Chapter 3

Effects of disallowance of item 16525: evidence in support of disallowance of item 16525

Introduction

3.1 This chapter considers the effects of a disallowance of item 16525 in Part 3 of the Schedule to the Health Insurance (General Medical Services Table) Regulations 2007 (item 16525) with focus on evidence in support of disallowance of the item and/or limiting the item to specific circumstances.

3.2 Submissions in support of a disallowance generally focused on five key areas: termination for fetal abnormality; the use of psychosocial grounds for termination; the methods of termination used; the 'unethical' role of Medicare as a body responsible to preserve life and health; and the ill-effects on the physical and mental health of women who have undergone a termination. A vast number of such submissions argued that item 16525 was utilised to terminate fetuses that could otherwise survive outside of the uterus and questioned both the validity of the definitions of the services provided under the item as well as the services actually claimed under the item number by medical practitioners.

3.3 Some submitters in favour of the disallowance of the current item 16525 held that it was important to introduce alternative provisions for cases of lethal fetal abnormality, serious risk to the life of the woman in question or intrauterine death.[1]

Terms of item 16525

3.4 The committee received much evidence which raised concerns about the terms of item 16525 both in relation to the descriptors included in the item and the interpretation of the descriptors. Evidence indicated that there is no shared understanding of the meaning of the phrases used to describe two indicators for claims under item 16525, that is, 'gross fetal abnormality' and 'life-threatening maternal disease'. Dr David van Gend from the World Federation of Doctors Who Respect Human Life, for example, commented that although the item was 'no doubt drafted in good faith', because of loose definitions, 'it is open to subjective interpretation by doctors, and terrible abuse'.[2]

3.5 Family Voice Australia provided the following evidence which encapsulates the concerns that are held in relation to the terms of item 16525:

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1 See for example, Catholic Health Australia, *Committee Hansard,* 29.10.08, pp2-3.

2 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.45.

> At least some practitioners who provide abortions and claim under this item number interpret gross foetal abnormality to mean any foetal defect whatsoever however trivial, interpret life-threatening maternal disease to mean simply that a woman does not want to be pregnant and that not wanting to be pregnant can be understood as posing sufficient threat in itself without any other compounding factors to her mental health and therefore, by extension, be called a life-threatening maternal disease.[3]

Intrauterine fetal death

3.6 Many submitters supported the need for a Medicare item to cover the management of labour where there had been an intrauterine fetal death which had occurred spontaneously.[4] Pregnancy Help Australia commented that it was of the opinion that 'no mother should be expected to carry to term of 40 weeks any child with dies in utero'. Rather, there is an expectation that 'medical practice is to intervene and manage such a situation with dignity for all concerned'.[5] The Lutheran Church's Commission on Social and Bioethical Questions also stated that:

> In cases of genuine stillbirth during the second trimester where a fetus dies in utero from natural or accidental causes there is no moral question raised by the need to induce and manage labour to achieve the delivery of the stillborn infant. A Medicare item such as 16525 obviously remains appropriate for genuine stillbirth where the fetal death is not the result of a deliberate termination of pregnancy.[6]

3.7 The Australian Christian Lobby (ACL) maintained that if the 'child dies in the womb then of course it must be delivered to protect the mother'. According to the ACL, this is not an abortion but rather the management of a terribly sad event.[7]

3.8 The World Federation of Doctors Who Respect Human Life noted that any item which covered intrauterine death should specify intrauterine fetal death 'other than where caused by procured abortion' as 'of course, when you cause intrauterine fetal death injection of potassium chloride into the heart, or by the partial birth abortion method, the baby is dead before delivery, so it is intrauterine fetal death'.[8]

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3 Mr Richard Egan, Family Voice Australia, *Committee Hansard,* 30.10.08, p.47.

4 Catholic Women's League of Australia, *Submission 208*, p.3; Medicine with Morality, *Submission 179*, p.1; World Federation of Doctors Who Respect Human Life, *Submission 211*, p.2.

5 Pregnancy Help Australia, *Submission 186*, p.1.

6 Commission on Social and Bioethical Questions, Lutheran Church of Australia, *Submission 213*, p.2.

7 Australian Christian Lobby, *Submission 204*, p.8.

8 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.48.

3.9 Catholic Health Australia commented that it would support the disallowance of item 16525 if provision was also made to differentiate between terminations of pregnancy and procedures relating to miscarriage or other forms of non-pregnancy termination to ensure that women are not disadvantaged.[9]

Gross fetal abnormality

3.10 'Gross fetal abnormality' was understood in contradictory ways by witnesses and a number of submissions pointed to the lack of a definition or any guidance given in item 16525 for the term. Dr Brian Richards of the Department of Health and Ageing commented:

> Generally the term 'gross' in medical parlance indicates something that is macroscopically visible—that is, it does not require the aid of a microscope to identify. It is an abnormality that is obvious to the naked eye. While a pregnancy that is continuing, these days it is generally something that can be identified on ultrasound.[10]

3.11 The department went on to state:

> The medical terms used in just about every item in the medical benefits schedule is not specifically defined in the regulations. They are understood by the medical profession and interpreted by the medical profession in alignment with the clinical relevance. It would need to be an interpretation that would be generally accepted in the profession.[11]

3.12 Dr Lachlan Dunjey of Medicine with Morality commented that at one time 'gross' was considered to be 'lethal' and inconsistent with life.[12] Professor David Ellwood stated:

> My interpretation of the phrase 'gross foetal abnormality' really means a significant or severe foetal abnormality. The idea that it is something that is visible to the naked eye is nonsense. We use technology, ultrasound, genetic testing and metabolic testing these days. In my experience, it is not anything to do with whether or not this is something that you can see with the naked eye.[13]

3.13 However, submitters commented that it is now left to the practitioner's clinical decision as to what constitutes a gross fetal abnormality.[14] As a consequence, gross

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9 Catholic Health Australia, *Submission 190*, p.1.

10 Dr Brian Richards, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.11.

11 Dr Brian Richards, Department of Health and Ageing, *Committee Hansard*, 29.10.08, p.28.

12 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard*, 29.10.08, p.48.

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

14 Pregnancy Help Australia, *Submission 186*, p.1; Commission on Social and Bioethical Questions, Lutheran Church of Australia, *Submission 213*, p.2.

fetal abnormality has come to mean 'any abnormality or considered defect'.[15] This includes defects which are correctable.[16]

3.14 Dr David Knight also commented on the term 'gross fetal abnormality':

> I think it is probably a bad term and I think it is capable of being misunderstood. My understanding of it is: it is a lethal foetal deformity or a deformity of such magnitude that it would prevent a human being from leading a normal life. That would be my understanding of the word 'gross'. I can see how it could be misinterpreted or misunderstood, and I would think that perhaps a better term should be found.[17]

3.15 The Australian Family Association pointed to the proportion of second trimester terminations which take place in private clinics as a suggestion that the term 'gross foetal abnormality' is often 'treated with a broad interpretation'.[18] The Association added that item 16525 is:

> …being notoriously abused by a broad interpretation on the part of medical practitioners, especially in private clinics who have a financial–in some cases ideological–stake in the termination. An assertion of professionalism, especially on the part of private abortion providers, is no guarantee of the integrity of the process.[19]

3.16 Concern about termination for 'trival' abnormalities focused on children with Down syndrome, dwarfism, cleft lip and cleft palate. The Australian Family Association for example, commented that termination on the grounds of gross fetal abnormality was 'notoriously abused in the case of Down's syndrome, dwarfism and other conditions that could hardly be described as "gross"'.[20] Witnesses noted that in Victoria it has been identified that 90 per cent to 95 per cent of children with disabilities such as Down syndrome are aborted.[21]

3.17 The Australian Christian Lobby also noted that in 2003-04 at least three late term terminations were conducted in Victoria 'solely because they had cleft lip or cleft palate and lip and no other disabilities'.[22] Mr Christopher Meney of the Life, Marriage and Family Centre commented:

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15 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard*, 29.10.08, p.46.

16 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.46.

17 Dr David Knight, *Committee Hansard*, 30.10.08, p.73.

18 Australian Family Association, *Submission 177*, p.2.

19 Australian Family Association, *Submission 177*, p.3.

20 Australian Family Association, *Submission 177*, p.2; see also Medicine with Morality, *Submission 179*, p.1; Right to Life Australia, *Submission 198,* p.1.

21 Mrs Rita Joseph, *Submission 20*, p.5; see also Mr Richard Egan, Family Voice, *Committee Hansard*, 30.10.08, p.43;

22 Australian Christian Lobby, *Submission 204*, p.8.

> We know that in some cases people are aborted because of a cleft lip or a cleft palate. It is a terrible thing to think that somebody's life is not worth living because they have something which can easily be remediated through modern surgery.[23]

3.18 The Archdiocese of Adelaide concluded:

> The fact that such abortion funding has been made for such minor disabilities as a cleft palate or missing digits makes a mockery of *gross fetal abnormality* and, we believe, every disabled person by association.[24]

3.19 In order to overcome these difficulties with this descriptor, Dr Dunjey suggested that the wording be changed to 'lethal' abnormality rather than 'gross'. [25] Dr van Gend also supported the rewording of the descriptor:

> We heard very clearly this morning from the health department spokesman, Dr Richards, that 'gross' means anything detectable, including cleft lip and including, no doubt, a missing finger—that is what gross means—and that that would be covered by the current indication. That is not the spirit of this item and it would be necessary to be quite firm in the redrafting and limit it to lethal. If you have any word other than 'lethal' abnormality the floodgates are open to the subjective interpretation of the doctor. Again and again we hear it is up to the clinical decision of the doctor.[26]

3.20 It was argued that, as some conditions may be corrected by surgery, 'the unspoken philosophy behind allowing abortion for reasons of abnormality is one of eugenics: a less than perfect baby should not be born'.[27] The Australian Family Association commented on eugenics:

> …but where late-term abortion occurs, this raises other questions which are at odds with society's professed commitment to the rights of the disabled. Judgements are made about quality of life, and involve a denial of the obligations of society to support its most vulnerable members. To make such judgements is to approach the slippery slope of eugenics, while endorsing ideals such as the perfect or designer baby.[28]

3.21 A further argument put to the committee was that babies with gross fetal abnormalities should be born alive. Medicine with Morality stated:

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23 Mr Christopher Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard*, 30.10.08, p.5.

24 Archdiocese of Adelaide, *Submission 181*, p.7.

25 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard*, 29.10.08, p.48.

26 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.48.

27 Australian Christian Lobby, *Submission 204*, p.8.

28 Australian Family Association, *Submission 177*, p.1.

> When gross fetal abnormality is present with associated conditions considered life-threatening to the mother, once again the baby can be delivered–alive–and nature allowed to take its course with the baby being nursed in conditions of nurture and comfort.[29]

3.22 A number of submitters commented that termination for minor or easily treatable conditions could be viewed as discrimination against a person with a disability and therefore a breach of United Nations treaties to which Australia is a signatory. One of the conventions frequently cited was the *Convention on the Rights of Persons with Disabilities*. Mrs Joseph commented that there was a failure to adhere to Article 3 of the General Principles of the convention, that is, 'to nurture receptiveness to the rights of children with disabilities and to promote positive perceptions and to promote positive perceptions and greater social awareness towards such children'.[30] Mrs Joseph went on to state that abortion on the ground of 'gross fetal abnormality' allowed 'extreme prejudice' against children detected before birth to have disabilities and 'cannot be reconciled with the treaty's core commitment: acceptance of and respect for all human beings with disabilities'.[31]

3.23 It was also argued that it is inconsistent that the Commonwealth has become a signatory to this convention and provide disability support services when at the same time, 'supporting and financing abortion based precisely upon the presence of a disability'. [32] Family Voice Australia commented:

> The convention includes a right to life for the disabled. Measures which inflict death on an unborn child solely because of disability, or measures which fund such procedures, are clearly in conflict with the convention.[33]

3.24 Mrs Rita Joseph provided arguments in relation to two further United Nations treaties: the *International Covenant on Civil and Political Rights (ICCPR)* and the *Convention on the Rights of the Child.* In relation to the ICCPR, Mrs Joseph stated that the intentional 'deprivation of life' of the unborn child because of disability contravened article 6 of the ICCPR and 'fails the common law tests of absolute "necessity" and strict "proportionality"'.[34] In addition, the *Preamble* to the *Convention on the Rights of the Child* provides for 'special safeguards and care' for all children 'before as well as after birth'.[35] To allow selective termination violates the 'fundamental human rights principle of non-discrimination' which imposes a legal obligation to 'eliminate the practice of treating some children with respect because

29 Medicine with Morality, *Submission 179*, p.1

30 Mrs Rita Joseph, *Submission 20*, p.2; see also *Committee Hansard*, 29.10.08, pp80–81.

31 Mrs Rita Joseph, *Committee Hansard*, 29.10.08, p.90.

32 Archdiocese of Adelaide, *Submission 181*, p.7.

33 Mr Richard Egan, Family Voice Australia, *Committee Hansard*, 30.10.08, p.36.

34 Mrs Rita Joseph, *Submission 20,* p.2.

35 Mrs Rita Joseph, *Submission 20*, p.4; see also *Committee Hansard*, 29.10.08, p.89.

they are "normal" and other children with contempt because they have "foetal abnormalities"'.[36]

3.25 In relation to arguments concerning the rights of women, Mrs Joseph commented:

> …there are certain principles that are just basic to human rights law, and one of them is the principle of indivisibility. That principle says that the abuse of one person's rights cannot be justified by upholding another person's rights. It requires that human rights protection of both the mother and her unborn child be observed. Both the mother and unborn child have equal rights that stem from the inherent dignity and worth of all members of the human family. When the indivisibility principle is applied, the individual state's misperceived duty to provide expectant mothers with abortion services cannot be performed at the neglect of the more fundamental duty to uphold the rights of their children to special safeguards and care, including appropriate legal protection before as well as after birth. The right to life is a supreme right and basic to all human rights.[37]

3.26 Witnesses also responded to comments concerning the costs to the community of supporting a person with a disability.[38] Mr Christopher Meney of the Life, Marriage and Family Centre commented:

> I think the whole nature of a community means that people are given the support that is necessary for their particular circumstances. All of us go through life at different stages requiring different levels of social support. Some require early medical assistance and expensive support at an early stage; others might require it later. It would be an important part of what we are trying to do as a society in Australia to say that everyone should have the opportunity to have the best support that can be made available for them. I think that we can be quite clinical sometimes in looking at people and thinking that certain sorts of attributes or abilities are of less value. I think that it is very important for us to remember that many of the contributions made by people in our community come from people whose parents may very well have decided not to have them were their disabilities detected in utero at an early stage. Some of them have led very flourishing lives, and those contributions to the community from those people may not have been forthcoming. We can never predict exactly what wonderful gifts people can bring forth in terms of their capacities. I think it is very important for us to be respectful of that. As a society, we should encourage all members of the community to look at individuals in terms of people who have great gifts.[39]

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36 Mrs Rita Joseph, *Submission 20*, p.5.

37 Mrs Rita Joseph, *Committee Hansard*, 29.10.08, p.98.

38 Australian Reproductive Health Alliance, *Submission 199,* pp11–12; Parliamentary Group on Population and Development, *Submission 436,* pp10–11.

39 Mr Christopher Meney, Life, Marriage and Family Centre, *Committee Hansard*, 30.10.08, p.5.

Life threatening maternal disease

3.27 Item 16525 includes termination for 'life threatening maternal disease'. Some submitters noted that cases of life threatening maternal illness are very rare. The Australian Family Association, for example, commented that Victorian records 'reveal no cases where second or third trimester terminations were carried out to preserve the physical health of the mother'.[40] It was also stated that where there was a case of life threatening maternal disease, termination should be an option. The Australian Christian Lobby indicated that it considered termination acceptable 'where there is a genuine and unavoidable choice to be made between the life of the mother and the life of the child'. In these cases, 'the intent here is not to terminate the life of the fetus but to preserve the life of the mother: better one life saved than two lives lost'.[41]

3.28 However, the Catholic Archdiocese of Adelaide noted that if there was the presence of a life threatening maternal disease then that would mean the women concerned would be best cared for in a hospital, rendering item 15625 redundant and concluded 'we find it hard to imagine that a woman with a significant life threatening maternal disease would present at a private clinic rather than a hospital'.[42] This was a view also supported by Dr David Knight who stated that 'it is obviously absurd to expect that [private] clinics can handle terminations of pregnancy in women who are so ill that they can no longer continue with the pregnancy'.[43]

3.29 A further matter raised with the committee was that terminations may not always be the only option in the case of life threatening maternal disease. Witnesses argued that a different outcome to a termination could be achieved in many cases as medical and obstetric care has advanced to a high degree and there is great success in treating women who may have a concomitant illness.[44] Medicine with Morality stated that in the rare instance of life threatening maternal disease, induction and labour can be performed without termination and 'delivery of the baby would then take place and be managed appropriately as any other baby born at that level of maturity'.[45] Medicine with Morality provided additional comments in evidence:

> It is unfortunate that termination of pregnancy has become synonymous with abortion when in fact a pregnancy can be terminated by induction of labour with delivery of a live baby. So pregnancy is a condition of the mother. The baby of course is involved, but we can terminate that pregnancy by induction of labour in instances where there is gross foetal abnormality, in instances where there is risk to the life of the mother, and

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40 Australian Family Association, *Submission 177*, p.2.

41 Australian Christian Lobby, *Submission 204*, p.9; see also *Committee Hansard,* 29.10.08, p.95.

42 Catholic Archdiocese of Adelaide, *Submission 181,* p.5.

43 Dr David Knight, *Committee Hansard*, 30.10.08, pp70–71.

44 Catholic Women's League of Victoria and Wagga Wagga, *Submission 203*, p.1; see also *Submission 186*, p.2; *Submission* 184, p.1.

45 Medicine with Morality, *Submission 179*, p.1.

> we can have a live baby at the end of that, and maybe one which is viable. In instances of gross foetal abnormality incompatible with life but where the baby may be born alive, the mother then has a chance to cuddle that baby, to name that baby, until the baby dies. I have been witness to this kind of event, rather than killing the baby in utero and having a dead baby.[46]

3.30 The Endeavour Forum stated:

> Second trimester babies have to be delivered in much the same way as full-term babies, and if indeed the pregnancy has to be terminated because of a serious problem with the mother's health (this situation occurs very rarely) then birth should be induced as late into the pregnancy as possible and the baby given a chance of survival…"Mother's health is being falsely used to justify abortions for psycho-social reasons. Mothers with an unwanted pregnancy should be encouraged to give birth and make them available for adoption. There is never a good reason to terminate a second trimester pregnancy'.[47]

3.31 The Catholic Archdiocese of Adelaide concluded:

> From the time when an unborn child can safely survive outside the womb there are clearly other options available other than abortion. It is worth considering…that both abortion methods used in second trimester abortions (and later) actually 'deliver the child'.[48]

3.32 Of much greater concern to submitters was the use of maternal psychosocial conditions under the indicator of 'life-threatening maternal disease' as a ground for termination. It was argued that psychosocial reasons encompassed a range of factors, including economic factors and breakdown of relationships. Dr Christine Tippett of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists provided the committee with some indicators of psychosocial conditions including 'women who are very deprived, socially and economically', are often young women, drug addicts and homeless. This category also includes women for whom 'sex outside marriage is a religious taboo'.[49]

3.33 The World Federation of Doctors Who Respect Life that psychosocial 'means there is no medical problem with the mother or the baby, but the parents request abortion because of economic or emotional stress'.[50] As a result, it was argued that termination for psychosocial reasons was easily obtained.[51] Submitters also noted that

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46 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard*, 29.10.08, p.51.

47 Endeavour Forum, *Submission 184*, p.1.

48 Catholic Archdiocese of Adelaide, *Submission 181,* p.6.

49 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.85.

50 World Federation of Doctors Who Respect Human Life, *Submission 211*, p.3.

51 Australian Christian Lobby, *Submission 204*, p.9.

in practice, it is a clinical decision of the practitioner as to what falls within this indicator.[52]

3.34 It was noted in submissions that psychosocial reasons were given as the most frequent ground for late term termination and pointed to the data available from Victoria. In 2005 in that state, 108 late term terminations were undertaken for psychosocial reasons and only 23 for congenital abnormality.[53] Family Voice Australia commented on the data from Victoria for 2006 which indicated that over 50 per cent of all post-20 week terminations (150 out of 298) performed were for maternal psychosocial indications. Ninety eight terminations for maternal psychosocial indications were performed at 23 weeks gestation or later, 'that is after fetal viability'.[54]

3.35 Medicine with Morality concluded that:

> From the figures in Victoria, I think it is clear that the vast majority of abortions were for psychosocial distress and therefore, yes, elected by the mother and agreed to by the doctor. Some were due to foetal abnormalities of various descriptions and descriptions which, in my view, certainly do not fit within the range of lethal abnormality. The vast majority of these were for elective reasons and should not be given ipso facto national approval by granting medical benefits for these procedures.[55]

3.36 Submitters also pointed to the difference in the rate of termination for psychosocial reasons between the public and private sectors. Dr van Gend pointed out that in Victoria for the 581 abortions over 20 weeks in the period 2001-05 for psychosocial reasons of which 'only four were attended to in public hospitals'.[56] Dr van Gend concluded 'therefore, post-20 weeks for psychosocial reasons is a commercial clinic venture. They are not dealt with at the public hospital because they would not be considered valid grounds.'[57]

3.37 Family Voice Australia also commented that:

> And in fact the women who are resorting to the private abortion clinics and getting this Medicare payment are doing it because the terms on which they want the abortion are not provided at the public hospital. As many of the witnesses from public hospitals have said, they are not offering abortions

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52 See for example, Commission on Social and Bioethical Questions, Lutheran Church of Australia, *Submission 213*, p.2.

53 Australian Christian Lobby, *Submission 204*, p.9.

54 Family Voice Australia, *Submission 176*, p.3.

55 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard*, 29.10.08, p.52.

56 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.53.

57 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.51; see also Australian Christian Lobby, *Submission 204*, p.10.

> for maternal psychosocial indications in the second trimester, and that is what the private clinics are offering that the public hospitals are not.[58]

3.38 Witnesses commented that the public hospitals and major private hospitals provided 'checks and balances' in the decision for a late term termination to proceed.[59] Requests for terminations are considered by ethics committees of 'impartial people without vested interests'.[60] Dr David Knight commented that it was doubtful 'that the processes of ethics committee approval, peer review, audit and ongoing patient support are present in those private abortion clinics where late termination of pregnancy is being performed'.[61]

3.39 In order to ensure that the intent of this descriptor was re-established, that is the woman's life is genuinely at risk, changes to the wording were suggested. Dr van Gend, while noting that item 16522 of the MBS does not fit with intrauterine death or lethal fetal abnormality, indicated that it could be used as the basis for new wording of item 16525. Dr van Gend stated:

> …to keep the integrity of the item and direct the money to where it is intended, you would need to have something firmer. May I suggest for your consideration that you simply move to the item above, 16522, and rephrase the phrase they use in that item, which is 'conditions that pose a significant risk of maternal death'. That is far harder to construe in terms of stress, however grave the stress, but stress we all have to face. 'Significant risk of maternal death' would, I think, give integrity back to the descriptors. Then you would reissue the item with all its valid indications intact and that would keep faith with the public.[62]

3.40 The notes for item 16522 discuss the term as follows:

> Conditions that pose a significant risk of maternal death referred to in Item 16522 include:
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> - severe pre-eclampsia as defined in the consensus Statement on the Management of Hypotension in Pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
> - cardiac disease (co-managed with a consultant physician or a specialist physician);
> - coagulopathy;
> - severe autoimmune disease;
> - previous organ transplant; or

58 Mr Richard Egan, Family Voice Australia, *Committee Hansard*, 30.10.08, p.46.

59 Mr Christopher Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard*, 30.10.08, p.2.

60 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.50.

61 Dr David Knight, *Committee Hansard*, 30.10.08, p.70.

62 Dr David van Gend, World Federation of Doctors Who Respect Human Life, *Committee Hansard*, 29.10.08, p.49.

- pre-exisiting renal or hepatic failure.[63]

3.41 Dr Dunjey also supported such a change and commented that:

> The word 'significant' is not important; it is the word 'death' versus the word 'life'. 'Life-threatening' incorporates psychosocial risk to the life and well being...If you change that very subtly from 'life-threatening' to 'risk of maternal death', you have not changed the valid indications at all. It still means the same diseases—pre-eclampsia, major renal or heart disease and a few others listed in the Medicare schedule—but you have made it very hard for abuse to occur because [of] economic stress as an indication for late abortion.[64]

Termination methods

3.42 Many submissions in support of the disallowance of item 16525 referred to the methods utilised to abort the fetus in the second trimester. Concerns regarding termination methods focused on both the techniques utilised, particularly surgical procedures, as well as the pain inflicted on the fetus.[65] Submitters also reported that, in some instances, termination had resulted in the birth of a living child which was then left to die.

Surgical terminations

3.43 Two surgical methods of termination – dilation and evacuation and a breech delivery followed by cranial decompression (sometimes known as partial birth termination) – raised much concern in relation to the methods of the procedures, the dangers to mothers and fetal pain.

3.44 The committee was provided with details of the two surgical methods. Of particular concern was the use of the method described by witnesses as 'partial birth termination'. This method was described as being cruel, inhumane and an 'absolutely abhorrent assault on a viable child'.[66] The Catholic Guild of St Luke described the procedure as:

> The entire infant is delivered except the head. Scissors are jammed into the base of the baby's skull. A tube is inserted into the skull and the brain is sucked out.[67]

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63 http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=T4.6&qt=NoteID (Accessed 12.10.08).

64 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard*, 29.10.08, p.54.

65 See for example, The Australian Family Association, *Submission 177*, p.1; Family Council of Victoria, *Submission 485*, p.1; Medicine with Morality, *Submission 179*, p.2; Australian Christian Lobby, *Submission 11*, p.4.

66 Australian Christian Lobby, *Submission 11*, p.4; see also, Family Council of Queensland, *Submission 206*, p.1.

67 Catholic Medical Guild of St Luke, *Submission 207*, p.1.

3.45 Submitters noted that this termination method is banned in the United States. The World Federation of Doctors Who Respect Human Life stated that 'the Senate and the Supreme Court of the United States, and the American Medical Association, have all condemned [this method] as "gruesome, inhumane, and never medically indicated"'.[68]

3.46 Medical practitioners appearing before the committee raised concerns about the safety for women of these procedures for second term terminations. Dr David Knight commented:

> It is really extremely dangerous to attempt to terminate a pregnancy after about 15 or 16 weeks by dilatation and curettage. That certainly is and has been done, but it is extraordinarily dangerous for the woman. There are risks of tearing the cervix, risks of perforating the uterus, risks of haemorrhage, risks of shock—these sorts of things unquestionably occur if you attempt this kind of procedure.
>
> It is much safer for the woman, if you have to terminate a pregnancy after 14 weeks, to induce a labour of a sort and have the foetus expelled and then try to deliver the placenta afterwards. If the baby is expelled and you have to deliver the placenta separately then curettage is a lot safer because you are not dealing with large foetal parts.[69]

3.47 Dr Knight concluded:

> I have certainly performed lots of curettages on women who have had an intrauterine death up to about 14 weeks but I honestly would not be game to do it after about 14 weeks because of the enormous risks involved. Such terminations really need to be done in proper facilities, with intensive care units and blood transfusion services freely available, because they are so dangerous.[70]

3.48 Dr David Baartz pointed to reported comments by the then President of the Queensland Branch of the Australian Medical Association that as late terminations presented 'very significant dangers to women' they should only be performed in public hospitals.[71] Dr Baartz commented that the president had responded to revelations about the series of major and life-threatening injuries sustained by women having late term terminations in the private clinics.[72]

3.49 Dr Baartz went on to note that this position reflected that of the Queensland branch of the Royal Australian and New Zealand College of Obstetricians and

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68 World Federation of Doctors Who Respect Human Life, *Submission 211*, p.2.

69 Dr David Knight, *Committee Hansard,* 30.10.08, p.73.

70 Dr David Knight, *Committee Hansard*, 30.10.08, p.74.

71 Dr David Baartz, *Committee Hansard*, 30.10.08, p.71.

72 Dr David Baartz, *Committee Hansard,* 30.10.08, p.71.

Gynaecologists, which said, 'There is absolutely no justification for termination of pregnancy after 20 weeks by anyone other than a recognised specialist.'[73]

3.50 It was also argued that, contrary to the accepted view, there is strong evidence that a fetus feels pain before 24-26 weeks. The Australian Christian Lobby pointed to several lines of evidence including that premature babies of 23-26 weeks gestation show signs of pain perception and awareness; and that there is evidence that stress hormones are released during invasive procedures on fetuses down to 18 weeks gestation or earlier.[74]

3.51 The World Federation of Doctors who Respect Human Life stated that:

> We know from expert testimony that babies in the late second trimester are likely to feel more exquisite pain than older infants, due to the immaturity of inhibitory pain pathways; yet we know that in the published lecture notes of a leading Australian abortion doctor no pain relief is given to babies over 20 weeks of age during a procedure that inflicts extreme pain.[75]

3.52 Dr Dunjey of Medicine with Morality commented that there were conflicting views about fetal pain but:

> …although there are more and more people who are recognising that, with babies of 20 weeks or even younger, any sort of reflex withdrawal from a needle, for instance, is not just due to reflex but is in fact due to the perception of pain—that in fact the pathways to the brain are already there and that those pathways will register pain. Dr Anand suggests that the pain felt by the foetus at that kind of maturity is in fact extreme and severe pain, and perhaps more than we can feel. So, although there is conflicting evidence, how can we possibly say that those children do not feel pain? This is also recognised by the fact that, okay, no anaesthetic is given to the baby at 24 weeks who is being terminated—by extreme and brutal methods which I am sure I do not need to enlarge on—but anaesthetic is given to the 24-week baby outside the mother's womb when it is being operated on. Although once upon a time no anaesthetic was given because it was considered that pain is not perceived, that at least is now recognised and is a part of those procedures. So why are we so inconsistent in saying that a baby that is still inside the safe-haven womb does not feel pain? We cannot establish that, and certainly, because we cannot establish it, it should be considered.[76]

3.53 Medicine with Morality also noted that an expert before the United States Senate had stated that:

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73 Dr David Baartz, *Committee Hansard*, 30.10.08, p.71.

74 Australian Christian Lobby, *Submission 204*, p.6.

75 World Federation of Doctors who Respect Human Life, *Submission 211,* p.2.

76 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard,* 29.10.08, p.47.

> …the pain experienced during 'partial birth abortions' by the human fetus would have a much greater intensity than any similar procedures performed in older age groups.[77]

Medical terminations

3.54 Medical terminations involve the administration of prostaglandin to induce delivery and injection of potassium chloride into the fetal heart to ensure that a live fetus is not delivered. However, some submitters commented that this form of late termination did not always lead to a stillbirth but could result in the delivery of a living child.[78] This is the case when potassium chloride is not used. The Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity made this comment in its annual report for 2006:

> …there are increasing registrations of neonatal deaths of pre-viable infants (20-22 weeks gestation) who exhibit transient signs of life after birth following terminations of pregnancy for congenital abnormalities using vaginal misoprostol.[79]

3.55 Dr David Baartz commented on the chances of survival at 22 weeks gestation where potassium chloride is not used:

> I do not do them, but I know that potassium chloride is used on occasions, but not always. Most of the time it is not used. Having said that, I have not personally known of any cases where, after this process that they go through, the baby has been alive. It is because the prostaglandin that they give is much stronger than the prostaglandins you would induce a natural labour with, one with someone at 39 weeks. The strength is about a hundredth of that because the cervagem is about 100 to 200 times as strong, so the contractions are so strong that the baby does not survive.[80]

3.56 The Australian Christian Lobby noted that in Victoria in 2005, 15 per cent of post-20 week terminations resulted in the delivery of a live born child 'who was then tragically left to die'.[81] While in 2006, 42 post-20 week terminations resulted in the delivery of a live-born child who died shortly afterwards.[82]

3.57 Mr Lyle Shelton of the Australian Christian Lobby commented in evidence that 'we do not understand how this can happen in a civil society…That situations

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77 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard,* 29.10.08, p.53.

78 Pregnancy Help Australia, *Submission 186*, p.1.

79 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.32.

80 Dr David Baartz, *Committee Hansard* (in camera), 30.10.08, p.4.

81 Australian Christian Lobby, *Submission 204*, p. 5.

82 Mr Christopher Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard*, 30.10.08, p.2.

where babies are born alive after botched terminations could also attract Medicare funding is unthinkable.'[83]

3.58 Family Voice Australia concluded:

> It is hard to imagine the cruelty and inhumanity involved in intentionally delivering child prematurely and then simply abandoning it to die. Some of these babies may be able to be survive if given the kind of neonatal care given to other prematurely delivered infants.[84]

Impact on women's health and well-being

3.59 The committee was provided with evidence which argued that termination of pregnancy has an adverse impact on women's health and well-being both in the short and long-term. Dr Dianne Grocott, Consultant Psychiatrist, provided the committee with the following:

> I have mostly seen evidence of depression, drug abuse, relationship breakdown and suicide attempts following abortion. I understand the psychological stress of unexpected pregnancy but I am not convinced that our society's current answer produces the best outcome.[85]

3.60 Dr Grocott went on to comment that unexpected pregnancies 'can be managed in such a way as to have a good outcome if sufficient support and resources are available'. Dr Grocott concluded:

> The practice of using abortion as a solution to psychosocial distress or failure of the pregnant woman's support network to support her so she can raise her child is ethically and medically unjustified, if the long-term and psychological costs are not ignored. This increasingly common practice occurs in a society where this evidence is suppressed or ignored, and by practitioners who do not see the long-term consequences of their interventions.[86]

3.61 Dr Lachlan Dunjey of Medicine with Morality also provided similar comments that 'the mother who, in her distress, has come to see that terminating the life of her baby at this later stage of pregnancy is her only option'. However:

> Killing the baby should never be seen as a solution for misery, and certainly should not have inferred national approval. In any case, we would argue that any temporary alleviation of distress would be counteracted by a later, greater distress when the full realisation of what has taken place hits home.

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83 Mr Lyle Shelton, Australian Christian Lobby, *Committee Hansard*, 30.10.08, p.82.

84 Family Voice Australia, *Submission 176*, p.4.

85 Dr Dianne Grocott, *Submission 341*, p.1.

86 Dr Dianne Grocott, *Submission 341*, p.2.

> Doctors have always known this to be true because we see these women in our practices.[87]

3.62 Witnesses cited research that indicated that lasting damage to emotional health of women who have undergone a termination. A recent New Zealand study found that 42 per cent of women who had terminations had experienced major depression which was double the rate of women who had never become pregnant. The risk of anxiety disorders also doubled. Women who had terminations were twice as likely to drink alcohol at dangerous levels and three times as likely to be addicted to illegal drugs compared with those who carried their pregnancies to term.[88]

3.63 A paper published in the *European Journal of Public Health* reported a 13 year study of Finnish women which found that deaths from suicide, accidents and homicide were 248 per cent higher among women in the year following a termination, than for women who had not been pregnant in the prior year. The majority of deaths were due to suicide. The suicide rate among women who had terminations was six times higher than that of women who had given birth in the prior year and double that of women who had miscarriages.[89]

3.64 A study published in the British Medical Journal found that 77 per cent of women aborting a disabled baby experienced an acute grief reaction and 46 per cent were still symptomatic and requiring psychiatric support six months later.[90]

3.65 Dr Grocott provided the committee with a list of selected references which indicated the likelihood of psychological problems is greater following second and third trimester abortions, abortions for fetal abnormalities and in cases of risk of life of the mother. Dr Grocott also commented that research on pregnant rape and incest victims has shown that those women who gave birth, even if they had considered abortion at some stage, were glad of the outcome.[91]

The number of services

3.66 Ms Rita Joseph argued that disclosure of the reasons for the use of item 16525 must be made a condition of Medicare funding as the present arrangements for its use 'fails abysmally to set conditions for ensuring that referrals for termination and

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87 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard*, 29.10.08, p.46.

88 Family Voice Australia, *Submission 176*, p.8 citing *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 47 (1), Jan 2008, pp16–24; see also Life, Marriage and Family Centre, *Committee Hansard*, 30.10.08, p.10.

89 Family Voice Australia, *Submission 176*, p.8 citing Gissler, M, 'Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000', *European Journal of Public Health,* 15(5): 459-63 (2005)

90 Mr Christopher Meney, Life, Marriage and Family Centre, Archdiocese of Sydney, *Committee Hansard,* 30.10.08, p.3.

91 Dr Dianne Grocott, *Submission 341*, p.1.

subsequent abortions are legally valid, objectively necessary and proportional in that the lethal harm planned for her child is balanced by the necessity to avoid a proportionately serious harm to the mother'.[92] In addition, there is a lack of information from state and territory governments about the number of terminations. This is 'itself an indictment, and a powerful piece of evidence that increased scrutiny of the abortion of such large numbers of unborn children is both necessary, and indeed long overdue'.[93]

Effects of disallowing item 16525

Reduction in the number of terminations

3.67 Submitters acknowledged that the disallowance of item 16525 would only impact on terminations provided for private patients and would thus have a limited impact on the number of terminations. However, Mr Meney of the Life, Marriage and Family Centre stated that this 'would be a small but significant step towards' a positive outcome for both mothers and children through the reduction in the number of terminations.[94]

3.68 The World Federation of Doctors Who Respect Human Life stated that while there is only small subsidy for item 16525 and that disallowance will not deter most adults from obtaining a termination, 'the principle at sake is that Australian taxpayers would not be compelled to subsidise the cruel and unjustifiable "on demand" abortion of entirely health babies of entirely health mothers, some older than the infants in our hospital nurseries'.[95]

3.69 Mrs Joseph argued that there would be an immediate improvement in human rights protection for vulnerable children at risk of termination because of their disabilities.[96]

3.70 It was also argued that the disallowance of item 16525 would allow the funds to be diverted to support services and counselling for women.[97]

Increase in procedures being undertaken in the public sector

3.71 Submitters saw as a major benefit the move of late term termination services to be provided in the public sector. The Life, Marriage and Family Centre commented that:

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92 Mrs Rita Joseph, *Submission 20*, p.6.

93 Mrs Rita Joseph, *Submission 20*, p.6.

94 Mr Christopherh Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard*, 30.10.08, p.2.

95 World Federation of Doctors who Respect Human Life, *Submission 211*, p.2.

96 Mrs Rita Joseph, *Submission 20*, p.9.

97 Family Life International, *Submission 178*, p.3.

> Whilst moving these cases into the public hospital system does not guarantee these abortions will not occur, it is likely it will result in a reduction in abortions and more parents choosing to keep their babies. Giving parents more time and information that will help them to adjust to the news and to discover this great gift that is their child is always a positive step. Deep down, we know that if there is some small way we can reduce the number of children aborted in the second trimester we are obliged to try to do so. Every child whose life is ended by abortion represents a tragic and irreplaceable loss not only to their mother, father, siblings and grandparents but to the while community.[98]

3.72 It was also argued that greater scrutiny and accountability of healthcare practitioners engaged in second trimester terminations would occur in the public sector as there are established procedures for late term terminations to be approved by ethics committees. In cases of fetal abnormality beyond 20 weeks gestation, an ethics committee considers the request for termination and makes a decision on whether or not the anomaly is lethal or severely disabling.

3.73 Many submitters also pointed to the small number of terminations being undertaken for psychosocial reasons in the public sector as evidence of greater scrutiny and consideration of requests for late term terminations for this reason. The Life, Marriage and Family Centre, Catholic Archdiocese of Sydney commented:

> Moving second-trimester abortions into public hospitals will hopefully decrease the number of abortions performed for psychosocial reasons or because the unborn child has a disability, due to the likelihood of greater scrutiny and accountability of health care practitioners within the public hospital system.[99]

3.74 Dr David Knight argued that there was no evidence that the safeguards established in the public sector exist in the private sector.[100]

3.75 Other benefits would also arise from limiting procedures to the public sector. These relate to the health and welfare of the mother as the public sector could provide access to multidisciplinary teams skilled in counselling and support. Mothers and their families would also have access to specialist services such as genetic counselling. Medicine with Morality commented that many women undergoing antenatal testing do not really understand the full significance of antenatal testing. When confronted with a diagnosis of an abnormality they need to make a decision with properly informed consent.[101] In the public sector, mothers and their families would receive information

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98 Mr Christopher Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard*, 30.10.08, p.4.

99 Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Submission 193*, p.1; see also Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard* 30.10.08, p.2.

100 Dr David Knight, *Submission 215*, p.1.

101 Dr Lachlan Dunjey, Medicine with Morality, *Committee Hansard,* 29.10.08, p.62.

about positive treatment options and support available for children with conditions such as cleft palate, spina bifida and Down syndrome.[102]

3.76 Dr Knight commented that the procedures are usually undertaken in a tertiary referral maternity hospital in a specialised unit and the patient receives extensive counselling prior to the procedure and support is provided by a multidisciplinary team including an obstetrician, midwife and clinical psychologist. However, the Life, Marriage and Family Centre commented that was unlikely to occur in the private sector as the medical practitioner involved is only interested in providing the service requested: that is, a termination.[103]

3.77 The committee also received evidence of the greater safety provided to women in the public sectors as more facilities are on hand including intensive care and the option of medical terminations is available. Medical terminations are generally not available in the private sector as they are undertaken over a period of time and were therefore not amenable to the practices in the private sector. Dr Knight commented:

> If anyone is doing abortions beyond 20 weeks and not inducing labour as the method by which they are doing it then they are putting the women's lives very seriously at risk. They are certainly putting the women's lives at risk if they are doing them in a small clinic which does not have all the facilities of a major hospital.[104]

Termination for fetal abnormality

3.78 A number of submissions upheld the view that life begins at conception and that abortion at any stage of pregnancy is tantamount to deprivation of life of the unborn child.[105] The argument is summarised by the Australian Christian Lobby:

> Removing Medicare funding of second-trimester or late-term abortions would save the lives of many children who are capable of independent living outside the womb, and who deserve a fighting chance of life.[106]

3.79 The World Federation of Doctors Who Respect Life commented that there has been a process of 'desensitisation' and that process:

> …leads us to consider aborting disabled babies purely because of economic burden on society is that we have, effectively, negated the humanity of any unborn child by approving the unlimited abortion licence. If it is open to adults to end the life of their unborn child, throughout pregnancy, for no

102 Mr Christopher Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard,* 30.10.08, p.4.

103 Mr Christopher Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard,* 30.10.08, p.4.

104 Dr David Knight, *Committee Hansard*, 30.10.08, p.74.

105 Australian Christian Lobby, *Submission 204*, p3.

106 Australian Christian Lobby, *Submission 204*, pp3–4.

> reason—as is now the case in Victoria, up to 24 weeks, at least, and beyond that purely on the colluding nod of two abortion clinic doctors—then what does that say about the status of any baby in the womb, let alone a disabled one who is going to cost society money? That is part of the desensitising process that has brought us to a fairly brutal state.[107]

Role of Medicare

3.80 It was widely argued that taxpayers, through reimbursement by Medicare, should not pay for the 'deliberate destruction of human lives'.[108] Right to Life Australia stated that:

> Healthcare monies are meant to be used for just that purpose–to provide good healthcare for the community. Killing babies in the womb is hardly providing good healthcare and it is totally discriminatory when one considers that healthcare monies–both State and Federal–are rightly used to provide good healthcare for those babies in the womb considered wanted by their parents.[109]

3.81 The Australian Christian Lobby also commented that Medicare is funding terminations using a practice that is banned in the United States while dilation and evacuation method 'should offend the sensibilities of even the most hard-hearted'. The Australian Christian Lobby concluded that 'as lay people, we do not understand why these practices are allowed—let alone funded by us through our compulsory Medicare levy'.[110]

3.82 Other submitters noted that ending of public funding of late term terminations will not end its availability. It was argued that as the Medicare refund is $267 for procedures that cost from well over $1,000 to $4,000, its removal would not be a serious impediment to most women.[111] It would still be available, were permitted under state laws, but at a personal not public costs.

3.83 The Australian Christian Lobby concluded:

> The concern is that people have a conscientious objection to abortion being performed in the second trimester, given the brutality of that method and the obvious pain that that causes to the [fetus]. Some members of the community feel that for that to happen because of disability, for psychosocial reasons or for economic reasons is wrong and yet they are forced to pay for it—we have no choice. That really plays on the consciences of many of us who believe that children, regardless of their

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107 Dr David van Gend, World Federation of Doctors Who Respect Life, *Committee Hansard,* 29.10.08, p.62.

108 Right to Life Australia, *Submission 198*, p.1.

109 Right to Life Australia, *Submission 198*, p.2.

110 Mr Lyle Shelton, Australian Christian Lobby, *Committee Hansard*, 29.10.08, p.82.

111 Mr Lyle Shelton, Australian Christian Lobby, *Committee Hansard*, 29.10.08, p.95.

> able-bodiedness or otherwise, have every right to enjoy life and the things that we all enjoy. We know indeed in many cases they can do that, and we also know that there are instances where abortions are performed in the second trimester not for reasons of any abnormality at all but for cleft palates and even for economic reasons, as you have all heard at this hearing. That goes to the heart of our objections. If the parliament and the democratic processes say that we will continue to make these brutal practices legal and treat unborn babies in a way that is different to the way we treat animals, if that must be the case, please do not force us to pay for it.[112]

112 Mr Lyle Shelton, Australian Christian Lobby, *Committee Hansard*, 29.10.08, p.97.