Chapter 2

The terms of item 16525

Introduction

2.1 In this chapter the committee canvasses the terms of item 16525 including the basis on which payments are made and the procedures under the item. The data available on the use of this item is provided together with a discussion on the limitations of that data.

The terms of item 16525

2.2 The *Health Insurance Act 1973* provides that regulations may prescribe a table of medical services (other than diagnostic imaging services and pathology services) that set out items of medical services, the amount of fees applicable in respect of each item and rules for interpretation of the table. The Health Insurance (General Medical Services Table) Regulations 2007 currently prescribe such a table.

2.3 The items in the Medicare Benefits Schedule (MBS) relate to medical, optometrical and, in some cases, dental surgical services, provided on a private basis. The review of items already on the MBS is undertaken by the Medicare Benefits Consultative Committee. This committee is an consultative forum with representation drawn from the Department of Health and Ageing, the Health Insurance Commission, the Australian Medical Association and relevant professional craft groups of the medical profession. The reviews are designed to ensure that the MBS reflects current medical practice and encourages best practice. Proposed listings of new medical procedures and new technologies on the Schedule are assessed by the Medical Services Advisory Committee on the basis of evidence of safety, cost-effectiveness and of real benefit to patients.[1]

2.4 Item 16525 of Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007 is described in the Medicare Benefits Schedule as follows:

> MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.)
>
> Fee: $267.00 Benefit: 75% = $200.25 85% = $226.95.[2]

---

1 http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicarebenefits-index.htm#where (Accessed 13.10.08)

2 http://www9.health.gov.au/mbs/search.cfm?q=16525&sopt=I (Accessed 13.10.08).

2.5 Item 35643 is described as follows:

> EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)
>
> Fee: $196.85 Benefit: 75% = $147.65 85% = $167.35.[3]

2.6 An item number for the management of second trimester labour was first introduced on 1 October 1976 under the then Medical Benefits Scheme. On 1 November 1995 the current descriptor was introduced following a review of the obstetric services in the MBS. The Department of Health and Ageing (the department) informed the committee that the change was 'to ensure that it reflects and supports current obstetric practice'.[4]

2.7 Practitioners caring for private patients use these item numbers when providing services for women in private hospitals or alternatively for private patients being cared for in public hospitals. Medicare benefits are paid under item 35643 for procedures that may involve the termination of pregnancies in the first trimester and under item 16525 for procedures in the second trimester. The second trimester is generally considered to range between 13 and 26 weeks gestation.[5] As might be expected, fewer claims are processed under item 16525 than under item 35643 – 794 compared with 71,957 in 2007–2008.[6] The services provided under item 16525 are discussed further below.

The basis on which payments of benefits are made

2.8 The payment of Medicare benefits are made under the *Health Insurance Act 1973* (HI Act). Subsection 10(1) of the HI Act provides:

> Where, on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person, medicare benefit calculated in accordance with subsection (2) is payable, subject to and in accordance with this Act, in respect of that professional service.

2.9 The department noted that:

> The term 'professional service' is relevantly defined in subsection 3(1) of the HI Act as meaning, 'a service (other that a diagnostic imaging service)

---

3 http://www9.health.gov.au/mbs/search.cfm?q=35643&sopt=I (Accessed 13.10.08).

4 Department of Health and Ageing, *Committee Hansard* 29.10.08, p.12; *Answer to Question on Notice 29.10.08* (received 5.11.08).

5 Department of Health and Ageing, *Submission 218*, p.2.

6 For reasons explained later in this Chapter the sum of these two figures (71,957) does provide an accurate measure of induced terminations in Australia.

> to which an item relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner'.
>
> A 'clinically relevant service' is relevantly defined in subsection 3(1) of the HI Act as a service rendered by a medical practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered.
>
> …
>
> Medicare payments are payable under item 16525 (management of second trimester labour) when performed in accordance with the item descriptor under the *Health Insurance (General Medical Services Table) Regulations*…[7]

2.10 The department stated that a Medicare rebate is not available for second trimester labour outside the restrictions of the item, namely, intrauterine fetal death, gross fetal abnormality or life threatening maternal disease. The department went on to state that:

> It is a matter for the doctor's clinical judgment as to whether a patient's condition meets these second trimester requirements.[8]

2.11 Lawful termination of a pregnancy is regulated by the States and Territories and for a termination to be funded through Medicare it needs to be provided in accordance with State and Territory law.[9] The department provided the committee with legislative provisions and judicial considerations on the lawfulness of abortion in the States and Territories at Attachment A of its submission.[10]

Item 16525 descriptors

2.12 The three descriptors under item 16525 will be discussed in greater detail in the next two chapters. However, whilst the term 'psychosocial indications' is not included in the descriptor for the item, considerable attention was given to 'psychosocial' grounds for pregnancy termination throughout the inquiry and the committee sought further information on the definition of this term.

2.13 The Perinatal Society of Australia and New Zealand Perinatal Death Classification (PSANZ-PDC), which provides a uniform classification system for Australia, lists 'termination of pregnancy for maternal psychosocial indications' as

7 Department of Health and Ageing, *Submission 218*, p.3.

8 Department of Health and Ageing, *Submission 218*, p.3.

9 Department of Health and Ageing, *Submission 218*, p.3.

10 Department of Health and Ageing, *Submission 218*, pp5-15.

classification 5.1 under 'maternal conditions'.[11] The PDC does not provide a definition of 'psychosocial indications'. However, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) reviews perinatal deaths in Victoria in accordance with the PSANZ-PDC and considers 'psychosocial indications' as follows:

> 'Psycho-social' is a term in general use to encompass a range of reasons/conditions why a woman might take the very serious decision to terminate a pregnancy (with a normal fetus) at or beyond 20 weeks. Such reasons could include for example, the late discovery of an unplanned or forced pregnancy (maybe as the result of rape or incest), acute psychiatric disorders including severe depression/suicidal intention, or abandonment or other grave social/cultural problem. The term doesn't lend itself readily to precise definition or quantification, except the word 'severe' would always apply to all these psychological and social factors.[12]

2.14 The department noted that whilst the term 'psychosocial' was not defined in the *Health Insurance Act 1973* or the *Health Insurance (General Medical Service Table) Regulations 2007*, the Public Health Association of Australia provides some clarification:

> The definition of psychosocial indications differs within the legislation among different states. When psychosocial reasons for second and third trimester abortion are cited, this generally refers to serious mental illness of the mother.[13]

Procedures under item 16525

2.15 The explanatory notes to the MBS provide the therapeutic procedures under item 16525. Note T4.4 reads as follows:

> **Labour and Delivery (Items 16515, 16518, 16519, 16525)**
> Benefits for management of labour and delivery covered by Items 16515, 16518, 16519 and 16525 includes the following (where indicated):-
> - surgical and/or intravenous infusion induction of labour;
> - forceps or vacuum extraction;
> - evacuation of products of conception by manual removal (not being an independent procedure);

11 Perinatal Society of Australia and New Zealand, *Perinatal Mortality Audit Guideline; Section 7: Perinatal Mortality Classifications*, p. 116, http://www.psanzpnmsig.org/doc/Clinical%20Practice%20Guideline%20for%20PNM%20Section%207.pdf (Accessed 27.10.08).

12 Associate Professor Jeremy Oats, Chair, Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Email correspondence*, 5.11.08.

13 Public Health Association of Australia cited in Department of Health and Ageing, *Answer to Question on Notice, 29.10.08* (received 5.11.08).

- episiotomy or repair of tears.[14]

2.16 Professor David Ellwood has stated that methods used for late termination vary, depending on the indication, particularly the nature of a fetal abnormality, the gestation and the preferences of the individual practitioner and patient. Dr Ellwood went on to state that the most commonly used method is induction of labour using prostaglandins and noted that:

> A surgical procedure such as dilation and evacuation, although possible, is less likely to be used at gestations beyond 20 weeks due to the technical difficulties caused by fetal size and a higher rate of complications. Very infrequently, the method of choice may be either hysterotomy or caesarean section, if there are valid obstetric reasons for choosing this approach.[15]

2.17 Professor Ellwood concluded that 'the various laws and court decisions that guide practice in late termination do not really provide any direction as to the method that should be used, and some practitioners have expressed concern about the lack of legal clarity'.[16]

2.18 Information from Western Australia indicated that in 2005 the main procedure used for induced abortions was vacuum aspiration (suction curettage) (95.4 per cent) with dilation and evacuation accounting for 2.5 per cent and other methods, including prostaglandin, intravenous or intra-uterine infusion, another 2 per cent.[17] The authors of the Western Australian report observed that the predominance of vacuum aspiration as a method of inducing abortions is consistent with over 90 per cent of abortions taking place in the first three months of gestation.[18]

2.19 Terminations of pregnancy beyond 20 weeks gestation take place either by dilatation of the cervix, followed by evacuation or extraction of the contents of the

---

14 http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=T4.4 (accessed 13.10.08).

15 Ellwood, D, 'Late terminations of pregnancy – an obstetrician's perspective', *Australian Health Review,* 29(2) May 2005.

16 Ellwood, D, 'Late terminations of pregnancy – an obstetrician's perspective', *Australian Health Review,* 29(2) May 2005.

17 Straton J, Godman K, Gee V, & Hu Q. (2006). *Induced abortion in Western Australia 1999-2005*. Report of the WA Abortion Notification System. Department of Health. Perth, Western Australia, p.13.

18 Straton J, Godman K, Gee V, & Hu Q. (2006). *Induced abortion in Western Australia 1999-2005*. Report of the WA Abortion Notification System. Department of Health. Perth, Western Australia, p.13.

uterus, or by inducing labour to deliver the fetus followed by injection of potassium chloride into the fetus while it is *in utero*.[19]

Medicare claims under item 16525

2.20 The Department of Health and Ageing provided the following data on the use of item 16525 from January 1994 to 31 August 2008 (calendar years).

Table 2.1: Number of Medicare claims processed under item 16525 from January 1994 to 31 August 2008

Item/Year		Total Benefit ($)	Total Services
16525	1994	145,786	936
	1995	168,248	1,019
	1996	113,768	697
	1997	105,366	647
	1998	100,349	605
	1999	102,443	609
	2000	111,719	655
	2001	122,986	714
	2002	109,435	624
	2003	117,942	656
	2004	126,418	683
	2005	148,291	770
	2006	150,583	777
	2007	157,250	790
	2008	113,132	540
	Total	**1,893,716**	**10,722**

Source: Department of Health and Ageing, *Submission 218*, p.1.

2.21 The following tables show the number of Medicare claims processed under item 16525 for the period July 1998 to June 2008; the cost of those claims; claims per 100,000 of the Australian population; and the age of those making the claims.

19 Medical Practitioners Board of Victoria, *Report on late term terminations of pregnancy, Department of Human Services, Victoria,* April 1998 cited in Angela Pratt, et al., *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection*, Parliamentary Library, Research Note, 14.2.05, number 9, 2004–05, endnote 7.

Table 2.2: Number of Medicare claims processed under item 16525 - July 1998 to June 2008[20]

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	Services	Services	Services	Services	Services	Services	Services	Services	Services
1998/1999	188	157	118	54	48	22	6	4	597
1999/2000	210	196	108	57	46	18	5	5	645
2000/2001	209	229	124	59	45	11	7	8	692
2001/2002	208	191	116	59	42	8	7	5	636
2002/2003	246	170	133	53	31	9	8	10	660
2003/2004	203	179	140	60	27	12	11	5	637
2004/2005	222	304	122	57	29	18	8	7	767
2005/2006	221	272	112	54	54	26	11	5	755
2006/2007	220	286	123	67	59	20	14	13	802
2007/2008	242	286	113	57	49	27	15	5	794
Total	2,169	2,270	1,209	577	430	171	92	67	6,985

Source: Medicare Australia Statistics.

Table 2.3: Cost of Medicare claims under item 16525 - July 1998 to June 2008[21]

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit
1998/1999	31,493	26,144	19,658	9,013	8,014	3,660	1,026	692	99,700
1999/2000	35,560	33,325	18,365	9,654	7,765	3,053	848	846	109,416
2000/2001	35,936	39,017	21,378	10,193	7,737	1,830	1,202	1,373	118,667
2001/2002	36,131	33,164	20,202	10,140	7,247	1,392	1,201	874	110,352
2002/2003	43,645	30,105	23,710	9,404	5,553	1,610	1,421	1,785	117,234
2003/2004	36,922	32,634	25,509	10,917	4,937	2,185	2,019	908	116,031
2004/2005	41,714	56,781	22,781	10,650	5,396	3,365	1,490	1,302	143,479
2005/2006	44,418	52,054	21,972	10,308	10,305	4,957	2,093	970	147,077
2006/2007	43,037	55,587	24,639	13,005	11,473	3,871	2,700	2,531	156,843
2007/2008	54,239	57,399	22,423	11,342	9,705	5,351	2,969	997	164,425
Total	403,094	416,211	220,638	104,626	78,132	31,275	16,969	12,279	1,283,225

Source: Medicare Australia Statistics.

20 Australian Government, Medicare Australia, Medicare Australia Statistics, http://www.medicareaustralia.gov.au/statistics/mbs_item.shtml, (Accessed 1.10.08).

21 Australian Government, Medicare Australia, Medicare Australia Statistics, https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml, (Accessed 1.10.08).

Table 2.4: Claims per 100,000 population under item 16525 - July 1998 to June 2008[22]

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
1998/1999	3	3	3	4	3	5	2	2	3
1999/2000	3	4	3	4	2	4	2	2	3
2000/2001	3	5	3	4	2	2	2	4	3
2001/2002	3	4	3	4	2	2	2	2	3
2002/2003	4	3	3	3	2	2	2	5	3
2003/2004	3	3	3	4	1	2	3	2	3
2004/2005	3	6	3	4	1	4	2	3	4
2005/2006	3	5	3	3	3	5	3	2	4
2006/2007	3	6	3	4	3	4	4	6	4
2007/2008	3	5	3	4	2	5	4	2	4

Source: Medicare Australia Statistics.

Table 2.5: Patient Demographics under item 16525 - July 1998 to June 2008[23]

Item 16525	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
0-4	0	0	0	0	0	0	0	0	0
5-14	1	5	0	1	1	0	0	1	9
15-24	144	473	59	23	18	49	3	12	781
25-34	1,175	1,040	652	335	246	61	42	28	3,579
35-44	831	736	493	216	162	61	46	26	2,571
45-54	18	15	5	2	3	0	1	0	44
55-64	0	0	0	0	0	0	0	0	0
65-74	0	0	0	0	0	0	0	0	0
75-84	0	0	0	0	0	0	0	0	0
>=85	0	0	0	0	0	0	0	0	0
Unknown	0	1	0	0	0	0	0	0	1
Total	2,169	2,270	1,209	577	430	171	92	67	6,985

Source: Medicare Australia Statistics.

2.22 As may be observed from the above tables, the number of Medicare claims processed annually under item 16525 remained relatively static for the first six years of the ten year period; increased in 2004-2005 and have since remained relatively static at the higher level. The same pattern can be noted in Table 2.4 which shows that

22 Australian Government, Medicare Australia, Medicare Australia Statistics, https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml, (Accessed 1.10.08).

23 Australian Government, Medicare Australia, Medicare Australia Statistics, https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml, (Accessed 1.10.08).

claims made per 100,000 of the population increased from three to four in 2004-2005 and have since remained at that level.

2.23 According to recent evidence provided by Medicare Australia, the national average for 2007, for example, was 3.7 item 16525 services per 100,000 population. Comparatively, the average for the first eight months of 2008 (to 31 August), was 2.5 item 16525 services per 100,000 population.[24]

2.24 Table 2.3 demonstrates that the cost of benefits paid in relation to the claims also increased in 2004-2005 from earlier levels.

2.25 Medicare Australia provided the committee with the number of providers who claimed item 16525 during the full year of 2007 and part year of 2008 to 31 August. Data in three states have been aggregated to other states due to data size.

Table 2.6: The number of providers that have claimed item 16525 from Medicare

	Number of providers					
	NSW/ACT	**VIC/TAS**	**SA/NT**	**QLD**	**WA**	**Total**
January to December 2007	110	91	33	53	22	309
January to 31 August 2008	92	74	26	52	22	266

Source: Medicare Australia, Answer to Question on Notice

Services to which item 16525 applies

Limitations of the Medicare data

2.26 The above tables indicate the total number of services provided under item 16525. However, the MBS data is only available for all services provided under the item and it not available for each indicator or the circumstances of the labour. The department informed the committee that:

> …the services to which item 16525 relates includes both spontaneous abortions (miscarriages) and medical or induced abortions (terminations). It is thus not possible to determine how many services receiving payment under this item were the result of either a spontaneous or induced procedure.[25]

2.27 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) stated that 'it is known that 16525 is used for services that manage fetal death in utero, miscarriage and life threatening maternal disease in the second trimester, it is therefore difficult to extrapolate the use of item 16525 for

24 Medicare Australia, *Answer to Question on Notice 29.10.08* (received 10.11.08).

25 Department of Health and Ageing, *Submission 218*, p.1.

termination of pregnancy when it is not known if the procedure is induced or spontaneous'.[26]

Indications for second trimester terminations provided by other data sources

2.28 While it is not possible to breakdown the Medicare data on item 16525, an indication of the reasons for terminations of second trimester pregnancies is available for South Australia, Victoria and Western Australia. RANZCOG noted that South Australia conducts the only reliable termination of pregnancy data collection, recording all instances of termination of pregnancy.[27] The data reported for South Australia for 2006 indicated that there were 78 late terminations (performed at 20 weeks gestation or later) with 51 per cent of these were for 'fetal reasons'.[28] Late term terminations accounted for about 1.5 per cent of all terminations in South Australia.

2.29 RANZCOG noted that the data from Victoria suggested that termination after 20 weeks gestation amounts to 1 per cent of all terminations performed.[29] The Victorian Consultative Council on Obstetrics and Paediatric Mortality and Morbidity publishes data on perinatal deaths. The council's annual report for the year 2006 reported, in relation to perinatal deaths from termination of pregnancy, that:

> As a result of increasing uptake of prenatal ultrasound and diagnostic procedures, congenital abnormalities are now frequently being diagnosed in mid trimester pregnancies leading on to terminations of pregnancy (TOP). When the termination procedure occurs at or beyond 20 weeks gestation, regardless of the method of termination, it is a legal requirement that these cases be recorded as births and perinatal deaths. In 2006 there were 106 stillbirths and 42 neonatal deaths in this category, 17.7% of perinatal deaths. TOP procedures undertaken for maternal psychosocial indications only at or beyond 20 weeks gestation also require registration as births and perinatal deaths (in 2006 there were 150 stillbirths in this category, which comprised 18.0% of perinatal deaths). 60% of TOPs =>20 weeks for maternal psychosocial indications were undertaken for women whose place of residence was outside Victoria.[30]

2.30 Some Victorian data are provided for termination of pregnancy between 20 and 27 weeks gestation. In 2006, 144 terminations were performed for congenital

---

26 RANZCOG, *Submission 523*, pp1–2.

27 RANZCOG, *Submission 523*, p.2.

28 Chan A, Scott J, Nguyen A-M, Sage, L. *Pregnancy Outcome in South Australia,* Pregnancy Outcome Unit, Department of Health, Government of South Australia, November 2007, p.40.

29 RANZCOG, *Submission 523*, p.2.

30 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity. *Annual Report for the Year 2006, incorporating the 45th Survey of Perinatal Deaths in Victoria*. Melbourne, July 2008, p.12.

abnormality and 150 were performed for maternal psychosocial indications with no fetal abnormality.[31]

2.31 Western Australian legislation also requires that terminations be notified. A report of these notifications shows that in 2005 there were 507 induced abortions in the State after a gestational age of 13 weeks. Four-nine (0.6 per cent) were carried out at gestation of 20 weeks and over.[32] Nearly all of those terminations would have occurred in the second trimester and should be reflected in the claims data for Medicare item 16525. However, there were only 29 claims made from Western Australia in 2004-2005. The discrepancy in the figures may be explained in that in 2005 there were 688 terminations in metropolitan and rural public hospitals[33] and Professor Ellwood stated that all late terminations in Western Australia are performed in that State's tertiary women's hospital.[34]

2.32 There is some information provided in the Western Australian data concerning the reasons for terminations, but none of that information is provided for various stages of gestation. The information that has been reported is as follows:

> In the four year period [2002-2005] 1.95% of all induced abortions (622 cases) were carried out for suspected or identified congenital malformations, with 14.6% of these (91 cases in four years) due to suspected or identified Neural Tube Defects (such as spina bifida and anencephaly).[35]

2.33 An estimate quoted in the final report of the Victorian Law Commission on abortion law suggests that 4.7 per cent of abortions in Australia occur after 13 weeks but before 20 weeks and that 0.7 per cent occur after 20 weeks.[36]

---

31 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity. *Annual Report for the Year 2006, incorporating the 45th Survey of Perinatal Deaths in Victoria*. Melbourne, July 2008, p.13.

32 Straton J, Godman K, Gee V, & Hu Q. (2006). *Induced abortion in Western Australia 1999-2005*. Report of the WA Abortion Notification System. Department of Health. Perth, Western Australia, p.12.

33 Straton J, Godman K, Gee V, & Hu Q. (2006). *Induced abortion in Western Australia 1999-2005*. Report of the WA Abortion Notification System. Department of Health. Perth, Western Australia, p.11.

34 Ellwood, D, 'Late terminations of pregnancy – an obstetrician's perspective', *Australian Health Review,* 29(2) May 2005.

35 Straton J, Godman K, Gee V, & Hu Q. (2006). *Induced abortion in Western Australia 1999-2005*. Report of the WA Abortion Notification System. Department of Health. Perth, Western Australia, p.14.

36 Narelle Grayson et al, *Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia*, (2005), quoted in Victorian Law Commission, *Law of Abortion: Final Report*, Victorian Government Printer, Melbourne, March 2008, p.36.

2.34 Other comments relating to the Medicare data were provided in evidence. It was noted that services under item 16525 are provided on a private basis and thus does not include services provided to public patients. RANZCOG stated:

> In Australia most second trimester terminations are performed in public hospitals, for these, the 16525 item is not used but the jurisdictions and indirectly the federal government supports these services in that they fund the public hospital system.[37]

2.35 Professor Ellwood in a 2005 article for the *Australian Health Review* commented on late term terminations in the public sector and stated it is highly probable that analysis of the data would confirm 'that the numbers in the public sector are small and the indications are almost always for compelling medical reasons to do with the fetal prognosis'. Professor Ellwood noted that in Western Australia procedures 'are done for reasons of severe fetal abnormality or serious maternal illness' in a tertiary women's hospital. In NSW and Victoria processes in the major public hospitals are similar and that 'in practice, late terminations in public hospitals are almost always for reasons of severe fetal abnormality, or where the mother has a life-threatening illness exacerbated by the pregnancy'.[38]

2.36 The MBS data also excludes women who have procedures in private settings to which item 16525 may apply but who do not claim a Medicare rebate. In addition, the department informed the committee that there is no Medicare item for terminations in the third trimester.[39] Thus the Medicare data does not include terminations conducted after 24 weeks (though the available evidence suggests that the number of these is relatively small).[40]

Improving data reporting

2.37 As evidenced in the discussion above, there are limited data available on second trimester terminations generally in Australia and in relation to the services provided under item 16525.

2.38 Witnesses commented on these two aspects of data collection. RANZCOG stated that 'rates of termination of pregnancy in Australia are poorly documented'.[41] Ms Letitia Nixon from SHine SA commented:

---

37 RANZCOG, *Submission 523*, p.2.

38 Ellwood D, 'Late terminations of pregnancy – an obstetrician's perspective', *Australian Health Review,* 29(2) May 2005.

39 Department of Health and Ageing, *Submission 218*, p.2.

40 Pratt A, Biggs A, Buckmaster L., *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection*, Research Brief, 14 February 2005, no. 9, 2004-05, ISSN 1832-2883, Parliamentary Library, Department of Parliamentary Services, Parliament of Australia, p.6.

41 RANZCOG, *Submission 523*, p.1.

> Speaking from a South Australian perspective—and we are one of the states that gathers data—there is not an adequate data reporting system in Australia. That is clearly one of the issues you are struggling with around this item. Obviously this item is used overwhelmingly—and that data is further clear from South Australia—around managing second trimester labour for a range of foetal and maternal indications that have nothing to do with planned terminations of pregnancy.[42]

2.39 Ms Nixon further noted that at times, as South Australia has good data, 'it gets extrapolated for the whole country'.[43] The lack of national uniformity in data collection was also highlighted by Dr Janet Mould of the National Foundation for Australian Women who noted:

> There are of course a number of morbidity and mortality data collections in hospitals but, unfortunately, to the best of my knowledge they do not involve private hospitals. So this country could really do with a national data collection on morbidity and procedures. Having said that, there are a number of collections, and Victoria stands out here as having a collection that you would be aware of in this area.[44]

2.40 Dr Edith Weisbert of Family Planning NSW held the same view:

> I think that the major issue in Australia is that there are no good data on the termination of pregnancies and there are no consistent data throughout the country. It is high time that we set up a system whereby we had accurate information and then we could look at whether this in fact is a discussion that should be taking place.[45]

2.41 Some researchers have discussed options for collecting more reliable data on terminations at the national level. In a brief compiled by the Commonwealth Parliamentary Library three options for collecting more reliable data were canvassed: changing the way that terminations are recorded by Medicare; establishing uniform hospital data reporting to the Australian Institute of Health and Welfare; and implementing nationally the South Australian system of termination notification and data collection.[46] Other researchers have suggested working towards a de-identified

---

42 Ms Letitia Nixon, SHine SA, *Committee Hansard*, 29.10.08, p.32.

43 Ms Letitia Nixon, SHine SA, *Committee Hansard*, 29.10.08, p.32.

44 Dr Janet Mould, National Foundation for Australian Women, *Committee Hansard*, 30.10.08, pp56–57.

45 Dr Edith Weisberg, Family Planning New South Wales, *Committee Hansard*, 29.10.08, p.38.

46 Pratt A, Biggs A, Buckmaster L, *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection*, Research Brief, 14 February 2005, no. 9, 2004-05, ISSN 1832-2883, Parliamentary Library, Department of Parliamentary Services, Parliament of Australia, p.6.

national collection, perhaps coordinated through the Australian Institute of Health and Welfare, of a list of agreed data from hospitals and private clinics.[47]

2.42 Options for improved data collection were also canvassed in evidence. Catholic Health Australia commented on Medicare data and stated that there is no way to reliably quantify the number of terminations funded by Medicare and suggested that if a separate MBS item for pregnancy terminations were introduced, women would be required to declare that they had had a termination when claiming the Medicare rebate. Catholic Health concluded that:

> This record of the termination would remain on their Medicare record permanently. Whilst this may assist in better informing policy decisions through improved data collection, such a move would more likely represent the placing of an additional burden on a women who has undergone a termination and potentially expose a women to a breach of privacy at the time of the termination or at a later stage in her life.[48]

2.43 Dr Andrew Pesce also commented on complications that may arise if data was reported against each descriptor of item 16525:

> Data collection is always good. The more we know, the more we can do what we want to do and avoid the unintended consequences of what we might think we are doing. So I think it is high time we had much better statistics and more robust data on this topic in Australia; it basically does not exist.
>
> The only cautionary note I would make is that I think it cannot be linked to Medicare item numbers. Medicare item numbers are a claiming thing for doctors so that we can pay for medical services. It is not a statistical tool to try and find out the subtleties of why we are doing a medical treatment or who we are doing it for. We must protect patient confidentiality. It would be very simple for any institution which was able to claim for any of these services—and they are always performed in institutions—to make it a requirement that they had to, in a de-identified way, provide all of this data, which would give us everything we wanted. We could go into the minutest details of what we need and get exactly what we wanted to know, and not threaten the confidentiality of the patient, who has to go to a Medicare office with an MBS item number where they would say: 'Oh, you had an abortion. Ooh, you had a psychosocial abortion.' Data is good, but you will get a lot better if you actually think about what data you want and have it collected properly and systematically in a de-identified way rather than mucking around with MBS item numbers, pretending you are going to find out things that you do not currently know.[49]

---

47 Chan A and Sage L, *Estimating Australia's abortion rates*, Medical Journal of Australia, Volume 182, Number 9, 2 May 2005, p.447.

48 Catholic Health Australia, *Submission 190*, p.2.

49 Dr Andrew Pesce, National Association of Specialist Obstetricians and Gynaecologists and, Australian Medical Authority, *Committee Hansard*, 29.10.08, p.104.

2.44 A further problem in relation to data collection is the lack of consistent definitions. This problem was highlighted by Professor Ellwood in his evidence:

> One of the problems about data collection is definition. Is it a termination of pregnancy if you are simply inducing labour early in pregnancy when the baby has a condition that is incompatible with life? For example, anencephaly in the foetus, which is incompatible with life after birth: should that be classed as a termination of pregnancy if you end the pregnancy at 24 weeks as opposed to waiting until 40 weeks?[50]

2.45 There are a number of different data gathering methods across the country. The Perinatal Society of Australia and New Zealand (PSANZ) in consultation with various States and Territories established the Perinatal Mortality Classifications with the intention of uniform application. The following provides an overview of the development of the PSANZ classifications:

> In Australia and New Zealand, the different states have developed or used different classifications, either within hospitals or for statewide data. In 1996, interested groups, mainly committees responsible for the review and classification of perinatal deaths in their respective states and the National Perinatal Statistics Unit, met for the first time in Brisbane, Queensland, to discuss a classification for national use. Little progress was made until the Perinatal Society of Australia and New Zealand (PSANZ) annual conference in 2000 in Brisbane where the Queensland and South Australian representatives were asked to develop mutually acceptable national classifications from the ones they used for their states…Their collaboration resulted in the development, with colleagues in other Australian states and New Zealand, of the Australian and New Zealand Antecedent Classification of Perinatal Morality (ANZACPM) based on obstetric antecedent factors, and the Australian and New Zealand Neonatal Death Classification (ANZNDC), based on neonatal causes. With the establishment of a Perinatal Mortality Classification Special Interest Group (SIG) within PSANZ…it was agreed in 2003 that the classifications would be renamed PSANZ-PDC (Perinatal Death Classification) and PSANZ-NDC (Neonatal Death Classification).[51]

2.46 In its most recent Australia's mothers and babies report, the Australian Institute of Health and Welfare National Perinatal Statistics Unit (NPSU) noted the following in relation to the application of the PSANZ-PDC and PSANZ-NDC classifications across States and Territories:

> Applying these classifications reveals considerable variability by jurisdiction in the leading cause of perinatal death. This is because this category includes late terminations undertaken for psychosocial indications, the majority of which are undertaken in Victoria. There may also be some

---

50 Professor David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.106.

51 Chan, A. et al, *Classification of perinatal deaths: Development of the Australian and New Zealand classifications*, Journal of Paediatrics and Child Health, Volume 40, 2004, p.342.

> differences in the ranking related to jurisdictional differences in applying the classifications and small numbers in some categories.[52]

2.47 Each year, the NPSU collects information from the States and Territories to establish the Perinatal National Minimum Data Set (NMDS). In 2008, the NPSU published a compliance evaluation of data provided by the states and territories for each year from 2001 to 2005. The NPSU noted in the evaluation that the NMDS is 'contingent upon a national agreement to collect uniform data and to supply it as part of the national collection'. The NPSU continued:

> This means that data elements should be collected or at least reported using standard definitions and domain values and reported for all births within scope. However, there tends to be some variation in the way in which data is reported among the states and territories.[53]

2.48 The NPSU also commented on data collection for terminations of pregnancy:

> There are inconsistencies among the states and territories in how terminations of pregnancy are identified in their data collections and some jurisdictions cannot separately identify those performed for psychosocial reasons from births.[54]

2.49 Similarly, a November 2008 report on neutral tube defects in Australia by the NPSU noted problems of perinatal data collections:

> Stillbirths in all states and territories include terminations of pregnancy carried out at 20 weeks gestation or thereafter or resulting in the delivery of a fetus weighing 400g or more. Some states are able to distinguish these late terminations of pregnancy from still births, but some states cannot differentiate them.[55]

Conclusion

2.50 The evidence before the committee points to a lack of data on terminations performed in Australia. The committee believes that there is an urgent need to improve the collection and recording of perinatal and neonatal data generally. The improvement of perinatal and neonatal data collection will have ramifications for

---

52 Australian Institute of Health and Welfare National Perinatal Statistics Unit, *Australia's mothers and babies 2005*, Perinatal Statistics Series Number 20, November 2007.

53 Australian Institute of Health and Welfare National Perinatal Statistics Unit, *Perinatal National Minimum Data Set compliance evaluation 2001 to 2005*, Perinatal Statistics Series Number 21, October 2008, p.1.

54 Australian Institute of Health and Welfare National Perinatal Statistics Unit, *Perinatal National Minimum Data Set compliance evaluation 2001 to 2005*, Perinatal Statistics Series Number 21, October 2008, p.7.

55 Australian Institute of Health and Welfare National Perinatal Statistics Unit, *Neural tube defects in Australia. An epidemiological report*, November 2008, p. 9.

health care policy and practice across Australia as it will provide improved data to inform government and the medical profession.

2.51 In order for this to be achieved, uniform data from all jurisdictions is required as well as the use of one classification system across the country. This would not only improve data for the purposes of analysis and comparison, but also enable consistency in relation to definitions.

Recommendation 1

2.52 The committee recommends that Australian Health Ministers' Conference ensure the prompt application of the Perinatal Society of Australia and New Zealand Perinatal Mortality Classifications across all States and Territories.

2.53 The committee recognises that improvement in data quality and consistency is essential for a complete national collection. The committee notes that the NMDS is reliant upon national agreement to provide uniform data as part of a national collection. It therefore encourages the Australian Health Ministers' Conference to work with the National Perinatal Data Development Committee and other key stakeholders to ensure that, across all States and Territories, comprehensive uniform data is provided to the NMDS.

Recommendation 2

2.54 The committee recommends that Australian Health Ministers' Conference secure an agreement with all jurisdictions to work towards providing complete and uniform data to the Perinatal National Minimum Data Set.

The regulatory impact of the disallowance of item 16525

2.55 Whilst the committee was not required under its terms of reference to make recommendations on the motion of disallowance of item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007, consideration of the terms of reference encompassed the effects of a disallowance which include that of the regulatory context.

2.56 The committee received evidence from the Department of Health and Ageing that a disallowance of the item would result in the cessation of payments for procedures currently within the terms of item 16525.[56] The introduction of a new and/or modified item would follow the standard regulatory process. The usual timeframe for standard new regulations is six months and the department commented:

> The recommended time frame to draft new regulations by the Office of Legislative Drafting and Publishing is eight to 12 weeks. That is the recommended time frame to draft new regulations. Following that time frame, those regulations have to be presented to executive council, and the

56 Department of Health and Ageing, *Submission 218*, p.2.

> recommended time frame for that is around four to six weeks. It would also obviously have to fit into the executive council meeting time frames, and they meet, as you would know, on a fortnightly basis. So it would really depend on all of those mechanisms.
>
> As well, we would have to liaise with Medicare Australia as to how soon they could implement a new item on their system. The time frame for that also depends on what restrictions are on that item. The more restrictions on the item, the more potential work for Medicare Australia to implement.[57]

2.57 However, the department did agree that there had been instances where regulation had been made more quickly.[58] The department went on to state that a six-month timeframe as opposed to a shorter timeframe would enable consultation with the medical profession:

> The six-month time frame that was quoted initially allows for what is usual, which is a period of consultation with the medical profession, usually managed through the AMA and the relevant craft groups. The Medicare Benefits Schedule is essentially a list of services that the medical profession advises government are clinically relevant services, and the item descriptors are generally developed in consultation between the department and the medical profession so that it reflects the service that is rendered by medical practitioners.[59]

2.58 The committee sought advice from the department on ways to improve understanding of the uses of item 16525. The department did not support the further splitting of the item and noted that this would require a change to the regulations. As to administrative means, the department stated:

> But there are various mechanisms that could be available, such as working with each state's and territory's births and deaths registry, or, potentially, splitting the item—though, once again, if you were to split all items there would be far too many items. Another mechanism could be that when the procedure is performed that particular report has to be provided to Medicare Australia. So there are various administrative mechanisms, but they would require a regulatory change and it depends on what mechanism is the preferred one as to what the regulatory change would be and how much of a regulatory change that would be.[60]

2.59 Other options considered include modifying the current item descriptor to either specify a procedure or prohibit a procedure which, according to the department,

---

57 Mr Michael Ryan, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.15.

58 Mr Michael Ryan, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.24.

59 Dr Brian Richards, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.18.

60 Mr Michael Ryan, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.14.

could be achieved either through a rule of interpretation to the particular item or an amendment to the particular item.[61]

2.60 The Health Insurance (General Medical Services Table) Regulations 2008 were tabled in the Senate on 10 November 2008. The last day for giving notice of a motion to disallow item 16525 in Part 3 of Schedule 1 to these regulations, if the currently advised sitting days are followed, would be 23 February 2009.

Retrospective implementation

2.61 If item 16525 were disallowed, there would be a period of some months during which time no regulations would be applicable for services under the item and therefore no Medicare benefits could be paid. When questioned about retrospective implementation of the regulation to cover the gap period, the department noted:

> Retrospective implementation of regulation is allowed under the Acts Interpretation Act as long as it does not impinge on private bodies. That means that the only liability is on the Commonwealth. Given that this procedure is predominantly done in hospital, there are private health insurers who are required, where the procedure is performed within that setting, to outlay the private health benefits to their constituents. We would have to be very careful that we do not impinge a retrospective liability on those private health insurers.[62]

Potential impact of disallowance on private health insurance

2.62 The impact of a disallowance of item 16525 on private health insurance was raised by the Department of Health and Ageing. The department stated:

> If item 16525 were disallowed private health insurers would not be obligated to pay benefits to their members for this service. Health insurers can pay benefits for a wide range of health care services that are not covered under Medicare but this would be a decision for the individual fund.[63]

2.63 The Australian Health Insurance Association (AHIA) responded that:

> Private Health Funds are not obliged to pay benefits for this service if it is not listed on the Medicare Benefits Schedule.[64]

2.64 The AHIA went on to comment on the level of benefits paid:

> According to the Australian Government's Medicare Benefits Schedule (November 2007), the fee for Item 16525 is $267.00 and the Medicare

---

61 Mr Michael Ryan, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.19.

62 Mr Michael Ryan, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.19.

63 Department of Health and Ageing, *Submission 218*, p.4.

64 Australian Health Insurance Association, *Answer to Question on Notice 30.10.08* (received 3.11.08).

benefit paid is 75% = $200.25. Private Health Funds are required to pay the difference between the Scheduled Fee and the Medicare Benefit (25%). In addition, Funds negotiate directly with medical practitioners to determine the percentage of the gap which is payable. This will vary between Funds.[65]

65 Australian Health Insurance Association, *Answer to Question on Notice 30.10.08* (received 3.11.08).