Memorandum 1

Submission from the Department of Health

Introduction

1. This memorandum sets out the Government's position on abortion and highlights the action the Department of Health is undertaking to improve reproductive health. The memorandum also sets out the evidence to support current policy on abortion, where appropriate**.**

The Government's position on abortion

2. The current law governing abortions (the Abortion Act 1967) in England, Scotland and Wales was introduced by a private member's bill brought by David Steel MP.

3. The introduction of this legislation was prompted by a number of factors including a strong lobby by the women's movement and political will to safeguard women by reducing the number of illegal abortions being carried out and the number of resulting deaths. The (then) Council of the Royal College of Obstetricians and Gynaecologists (RCOG) also published a report calling for a number of measures to safeguard women and to clarify the existing law.

4. In 1967 and 1990, Parliament decided, on a free vote, that abortions may lawfully be carried out in the circumstances specified in the Abortion Act. It is accepted Parliamentary practice that proposals for changes in the law on abortion have come from back-bench members and successive governments have taken the view that such matters should be decided by members voting freely in accordance with their own conscience. The Government does however have a duty to see that the provisions of the Act are properly applied until, and unless, Parliament chooses to further amend that law.

5. The Abortion Act is a reserved issue. However, the provision of services is a devolved matter. The Department of Health deals with the policy on abortion services in England only but processes the abortion notification forms, and publishes the statistics, for abortions performed in England and Wales.

Current legal position

6. The Offences Against the Person Act 1861 (only applies in England and Wales) makes it an offence to intentionally procure a miscarriage, including for a woman to procure her own miscarriage.

7. The Infant Life (Preservation) Act 1929 (again only applies in England and Wales) makes it an offence to intentionally kill a child, capable of being born alive, before it has a life independent of its mother. It is a defence to show that the death was caused in good faith for the purpose only of preserving the life of the mother. The Act stipulates that if a woman has been pregnant for 28 weeks that shall be proof that the child was capable of being born alive. But, if medical evidence is that the foetus would be capable of being born alive, then

destroying the foetus could still be an offence under the 1929 Act, regardless of the age of the foetus. The Act says 28 weeks is the age above which there is prime facie proof that the child was capable of being born alive and therefore no further medical evidence on the issue would be needed.

8. The Abortion Act 1967 creates exceptions to the offences of procuring a miscarriage and child destruction. This Act makes an abortion legal where the pregnancy is terminated by a registered medical practitioner and where two registered medical practitioners agree that the grounds specified in the Act are satisfied. The legal time limit for most abortions in Great Britain is now 24 weeks. This was reduced from 28 weeks when the Abortion Act 1967 was amended by the Human Fertilisation and Embryology Act 1990. However, there is no time limit where there is a substantial risk that the child will suffer from a serious handicap, or the pregnancy will cause grave permanent injury to the physical or mental health of the mother, or put her life at risk.

Place of termination

9. Unless performed as an emergency, the Act states that all treatment for abortion has to take place in an NHS hospital or a place approved by the Secretary of State. Within the NHS, abortions have traditionally been carried out in gynaecology wards and day care units. Since the passing of the Act in 1967, the Department of Health has always taken the view that outside of the NHS only independent sector hospitals or clinics can obtain Secretary of State approval. The current definition of an approved place is an independent sector place registered with the Healthcare Commission under the Care Standards Act 2000. These must be subsequently approved under the Abortion Act by the Secretary of State for Health. All places must re-apply for approval every four years.

Conscientious objection

10. Except where treatment is necessary to save the life of or prevent grave permanent injury to the pregnant woman, "no person shall be under any duty ..... to participate in any treatment authorised by this Act to which he has a conscientious objection". It has been the case that if medical or nursing staff have strong ethical or moral objections to abortion work they should not be obliged to take this on. Their conscientious objection should not be detrimental to their careers and appointments. Further clarity on this clause was provided in a House of Lords judgment in 1988. This found that this exemption does not extend to giving advice, performing preparatory steps to arrange an abortion where the request meets legal requirements and undertaking administration connected with abortion procedures. The General Medical Council (GMC) booklet ‘Good Medical Practice’ states that doctors’ views about a patient’s lifestyle or beliefs must not prejudice the treatment they provide or arrange. If they feel their beliefs might affect the treatment, this must be explained to the patient who should be told of their right to see another doctor.

Notification

11. The Abortion Regulations make provision for the certification of the relevant opinion of the medical practitioners referred to in the Act and the giving of notice of abortions to the Chief Medical Officer (CMO). Practitioners are required to send to the CMO a notice of each termination on Form HSA4. In England, the Regulations require that Form HSA4 be submitted within 14 days of the procedure. This notification is used by the Department as an

aid to checking that terminations are carried out within the law. Form HSA4 requires detailed information relating to the procedure including the names and addresses of the doctors who certified there were grounds under the Act, gestation, method used and place of termination. Every form is checked and monitored by Department of Health officials, authorised by the CMO. The Department returns around 11,000 (approximately 5%) of forms each year due to missing information or to seek clarification on information given.

Key statistics

12. In 2006, for women resident in England and Wales:

- The total number of abortions was 193,700
- Age-standardised abortion rate was 18.2 per 1,000 resident women aged 15-44
- 89% of abortions were carried out at under 13 weeks gestation (a figure that has stayed steady over the last 10 years); 68% were at under 10 weeks
- 87% of abortions were funded by the NHS (55% of these took place in the independent sector under NHS contract, mainly by the providers BPAS and Marie Stopes International)
- 70% of abortions were performed surgically and 30% were medical abortions
- 1% of abortions were performed due to the risk that the child would be born seriously handicapped
- 2,948 performed at 20 weeks and over (1.5% of total performed). Of these, 1,262 were performed at 22 weeks and over (0.7% of total performed) and 136 at 24 weeks and over (majority performed due to fetal abnormality). 149 abortions were performed where the woman's life was at risk or to save the woman's life.

Methods of abortion

13. Different methods may be used to terminate a pregnancy, depending on duration of gestation and other circumstances relating to the individual woman. The most common method of abortion continues to be vacuum aspiration which was used in 64% of abortions in 2006. However, in recent years there has been a large increase in the use of the abortifacient drug Mifegyne (mifepristone also known as RU486). Medical abortion accounted for about 30% of the total in 2006. The proportion of medical abortion has more than doubled in the last 5 years.

14. Medical abortion takes place in two stages. First, Mifegyne is given orally in a single dose. Forty-eight hours after the pill has been taken, a prostaglandin pessary is inserted into the vagina. The effect of this is to cause the uterus, already affected by the Mifegyne, to expel the pregnancy, generally within six hours.

15. During the Committee stage of the Human Fertilisation and Embryology Bill an amendment was passed, on a free vote, giving the Secretary of State power to approve classes of place (as opposed to individual places) where specified drugs may be used to carry out abortions in whatever manner was specified in the approval. The amendment anticipated the possibility that drugs like Mifegyne would be fully licensed and be available in places other than NHS hospitals or individually approved places. It was seen as an enabling provision should experience of the drug and the climate of opinion be right for such a move.

16. Progress is now being made to determine a "class of place". Two hospitals are currently being funded by the Department to run early medical abortion services in non-traditional settings, to evaluate the effectiveness and safety of provision in these settings. One site is within a community hospital; the other is in a stand-alone unit within an acute hospital. A formal evaluation is underway to assess the safety, effectiveness and patient acceptability of providing early medical abortion services in non-traditional settings.

The issues being considered by the Inquiry

17. As highlighted above, the Government's role is to ensure that the provisions of the Act are properly applied. Policy on abortion, particularly, ensuring early access to services for women who have grounds for abortion under the Act, and choice of method of procedure, has developed as part of the wider Sexual Health and HIV Strategy (more detail on this is at paragraph 39-45). The documents can be found at:
http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/Sexualhealthgeneralinformation/DH_4002168

The scientific and medical evidence relating to the 24-week upper time limit

(a) Developments, both in the UK and internationally since 1990, in medical interventions and examination techniques that may inform definitions of fetal viability;

18. In the 1980s a working party of the RCOG, established with Department of Health encouragement and including representatives of medical and midwifery professional bodies, was set up to look at medical advances in light of fetuses surviving before 28 weeks gestation. It recommended that the age at which a fetus should be considered as viable should be changed to 24 weeks. Their report, the report on Fetal Viability and Clinical Practice 1985, was sent to all RCOG Fellows and Members.

19. In 1990, Parliament agreed by a decisive majority, on a free vote, that the Abortion Act should be amended to lower the time limit from 28 to 24 weeks gestation in line with the clearly expressed and confirmed view of the main medical and professional bodies.

20. Our understanding is that the position has not changed - both the British Medical Association (BMA) and the RCOG are not convinced there is currently a need to change the time limits.

21. The Births and Deaths Registration Act 1953, as amended, provides for the registration of babies born dead after 24 weeks gestation and this is described as the legal age of viability. Guidance from the British Association of Perinatal Medicine introduces the concept of a "threshold of viability" as being from 22 to 26 weeks gestation. The British Medical Association's briefing paper "Abortion time limits" (2005) highlighted that gestational age is not the only factor that affects the possibility of a fetus being considered viable.

22. Whilst there have been medical advances in caring for premature babies, only a small number of babies born at under 24 weeks gestation can survive. Data (published in 2005) from the EPICURE study (Extremely Preterm Infants – a population based study of study and health status), established in 1995, shows the percentage of extremely premature babies who survived to 6 years of age as 1% at 22 weeks, 10% at 23 weeks, 26 % at 24 weeks and 43% at 25 weeks. Survival to 6 years of age (where disability is known) with moderate or severe

disability at those gestations is 50%, 64%, 51% and 40% respectively. The full study can be found at http://www.nottingham.ac.uk/human-development/Epicure/epicurehome/index.html

23. The Nuffield Council on Bioethics published a Report "Critical care decisions in fetal and neonatal medicine" was published in 2006. One of its conclusions was that caution is required over decisions to treat babies born up to 23 weeks, six days of gestation as most babies born at 23 weeks die or survive with some level of disability even if intensive care is given; survival and discharge from intensive care for babies born between 22 and 23 weeks is rare. The full report can be found at:
http://www.nuffieldbioethics.org/go/ourwork/neonatal/publication_406.html

24. DH has previously asked the RCOG to look at the issue of fetal pain and review the scientific evidence. The RCOG's report "Fetal Awareness, Report of a Working Party"(1997) concluded that before 26 weeks gestation the nervous system has not developed sufficiently to allow the fetus to experience pain. The report recommended further research. This was taken forward by the Medical Research Council and its advisory group's report was published in 2001. The group concluded that, although there have been some developments in research into fetal pain since the publication of the RCOG report, there is still a need for further research in many areas. The experience of pain in the unborn is still poorly understood. In particular, further research is needed to improve understanding of how the ability to feel pain develops in the fetus and newborn child, and to provide better ways of measuring fetal stress.

25. As there can be uncertainties surrounding estimates of gestational age, the RCOG's report recommended that the requirements for feticide or fetal analgesia and sedation should be consider for abortions at 24 weeks or later. The RCOG then issued a letter to its members in 2001 advising them that for all abortions at 22 weeks or more, the method chosen should ensure the fetus is born dead and to consider the instillation of anaesthetic and / or muscle relaxant agents beforehand.

26. The issue of why women seek late abortions was most recently considered by the Centre for Sexual Health Research at the University of Southampton. This study was published on 17 April 2007 and found that women present late because of:

- Failure to recognise the pregnancy earlier (this can disproportionately affect teenagers or women approaching their menopause)
- Delay in seeking abortion due to personal circumstances, including decision making
- Difficulty in accessing abortion services (not knowing where to go or not being referred promptly)

(b) whether a scientific or medical definition of serious abnormality is required or desirable in respect of abortion allowed beyond 24 weeks;

27. Parliament decided in 1990 that in some circumstances abortion should be available without time limit. Around 100 abortions take place each year at gestations beyond 24 weeks most of which are done on the grounds that "*that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.*" Parliament did not define serious handicap in the Act. Parliament chose to leave this to the expert judgement of the two doctors based on the merits of each individual

case. The doctors must form their own opinion about the seriousness of the handicap the child would suffer if born, taking into account the facts and circumstances of the case.

28. This position was recently challenged. In December 2003, the Rev. Jepson was granted permission to bring a judicial review of West Mercia police's decision not to prosecute two doctors who agreed to an abortion at over 24 weeks gestation because the fetus was diagnosed with bilateral cleft lip and palate. The Crown Prosecution Service announced in March 2005 that the two doctors had acted in good faith and that no prosecutions would be brought against them.

29. The Royal College of Obstetricians and Gynaecologists' guideline "Termination of Pregnancy for fetal abnormality" (1996) states that if an abnormality has been detected and two medical practitioners are of the opinion that there are grounds for an abortion under the Abortion Act, then the woman should be advised that she has this option.

30. Antenatal screening for Down's syndrome is offered within a timeframe of 10 to 20 weeks and the evidence based NICE Clinical Guideline "Antenatal Care, Routine Care for the healthy pregnant woman" recommends offering ultrasound screening for structural anomalies between 18 and 20 weeks. The purpose of antenatal screening is to offer women informed choice and women should be offered information about screening tests as early as possible in their pregnancy. The woman needs to be given enough information and time to help her understand the nature of the fetal abnormality and the probable outcome of the pregnancy in order that she can make an informed decision about the options available to her. If a time limit, or a time limit of lower than 24 weeks, were imposed for abortions for fetal abnormality this has implications for women who have abnormalities identified during the 18 – 20 week scan.

Medical, scientific and social research relevant to the impact of suggested law reforms to first trimester abortions

(a) the relative risks of early abortion versus pregnancy and delivery;

31. Abortion, both medical and surgical, is a very safe procedure and complications are uncommon. However, the RCOG guideline states that the evidence shows the risk of complications increases the later the gestation.

32. Deaths following abortion are extremely rare. There is about one death a year out of around 180,000 abortions. It is a Government requirement that all maternal deaths should be subject to confidential enquiry and all health professionals have a duty to provide the information required.

33. Maternal deaths in the UK, including deaths from abortions, for all women are at a rate of 53 per million maternities. This compares to a rate of about 5 per million for abortions alone.

34. It is the Government's policy to reduce numbers of unintended pregnancies and reduce the number of abortions. We are working to achieve this through implementation of the Sexual Health and HIV Strategy and the Teenage Pregnancy Strategy. http://www.dfes.gov.uk/teenagepregnancy

(b) the role played by the requirement for two doctors' signatures;

35. The requirement for two doctors' signatures was believed necessary when the 1967 Act was passed to ensure that the provisions in the legislation were being observed and to safeguard women.

(c) the practicalities and safety of allowing nurses or midwives to carry out abortions or of allowing the second stage of early medical abortions to be carried out at the patient's home;

36. One of the requirements of the Abortion Act 1967, as amended, is that a pregnancy may only be terminated by a registered medical practitioner.

37. In 1981, the Royal College of Nursing brought a case to clarify the legal position of nurses and their role in medical abortion. The House of Lords ruled that for medical abortion, the practitioner is not required to perform personally each and every action that is needed for the treatment but must personally decide upon and initiate the process of medical induction and take responsibility throughout (the doctor prescribes the drugs and signs the abortion notification form).

38. The role of nurses has changed considerably since 1967. All over the country nurses are working in new and innovative ways in sexual and reproductive health. Many are working in advanced and specialist clinical roles as independent practitioners and more creative posts are being developed in the NHS to maximise optimum use of nurses skills. There are currently around 15 Nurse Consultant posts in the sexual health field. Nurses have a valuable role to play in supporting women undergoing abortion. In some areas nurses are playing a leading role in providing abortion services. DH is working with the RCN and other professional bodies to ensure that the nurses role continues to be developed appropriately.

Improving access to early medical abortions

39. The Government agrees that women, who have grounds for an abortion, should be offered the choice of an early medical abortion and that PCTs and abortion service providers should ensure this provision exists. Currently, Mifegyne (mifepristone also known as RU486), the abortifacient drug used in medical abortion, is only licensed up to nine weeks gestation and then 12 weeks gestation beyond, therefore early access is essential. To encourage choice of procedure before nine weeks gestation, PCT's performance in this area is being measured by the Healthcare Commission. There has been an indicator on the percentage of NHS funded abortions performed at under 10 weeks gestation since 2002/3. The latest data for 2006 shows that progress is being made to increase early access: 65% of NHS funded abortion took place at under 10 weeks – compared with 51% in 2002. Use of medical abortion has increased from 5% in 1995 to 30% of abortions in 2006.

Evidence of long-term or acute adverse health outcomes from abortion or from the restriction of access to abortion.

40. The safety and psychological effects of abortion were considered by the RCOG in its updated evidence-based guideline, "The Care of Women Requesting Induced Abortion" (2004). In updating the guidance, the RCOG took account of the most recent national and international evidence. The guideline recommends that referral for further counselling should

be available for the small minority of women who experience long-term post abortion distress.

Government Action on Sexual Health

41. The first ever, National Strategy for Sexual Health and HIV was published in 2001 and its' Implementation Action Plan in 2002 (for England). The Strategy proposes a comprehensive and holistic model for modernising sexual health and reproductive services to provide a comprehensive range of services, shaping services around the needs and preferences of individual patients, responding to the needs of different populations and continuously improving quality services.

Government Action on Reproductive Health

42. One of the key aims of this Government, as set out in the Sexual Health and Teenage Pregnancy Strategy, is to reduce the number of unintended pregnancies and consequently abortions, through better access to contraception.

43. The provision of good quality contraceptive services is also essential to achieving the Public Service Agreement target to half the number of under 18 conceptions rates by 50% (from the Teenage Pregnancy Strategy's 1998 baseline of 46.6 conceptions per thousand females aged 15-17) by 2010 as part of a broader strategy to improve sexual health. Eighty percent of under 18 conceptions take place in 16 and 17 year old girls.

44. The cost benefit of contraceptives is well established and has been estimated at £11 for every £1 spent and it is estimated that the prevention of unplanned pregnancy by NHS contraceptive services already saves the NHS over £2.5 billion a year.

45. Through Choosing Health we have invested a significant amount (£40m) to improve access to contraceptive services (2006/07–2007/8) and in July 2006, the Government reduced the VAT rate on contraception from 17.5% to 5%. Primary care trusts (PCTs) completed a national questionnaire of contraceptive services. The results were published in May 2007 and will inform the publication of best practice guidance on reproductive healthcare by the Department of Health and help PCTs determine how best to meet gaps in local services. The guidance will be aimed at commissioners and providers emphasising the need to develop strong links between abortion and contraceptive services. From 2006/07, PCTs' performance in this area is being measured as part of their Healthcare Commission Annual Healthcheck. In addition, we are also examining the feasibility of undertaking pilots to provide women with tailored contraceptive packages following abortion. The pilots will also examine which groups of women are most vulnerable to repeat abortion.

Teenage Pregnancy Strategy

46. The Government's Teenage Pregnancy Strategy is tackling the high number of unplanned pregnancies among young women by: sending clear messages through its media campaigns on avoiding peer pressure and the importance of using condoms when they do become sexually active; improving the quality of sex and relationships education; improving young people's access to contraceptive and sexual health advice; and providing support to parents to help them have open and honest discussions with their children on sex and relationship issues.

47. Teenage pregnancy rates are reducing. Between the 1998 baseline year and 2005 (the latest year for which data are available) the under-18 conception rate has fallen by 11.8% to its lowest level for over 20 years. The under-16 conception rate has fallen by 12.1% over the same period. We are taking steps to ensure that a stronger focus is given to providing contraceptive advice to young women after a birth or abortion, to avoid repeat conceptions.

September 2007