Bill for the Inquiry into Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Bill 2005

Submission to Senate Committee for Committee for Community Affairs

There are two issues I would like to raise for the Committee's consideration. First, is the question of good governance arrangements and the rationale for creating bodies to deliberate on certain issues at "arm's length" from government. The second is what relevance the CHMD study has for the Committee's consideration of this Bill.

Governance arrangements

In considering the Bill, the Committee is being asked to consider whether the Minister for Health should lose his current discretion in respect of RU486. The Committee is not being asked to consider whether a woman should be able to receive medical assistance to terminate an unwanted pregnancy - it has for some time now been Australian policy across al jurisdictions to provide such assistance on public health grounds, whilst seeking to minimise unwanted pregnancy and STDs through the availability of provision of family planning services and contraception.

Similarly, the Committee is not being asked to make a determination about the efficacy and relative medical risks associated with RU486. There is an established process for making such determinations, and the Committee is, in effect, being asked to consider whether that process should be permitted to operate in this case.

Transparency, accountability and probity are well accepted features of good governance. When governments are faced with decisions that require expert consideration of technical matters, it is common practice to establish bodies that operate at arm's length. By selecting widely respected experts for these bodies, and by ensuring that they use clearly articulated criteria and processes for decision-making - as well as for the detection and handling of any conflict of interest that might arise - these bodies can make decisions on complex matters in a manner that can generate a high level of public confidence in the outcomes. Making the process highly accountable – with a clear decision-trail – increases this level of confidence. This would require advice considered by the Committee and the reasons for a particular decision to be well documented.

Ministerial discretion does not necessarily have the same characteristics. A minister is not necessarily an expert on the subject matter of the portfolio. The advice received by a minister, or the considerations used to reach a particular decision, are not necessarily transparent. Where electoral sensitivities are involved a minister may be tempted to, or rather expected to, take these considerations into account. Ministerial decisions influenced in this way may well result in different outcomes from those reached by disinterested experts making decisions on the basis of publicly stated criteria. Ministers will still be called upon to defend any process they establish or appointments they make,

and may also end up having to defend controversial decisions made by committees they have established. The history of independent decision-making bodies – statutory authorities and their ilk - shows regular swings between the two poles - placing large numbers of bodies at arm's length, and then drawing them back to central (ministerial) control. Wettenhall and Hood have written extensively on this phenomenon.

The Committee needs to consider whether the public interest in good governance is better served in this instance by maintenance of the Ministerial discretion, or by its removal. Removal would appear to permit a more transparent and directly accountable process of deliberation on the medical indications and contra-indications for the use of RU486.

Implications of the CHDS study (Fergusson et al 2005)

The findings of this study are not strictly relevant to the Committee's consideration of the Bill – as they do not involve RU486 nor do they deal with any arguments explicitly about the rationale for the use of ministerial discretion in this case. However, media reports indicate that the findings may be considered by the Committee and may influence some members to take a negative view of the Bill. Hence it is important that the Committee appreciates the limitations on the study published.

The paper published by CHDS on its web site is careful to make the following points.

First, the study did not collect the data that would permit comparison of the personal circumstances or the attitudes towards their own pregnancy of the two groups of young women who were identified as having been pregnant. Whether the pregnancy was planned or unplanned, whether it is wanted or not, whether the woman had a supportive partner or family, whether she had access to income and housing, whether she felt termination to be ethical in her circumstances – all of these factors might be expected to have some impact on decisions about pregnancy, and on subsequent mental health. The two groups may not have been identical on these factors – the group that continued with the pregnancy may have contained a much higher proportion of planned and/or wanted pregnancies than the group that terminated a pregnancy, or it may have had a much higher proportion of individuals living in a stable and supportive relationship with the father.

The CSHD plan to collect retrospective information on personal circumstances that might shed light on this question, and settle doubts about whether termination itself or the circumstances that led to it were implicated in the elevated risk of mental illness.

Second, based on whole population figures, the incidence of terminations reported in the study group was too low – only 80% of the expected level. Given that the group that reported never having been pregnant exhibited much lower rates of mental illness than both pregnant groups, under-reporting could have had a significant impact on the results. If the low termination rates did result from under-reporting, and if those denying pregnancy and termination were less likely to exhibit mental illness than those who did

report termination, this could have skewed the results. It may be difficult to clarify this question.

Thus, the elevated risk associated with pregnancy termination reported by the CHDS cannot be unequivocally attributed to the termination. However, the paper certainly highlights the need for further study in this area. It also indicates the need to ensure adequate support for young women who become pregnant, regardless of whether they decide to proceed with or to terminate their pregnancy.

Reference

Fergusson DM, Horwood LJ, Ridder EM. Abortion in young women and subsequent mental health. Journal of Child Psychology & Psychiatry, 2006; 47(1): 16-24.

Robyn Seth-Purdie
Canberra
16 January 2006

Background

I have PhD in Psychology and Diploma in Jurisprudence form the University of Sydney. I have worked as a researcher and policy analyst within the public sector for over twenty years – mostly in social policy and public administration. In 2002 and 2003 I worked as Senior Researcher with the National Institute for Governance at the University of Canberra, where I undertook consultancies and published papers on public sector governance. In 1999 I put together the evidence base for a national families strategy. In the course of that work I became acquainted with the work of the Christchurch Health and Development Study, the New Zealand group which late last year published a paper on abortion and subsequent mental health problems (Fergusson et al 2005) . Deputy Director of the CHDS, John Horwood, has generously provided analysis of CHDS data in response to my requests over the last 5 years, commencing with the relationship between the developmental risk factors for welfare dependency in early adulthood, and more recently, on the relationships between developmental risk factors and the probability of being a separated father or a single mother at a young age.

During the last 6 months I worked for the New Zealand Families Commission as Principal Analyst, Policy & Research.