginning of 2015 would ease the time pressure and enable more general practitioners to incorporate medical abortion into their practice.

Some impediments are harder to shift. The existing law in three jurisdictions (South Australia, the Australian Capital Territory and the Northern Territory) restricts abortions to “prescribed’ or ‘approved’ hospitals or clinics”. This is a significant limit to the uptake of medical abortion by general practitioners in those jurisdictions.²³ The Therapeutic Goods Administration requirement of the provision of emergency care means that women in remote communities, including many Indigenous

women, are currently unlikely to benefit from the availability of mifepristone.

The stigma attached to being an abortion provider continues to be a major disincentive for general practitioners, especially in small rural communities.^{32,33} General practitioners have also worried that if they become identified as providers of medical abortion, their practice will be overwhelmed by requests for abortion. A New South Wales sexual and reproductive health referral service reported that in the first year after mifepristone became a subsidised medicine, when about one third of their callers who were seeking an abortion were wanting a medical abortion, some of the small number of general practitioners on their referral list “requested to be removed from our database”.²⁸ While hoping for more, one doctor who I interviewed predicted that while a small number of progressive doctors would consider offering medical abortion to their patients most doctors will not do this. Further, she expected resistance from colleagues and local communities.

The need for a general practitioner to develop a relationship with a community pharmacy which will stock mifepristone and misoprostol has also been an impediment, particularly in rural communities. Even in Sydney, where a study of community pharmacists was conducted in the wake of the Pharmaceutical Benefits Scheme listing of mifepristone, only half of those interviewed “expressed pro-abortion views”.³⁶ Pharmacists who wish to dispense mifepristone are required to be registered with MS Health and must confirm that “the procedure has been fully explained and consent form signed”. The study found that pharmacists not already dispensing mifepristone felt that they lacked not only legal and clinical knowledge but also the skills and environment to provide counselling, their perception of the need to “explain”. They also reported workplace conflict over whether or not to dispense.

There have been some efforts to actively promote medical abortion to general practitioners. In Queensland, Children by Choice, a unique and long-standing abortion advocacy and referral NGO, have provided resources via their website and delivered workshops (online and by video link), in some instances in partnership with Family Planning Queensland. They have also actively identified potential doctors “in particular those in communities with the least access to abortion services to encourage them to become certified prescribers”.³² At the beginning of 2015, they reported little success in non-metropolitan areas,

although one Brisbane general practitioner has developed the necessary relationship with a pharmacist and begun to offer medical abortion in her group general practice at significantly less cost than a surgical abortion.³⁷ In Victoria, a unique *ad hoc* coalition of a public hospital, a university research body, NGO advocacy bodies and a private clinic was formed in late 2013 to facilitate the uptake of medical abortion in rural general practices by offering information and training sessions. As a result of these efforts, one major regional centre now has two general practices that provide medical abortion. The only charge to the woman is the cost of medication.³³ This inspiring expansion of the provision of affordable access to abortion through a general practice in a regional area is an isolated case thus far. In early 2015 MS Health, the distributor of mifepristone, expanded their promotional efforts by conducting a webinar for GPs to promote and inform about medical abortion. About one hundred participated.

In the context of the ongoing absence of any central public health coordination of abortion services in all jurisdictions,³³ and in the face of the slow uptake of medical abortion by general practitioners, telemedicine stands out as a method of materializing access, particularly for rural women. Marie Stopes have started a modest trial to offer medical abortion via telemedicine but the most significant development in this respect has been the launch of the Tabbott Foundation in September 2015. This new body pioneers an innovative business model for abortion provision. It has been established by an existing private provider to offer “an Australia-wide telephone consultation home medical termination of pregnancy service”, although women in the jurisdictions which require abortion to be performed in a hospital will not be served.³⁸ Women in rural and regional locations are the foundation’s main focus. For women with a Medicare card the cost is AU \$250. A news report at the end of their first week claimed that the foundation had been “so overwhelmed by prospective patients it cannot meet the demand”.³⁹

Conclusion

The 2006 overturning of the legislation which had prohibited the import of mifepristone was only the end of the beginning of the process of introducing medical abortion to Australia. In 2015, at the end of the second year of the regulated and subsidised availability of medical abortion, most women

who already had access to surgical abortion now have the choice of medical abortion. But the potential that medical abortion might solve problems of access to abortion for poorer women and those outside the metropolitan centres is thus far only beginning to be realised.

The introduction of medical abortion in primary health care settings will require the negotiation of the politics of abortion with an array of institutions and professions and in relationships beyond those currently engaged in providing abortions. On the one hand, this constitutes a multiplication of the locations and relationships where women's access to abortion might be, and has been, obstructed. On the other, it will mean an expansion of networks which create possibility for women's improved access to abortion.

It should be noted that questions about the suitability of medical abortion for all women and the models through which it is offered are not unique to Australia and are perhaps inevitable when a new technology of abortion is introduced.^{40,41} While the highest possible standards of care must be provided, comparing the conditions which have shaped the availability of medical abortion in Australia to those in less affluent countries reveals an overly cautious, highly regulated and medicalised system of provision in this country. Research in other countries is exploring the "safety and efficacy of ... non-physician providers", the development of tools that will override the need for follow-up visits, the role of community health workers in providing information and post-abortion care, and the use of

mHealth and other innovative approaches for providing information to women and to providers.⁴¹ While these innovations in health care are not all necessary or desirable in the Australian context, they expand the potential for medical abortion.

After Marie Stopes' initial commitment to making medical abortion more widely available, and alongside MS Health's ongoing commercial operation, the initiatives of individual activist, and now entrepreneurial, doctors and a small number of public and private clinics and NGOs have led the way in promoting medical abortion in the wake of the listing of mifepristone and misoprostol as subsidised drugs. The impact of the Tabbott Foundation is as yet an unknown but has the potential to radically increase access.

The absence of coordinated action by public health departments to address the problems that many women have in accessing abortion, and to promote solutions like the expanded availability of medical abortion, signify the limits of the long-standing neoliberal approach to abortion provision in Australia. The deferral to the market and to activist individuals and organisations to solve these problems means that the needs of women who cannot take advantage of the choices available to metropolitan women with economic means remain a call to action.

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Résumé

L'avortement chirurgical s'est pratiqué largement en Australie depuis le début des années 70, principalement dans des centres spécialisés privés. L'introduction de l'avortement médicamenteux a néanmoins été délibérément entravée et donc retardée sensiblement par comparaison avec des pays similaires. La mifépristone n'a été agréée pour importation commerciale qu'en 2012 et inscrite dans la liste des médicaments subventionnés par les pouvoirs publics en 2013. En dépit de l'optimisme de ceux qui s'emploient à élargir l'accès des femmes à l'avortement, la disponibilité accrue de l'avortement médicamenteux n'a pas encore corrigé le handicap dont souffrent les femmes pauvres et non métropolitaines. Après avoir relaté l'histoire de l'avortement médicamenteux en Australie, l'article s'intéresse au contexte dans lequel cette pratique est devenue disponible depuis 2013. Il avance que l'intégration de l'avortement médicamenteux dans les soins de santé primaires, qui placerait l'avortement dans de nouveaux environnements et élargirait l'accès des femmes, a été restreinte par la stigmatisation liée à l'avortement, l'excessive prudence des cadres institutionnalisés et le manque de responsabilité de la santé publique pour les services d'avortement. L'article se fonde sur des sources documentaires et des entretiens d'histoire orale menés en 2013 et 2015.

Resumen

En Australia los servicios de aborto quirúrgico son ofrecidos liberalmente desde principios de la década de los setenta, principalmente en clínicas especialistas particulares. Sin embargo, la introducción del aborto con medicamentos fue bloqueada deliberadamente y, por consiguiente, retrasada en gran medida en comparación con países similares. La mifepristona fue aprobada para importación comercial en 2012 y registrada como un medicamento subsidiado por el gobierno en 2013. Pese al optimismo de quienes buscan mejorar el acceso de las mujeres a los servicios de aborto, la mayor disponibilidad de los servicios de aborto con medicamentos aún no aborda la desventaja experimentada por mujeres pobres y no metropolitanas. Después de contar la historia del aborto con medicamentos en Australia, este artículo considera el contexto en el cual ha pasado a estar disponible desde el año 2013. Argumenta que la integración del aborto con medicamentos en el primer nivel de atención, la cual situaría la prestación de servicios de aborto en nuevos ámbitos y ampliaría el acceso de las mujeres, ha sido limitada por el estigma asociado con el aborto, por marcos institucionalizados demasiado precavidos y por la falta de responsabilidad del sector salud pública de los servicios de aborto. El artículo se basa en fuentes documentales y en entrevistas de historia oral realizadas en 2013 y 2015.