The Senate

# Standing Committee on Finance and Public Administration

## Item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007

November 2008

ISBN 978-1-74229-010-2

Printed by the Senate Printing Unit, Parliament House, Canberra.

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# Preface

In conducting the inquiry and in the preparation of this report, the committee considered that its primary role was to gather information to inform Senators about item 16525. The report describes the scope of item 16525 and the data available on the use of this item. The report then provides a discussion of issues in relation to the disallowance of the item raised in evidence by those groups and individuals who supported the continued Medicare funding of the item and those who did not support continued funding or only in very limited circumstances.

The committee has not made any recommendations in relation to the disallowance of item 16525. However, it notes that concerns were expressed over the lack of data on terminations in Australia and the committee has made two recommendations aimed at improving the collection of perinatal and neonatal data.

# Recommendations

**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.**

**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.**

# Chapter 1

# Introduction

## Terms of reference

1.1 On 18 June 2008, a motion was moved in the Senate by Senator Guy Barnett to disallow item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007. On 16 September 2008, the Senate passed the following resolution:

> 1. That the subject of the motion for disallowance of item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007 be referred to the Finance and Public Administration Committee for inquiry and report on and not before 13 November 2008.
>
> 2. That the committee in particular report on:
>
> (a) the terms of item 16525 of part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007;
>
> (b) the number of services receiving payments under this item and the cost of these payments;
>
> (c) the basis upon which payments of benefits are made under this item; and
>
> (d) the effects of disallowing this item.

1.2 Following referral of the inquiry to the committee, the motion to disallow item 16525 was withdrawn by Senator Barnett on 17 September 2008.

## Conduct of the inquiry

1.3 The inquiry was advertised in *The Australian* and through the Internet. The committee invited submissions from the Commonwealth Government and interested organisations and individuals.

1.4 The committee received 484 public and 45 confidential submissions. A list of individuals and organisations that made public submissions to the inquiry together with other information authorised for publication is at Appendix 1. The committee held two days of hearings in Canberra on 29 and 30 October 2008. Appendix 2 lists the names and organisations of those who appeared. Submissions and the Hansard transcript of evidence may be accessed through the committee's website at http://www.aph.gov.au/senate/committee/fapa_ctte/index.htm.

## Use of terms in evidence

1.5 During the inquiry, the committee found that the terms 'abortion', 'termination' and 'late term termination' were used in different contexts and had different meanings for some witnesses. The Department of Health and Ageing in its submission used both the terms 'abortion' and 'termination': it stated that services under item 16525 'relate to both spontaneous abortion (miscarriage) and medical or induced abortion (termination)'.[1] Some witnesses also used both the terms 'abortion' and 'termination' to refer to the cessation of a pregnancy as a result of either a spontaneous event or an induced event. However, the committee is mindful that many in the community use the term 'abortion', as some witnesses did, only in relation to an induced event.

1.6 In this report, the terms have been used interchangeably without any implied meaning as to whether an induced or spontaneous event has occurred.

1.7 Item 16525 is used for procedures during the second trimester of pregnancy. The second trimester is generally considered to range from 13 to 26 weeks gestation.[2] In evidence, many witnesses used the term 'late term termination' which the committee notes is generally understood to apply to terminations after 20 weeks gestation.

1.8 The committee notes that a significant preponderance of evidence supporting disallowance related to terminations occurring in the latter half of the second trimester. While it is not possible to ascertain the exact numbers of procedures claimed under this item number that occur before or after 20 weeks gestation, the committee also notes that the evidence indicates that the majority of such claims occur before the 20 week mark, this is, in the first half of the second trimester.

## Acknowledgment

1.9 The committee thanks those organisations and individuals who made submissions and gave evidence at the public hearing.

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

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

# 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]

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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)

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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

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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

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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]

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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:

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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

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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]

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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

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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

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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,

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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

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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).

# 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

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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

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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

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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.

# Chapter 4

# Effects of disallowance of item 16525: evidence in support of continued funding

4.1 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 continued funding.

4.2 Submitters in favour of continued funding under item 16525 stated that services performed under the item were clinically relevant and lawful.[1] Many such witnesses maintained that disallowance of the item would have serious negative health and financial repercussions whilst limiting the accessibility and affordability of publicly funded health services for the 'small proportion of women faced with a difficult and distressing circumstance'.[2]

## Services provided under item 16525 in Part 3 of the Schedule

4.3 Services provided under item 16525 relate to both spontaneous abortion (miscarriage) and medical or induced abortion (termination).[3] The National Association of Specialist Obstetricians and Gynaecologists noted that item 16525 would apply to women who 'are spontaneously miscarrying or are in spontaneous premature labour associated with the relevant clinical conditions'.[4]

4.4 The Australian Medical Association (AMA) stated that item 16525 provides a rebate for the 'surgical treatment of non-viable pregnancies' which may be required in a broad range of circumstances. According to the AMA, in all situations for which item 16525 procedures apply, 'the women have lost, or are losing their baby'.[5]

4.5 Dr Sally Cockburn elaborated on the circumstances of the termination services provided under item 16525:

> Labour can be medically induced for various reasons. In the circumstances under MBS item 16525 this would either be to evacuate the uterus in the situation where the foetus has died or where the uterus is intentionally

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1 Rural Doctors Association of Australia, *Submission 426*; Dr Sally Cockburn, *Submission 189*; National Foundation for Australian Women, *Submission 188*; Health Services Commissioner, Victoria, *Submission 205*; RANZCOG, *Submission 523*, p.1.

2 Family Planning Queensland, *Submission 201*, p.2. See also, The Royal Women's Hospital, *Submission 196,* 1; The Royal Australasian College of Physicians, *Submission 217*, p.1; Health Services Commissioner, Victoria, *Submission 205*, pp3–4.

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

4 The National Association of Specialist Obstetricians and Gynaecologists, *Submission 427*, p.3.

5 Australian Medical Association, *Submission 191*, p.1.

> evacuated for reasons of a maternal health crisis or a serious abnormality has been diagnosed in foetal development and the women has requested termination of her pregnancy, obviously in situations permitted under the particular State law.[6]

4.6 The Royal Australasian College of Physicians maintained that second trimester termination was an essential part of antenatal services:

> While in our experience second trimester termination is always a difficult decision, and never undertaken lightly, it is still a service that is essential to the range of antenatal services available to women in order to protect their safety and health.[7]

### *Intrauterine fetal death*

4.7 According to Family Planning NSW in cases where the fetus has died in utero, the pregnancy does not always spontaneously abort and it may be necessary to induce the termination of such a pregnancy.[8] This position is supported by other witnesses before the committee including Dr Cockburn who stated of item 16525:

> This service has been on the MBS for over 30 years. Clinically speaking, the procedures covered by it are essential to the wellbeing of Australian women. Following diagnosis of a foetal death in utero it is necessary to induce labour to end the pregnancy and remove the contents of the uterus because natural labour may not occur and there is a real risk of a serious haemorragic disorder occurring if the dead foetus remains in her uterus. Death of a woman can result. Induction of labour for this purpose is considered a safe procedure even after 24 weeks.[9]

4.8 Associate Professor Lachlan de Crespigny and Dr Susie Allanson maintained that untreated intrauterine fetal death risks complications including infection and clotting disorders which can potentially cause serious risk to the health and even the life of the pregnant women involved.[10] Similarly, Dr Cockburn stated that delaying the evaluation of the gravid uterus following fetal death in utero 'increases the risk of maternal bleeding disorders' which can be 'fatal'.[11]

### *Gross fetal abnormality*

4.9 Dr Peter Rischbieth from the Rural Doctors Association of Australia described gross fetal abnormality as a 'situation where there is an abnormality which will be incompatible with a long life':

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6 Dr Sally Cockburn, *Submission 189*, p.6.

7 Royal Australasian College of Physicians, *Submission 217*, p.1.

8 Family Planning NSW, *Submission 182*, p.3.

9 Dr Sally Cockburn, *Submission 189*, pp12–13.

10 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.3.

11 Dr Sally Cockburn, *Submission 189*, p.16.

> They may mean major heart, brain, kidney, stomach and digestive tract organ dysfunction which may be diagnosable using ultrasound techniques during pregnancy. Or significant genetic abnormalities that can be discovered on amniocentesis.[12]

4.10 Professor David Ellwood commented:

> Gross refers to the degree. One of my roles at the Canberra Hospital is chair of the Clinical Ethics Committee. I can say to you with all honesty that virtually all cases of late termination of pregnancy are either for conditions which are incompatible with extra-uterine life or where the foetal condition would be associated with very severe disability after birth.[13]

4.11 A number of submissions highlighted that the nature of fetal abnormalities, screening and diagnostic testing meant that cases of gross fetal abnormality were often not able to be diagnosed until the second trimester.[14] This was explained by Associate Professor de Crespigny and Dr Allanson:

> Reliable screening does not occur in early pregnancy but occurs at late gestation, may require repeat tests and may involve the woman and her family taking time to make a decision.[15]

4.12 SHine SA elaborated further:

> Amniocentesis, which is an invasive diagnostic test, is generally carried out at 15 – 18 weeks gestation and sometimes later. Receiving accurate results from this test generally requires two weeks. Sometimes amniocentesis needs to be repeated if the original sample was inadequate. This leaves women well into the second trimester of pregnancy contemplating a termination of the pregnancy for foetal abnormality, which is a difficult and sad decision to have to make. Women require access to safe services in this situation, whether they are public or private obstetric patients.[16]

4.13 Any delay in diagnosis of fetal abnormality will result in a delay in accessing termination services. Of diagnostic testing, Family Planning NSW stated:

> Women with a family history of genetic abnormality and older women are usually offered the opportunity for testing for chromosomal abnormalities during pregnancy, so that a decision can be made by the couple whether to continue the pregnancy in order to have a healthy baby. In some cases, unexpected sporadic abnormalities come to light on routine antenatal testing during the pregnancy. Of necessity, many of these diagnoses can

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12 Dr Peter Rischbieth, Rural Doctors Association of Australia, *Committee Hansard*, 30.10.08, p.20.

13 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.104.

14 The Royal Women's Hospital, *Submission 196*, p. 2; Dr Sally Cockburn, *Submission 189*, p.13; Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

15 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

16 SHine SA, *Submission 92*, p.3.

> only be made after the first trimester. While some may argue that there is never a reason to terminate a pregnancy, no matter how severe the abnormality, the Australian health care model aims to place the pregnant couple in the best possible position to have a positive outcome for their pregnancy. Careful and considered counselling, correct diagnosis and decision-making takes time. Many diagnoses will not be possible until well into or at the end of the second trimester, making a termination later than 14 weeks the only option for these couples.[17]

4.14 Dr Christine Tippett from RANZCOG also commented that currently in Australia 80 to 90 per cent of women have a mid-trimester ultrasound scan which is funded by Medicare. If an abnormality is detected there is an expectation that 'they will have a choice to terminate the pregnancy or not to continue the pregnancy'. Dr Tippett went on to state:

> Over 85 per cent of women have Down syndrome screening. This is provided and supported by federal and state government funding on the understanding those women may choose to terminate a pregnancy afterwards. On the one hand we are providing women with access to diagnostic imaging and to different diagnostic tests on the expectation that they will have a choice whether or not to continue a pregnancy.
>
> It seems to me to be somewhat contrary to then say, 'We have picked up an abnormality. You have decided that for you and for your family this is a major abnormality that will adversely impact on your child and your child's life and you have decided to terminate the pregnancy. Sorry but we do not think that is right. We have decided that these abnormalities are okay and these are not—so we will fund some and not the others.' I do not think that is very logical.[18]

4.15 Dr Cockburn noted that in some instances of gross fetal abnormality or where a woman's life is threatened by a medical condition if the pregnancy at a gestation below 22 weeks continues, women may request to have their pregnancy terminated but not for an abortion per se. Dr Cockburn explained that this is a 'plea from distressed parents that they may hold their hopelessly premature or abnormal baby before it dies'.[19]

4.16 The Atheist Foundation of Australia took the view that:

> Political assessment of what constitutes severe foetal abnormality is inappropriate. The pregnant female is in the best position to decide, on advice from the medical profession, whether or not to continue with the pregnancy.[20]

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17 Family Planning NSW, *Submission 182*, pp2–3.

18 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.83

19 According to Dr Cockburn, those born at 22 weeks or earlier have no chance of survival. Dr Sally Cockburn, *Submission 189*, pp6–7.

20 Atheist Foundation of Australia Inc, *Submission 183*, p.2.

### *Life threatening maternal disease*

4.17 The Department of Health and Ageing noted in its submission that examples of life threatening maternal conditions that pregnant women may experience include premature rupture of the membranes with infection, severe antepartum haemorrhage, severe pre-eclampsia, pulmonary hypertension and cyanotic heart disease.[21]

4.18 In relation to item 16525 services provided under this category, Dr Cockburn stated:

> It is even more difficult to dispute the clinical relevance of the need to have an MBS item number covering the situation where a woman requires termination of her pregnancy to save her in a serious medical crisis.[22]

*Psychosocial indications*

4.19 Contrary to the view that 'psychosocial indications' (PS) are commonly utilised as the basis on which medical terminations of pregnancy are carried out under item 16525, a number of submitters held that termination services provided under the item number are carried out primarily for reasons other than psychosocial. President of the Women's Hospitals Australasia, Professor David Ellwood, stated before the committee:

> Many women find themselves making a very difficult choice about termination of pregnancy in the second trimester, for reasons that are beyond their control—primarily to do with the inability to diagnose many serious foetal conditions or, indeed, many serious maternal illnesses until well into the second trimester.[23]

4.20 Professor Ellwood went on to state that 'it is extremely uncommon for there to be a request for termination of pregnancy beyond 20 weeks outside of this qualifier—foetal death, gross foetal abnormality or life-threatening maternal disease'. Furthermore 'about the only circumstance in which second trimester induction of labour is carried out because of life-threatening maternal disease is where it is truly life-threatening'. Professor Ellwood concluded:

> I do not think changing the wording would change practice at all because clinical practice around that qualifier really is limited to life-threatening maternal disease.[24]

4.21 Dr Andrew Pesce from the National Association of Specialist Obstetricians and Gynaecologists, stated in evidence:

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

22 Dr Sally Cockburn, *Submission 189*, p.13.

23 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.100.

24 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.105.

> The vast majority of requests for termination of pregnancy at this later stage of pregnancy occur for two reasons. Firstly, there might be an antenatal diagnosis of a significant foetal abnormality. There is increasing use of nuchal translucency and serum screening for Down syndrome, which when offered to women is very, very highly taken up. Probably about 95 per cent of women who are offered it will take the opportunity. Secondly, at the 18- to 20-week ultrasound scan when a woman goes to see how the baby is developing, there may be diagnosis of a major congenital heart problem or a major renal problem—something which sometimes is incompatible with life and sometimes could be compatible with life but with major disability and multiple surgeries. Women agonise about these decisions. They have to think about the children they have and what they are going to be going through and about the multiple surgeries which are required to correct congenital heart problems. I just cannot fathom how people can say that this is just some disorganised bimbo who has decided she is going to have a termination at 20 weeks. I am sure it happens, but the vast majority of the time that is not the case.[25]

4.22 Similarly, Dr Peter Rischbieth of the Rural Doctors Association of Australia held that:

> My understanding is that the decision to go ahead to have a termination is made if the continuation of the pregnancy may cause significant harm to either the foetus or the maternal health. There would be very few areas where the psychosocial aspects would be a key reason for a termination to be sought.[26]

4.23 Furthermore, the National Association of Specialist Obstetricians and Gynaecologists noted in its submission that there are 'no reliable data to determine the extent to which termination of pregnancy for PS indications contributes to the utilisation of 16525'.[27] The Family Planning Association of Western Australia stated in relation to such claims:

> Contrary to the view Senator Barnett made in his speech to the Senate on 24 June 2008, where he stated, "Late abortions are being done for 'maternal psychosocial reasons', which in reality means abortion on request", our experience is that women have to traverse, at times several legal and medical hurdles before they can have an abortion. The phrase 'abortion on request' negates the process a woman goes through when deciding her options and is an emotive phrase used by the anti-choice movement. There is a plethora of evidence that reports women take seriously their decision whether to continue with or terminate their pregnancy. Likewise there is strong evidence that where a woman has access to legal and safe abortion

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25 Dr Andrew Pesce, National Association of Specialist Obstetricians and Gynaecologists, *Committee Hansard*, 29.10.08, p.102.

26 Dr Peter Rischbieth, Rural Doctors Association of Australia, *Committee Hansard*, 30 October 2008, p.17.

27 National Association of Specialist Obstetricians and Gynaecologists, *Submission 427*, p.3.

> and makes her decision voluntarily, there is less immediate or long lasting psychological impact.[28]

4.24 Quoting 2006 data, Ms Letitia Nixon, Manager of SHine SA noted that of post 20 week gestation terminations in South Australia for example:

> There is a very small number—0.7 per cent—that might have been done for psychosocial reasons; primarily it is for maternal health conditions, foetal abnormalities or foetal conditions that are incompatible with life.[29]

4.25 It was also noted that in relation to Victoria, where the number of terminations for psychosocial indications are highest, there were 150 terminations of pregnancy of 20 to 27 weeks gestation for 'maternal psychosocial indications' undertaken in 2006. Of the 150, 90 such procedures (or 60 per cent) were carried out for interstate and overseas residents.[30] Associate Professor Lachlan de Crespigny informed the committee of the Victorian context:

> Data is available from 20 weeks, and that shows that almost three-quarters of the post-20 week terminations on Victorian women are for the diagnosis of foetal abnormality and something a little above a quarter for psychosocial reasons. They are classified as either one or the other. It is a simple classification. The situation is that terminations later in pregnancy, variously defined, are available in a very limited way across the country. So, even when termination is lawful, access can be extremely poor in many parts of the country and many parts of the state as well such that there is a group of women from around the country and even overseas who seek services in Victoria. So I think the Victorian and the non-Victorian figures need to be pulled apart to get any reasonable assessment of that. So, yes, there are psychosocial terminations done post 20 weeks, but it is the minority when one considers Victorian women.[31]

4.26 In relation to the seriousness of conditions under which the classification 'psychosocial' applies under item 16525 of the MBS, Dr Sally Cockburn stated:

> The word 'psychosocial' can be many things but in order to make a claim under this item number the psychosocial condition would have to be life-threatening for the mother.
>
> If you ask, 'What psychosocial conditions could be life-threatening?' some examples could be suicide, homicide—although you would hope you would be able to take her out of that sort of situation—or maybe a severe psychiatric condition that required medication that could be harmful to the foetus. But I think the term 'psychosocial' has been, if I may say so, bandied about as if it might be that I would like to buy a new pair of shoes to wear

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28 Family Planning Association of Western Australia, *Submission 194*, p.1.

29 Ms Letitia Nixon, SHine SA, *Committee Hansard*, 29.10.08, p.36.

30 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Annual Report for the Year 2006*, p.13.

31 Associate Professor Lachlan de Crespigny, *Committee Hansard*, 30.10.08, p.24.

> to the Cup. I have to say that in my experience in medicine I have never met a woman or seen a woman who would ever decide to terminate her pregnancy for a reason of a trivial nature. I would really like to put that on the record, because these are real people we are talking about, people who are probably watching us right now, and I think that they would be insulted to think that we are saying that maybe they will do it because they do not fit into their dress for the Cup.[32]

*Clinically relevant*

4.27 A number of witnesses before the committee maintained that services carried out under the item number were 'clinically relevant'. When questioned about the rigour applied to ensure that such services are 'clinically relevant', Mr Colin Bridge of Medicare Australia informed the committee:

> There is a process involving a separate agency, which is the Professional Services Review. Should, in the course of our examination of any medical Medicare item, we develop concerns about that particular issue, our role is to refer it to the Professional Services Review. The Professional Services Review is an agency within the department of health which has a range of powers to undertake investigation of that particular point, including, potentially, peer review.[33]

4.28 Mr Bridge further clarified, that from Medicare Australia's records, 'we have not been able to find any cases of that sort being referred from us or issues we have raised over the last 10 years'.[34]

***Termination methods***

4.29 Professor David Ellwood commented on termination methods and stated that from his knowledge of practices in the tertiary women's hospitals country, the only method used is one that induces labour. Professor Ellwood went on to note that 'I think the reference to partial birth abortions would be restricted to the private sector and, as far as I am aware, it is restricted to one clinic'.[35]

4.30 Dr Christine Tippett also commented on termination methods:

> I think there is a great deal of misunderstanding, too, about how pregnancy terminations and late pregnancy terminations are undertaken. There has been comment made and pictures shown—once again referring to Victoria—of procedures that I, in 30 years of practice, have never heard of

32 Dr Sally Cockburn, *Committee Hansard*, 30 October 2008, pp59–60.

33 Mr Colin Bridge, Medicare Australia, *Committee Hansard*, 29.10.08, p.22.

34 Mr Colin Bridge, Medicare Australia, *Committee Hansard*, 29.10.08, p.23.

35 Professor David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.104

> being done. I had to inquire as to what they were because I was unfamiliar with them. I have worked for a long time in the public system.[36]

4.31 In relation to practices in private clinics, Dr Tippett commented on one clinic in Victoria where a significant number of late terminations are undertaken and stated:

> That is the most regulated medical clinic in Victoria. There have been case reviews, and it has been looked at very carefully. I have a very good working knowledge of how that clinic works and I think it does provide a service for women. It does mean those women are not in the public system, and I think it provides a very valuable service.[37]

4.32 Dr Tippett also commented on the term 'left to die' and stated:

> I think it is a very unfortunate term, and I feel some disquiet that it has been used so generally here. If a pregnancy is terminated and the baby has the capacity to be born alive, and that can happen any time after 14 or 15 weeks, those babies will die if they are not given supportive care. As you get closer to 24 weeks they will take longer to die than if the pregnancy is terminated sooner.
>
> Those babies will die from hypoxia because they cannot breathe, they cannot get oxygen to their brain and although we think there is no difference in the way foetuses or babies of this gestation experience pain, in fact those babies are hypoxic just like an adult who becomes hypoxic and effectively unconscious and unaware of what is going on around them. I think one can be confident that these babies do not suffer.
>
> Secondly, where those babies are cared for will depend on the parents. Usually we tell parents that the baby may be born alive and if the parents say they do not want that to happen, the baby will be given an injection prior to or during the termination so that the baby is not born alive.[38]

4.33 Professor Ellwood made some comments concerning fetal pain:

> I am familiar with a lot of the scientific literature on foetal pain and I am aware that there is a lot of controversy around the gestational age at which the foetus is able to experience pain. I am not sure that the science has yet progressed to the point where you can answer the question honestly and say at a certain gestational age the foetus is able to feel pain and below it the foetus cannot.[39]

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36 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.84.

37 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.86.

38 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.87.

39 Professor David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.109.

## The effects of disallowing item 16525

### *Discriminatory to women*

4.34 A number of submissions including the Rural Doctors Association of Australia considered the potential disallowance of item 16525 as discriminatory to women particularly of low socio-economic backgrounds, Indigenous women and women living in rural and remote areas.[40] The Australian Reproductive Health Alliance (ARHA) and Royal Women's Hospital argued that disallowance would amount to an erosion of access to adequate health care for women.[41] Others including the Health Services Commissioner, Victoria and Dr Cockburn held that withdrawing the item could in fact increase maternal morbidity and mortality for those reasons.[42]

4.35 The ARHA highlighted that procedures undertaken under item 16525 include not only termination of pregnancy, but also procedures undertaken in the event of spontaneous miscarriage or premature labour. According to the ARHA, removing funding from this item would therefore remove funding from 'a series of legal and required medical procedures, denying women in this situation the access to funded healthcare afforded to other members of Australian society'.[43] This view was supported by Associate Professor de Crespigny and Dr Allanson who maintained that a disallowance will result in 'financial hardship, delay in service, or denial of appropriate medical care for some women suffering miscarriages or requiring other procedures for which this item is currently used'.[44]

4.36 The ARHA stated that removing the item has the potential to violate the human rights of women of reproductive age given that it would be 'tantamount to the government deciding who may give birth and who may not'.[45] This view was supported by the Parliamentary Group on Population and Development.[46] According to the ARHA, such a course of action would effectively result in one category of pregnant women denied government health and payment programs that are offered to

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40 Rural Doctors Association of Australia, *Submission 426*, p. 1. See also RANZCOG, *Submission 523*, p.2 and National Union of Students, *Submission 210*, p.1.

41 Australian Reproductive Health Alliance, *Submission 199*; Royal Women's Hospital, *Submission 196*. See also, Health Services Commissioner, Victoria, *Submission 205*; Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*; National Union of Students Women's Department, *Submission 210*.

42 Health Services Commissioner, Victoria, *Submission 205*, p.4; Dr Sally Cockburn, *Submission 189*, p.16. See also, Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.3.

43 Australian Reproductive Health Alliance, *Submission 199*, p.10.

44 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.4.

45 Australian Reproductive Health Alliance, *Submission 199*, p.12.

46 Parliamentary Group on Population and Development, *Submission 436*, p.4.

other pregnant women.[47] The Family Planning Association of Western Australia held that:

> The United Nations Committee on the Elimination of all forms of Discrimination Against Women (CEDAW), recognizes women's rights and equal citizenship. Underlying this is the right of the woman to choose what is best for her, situating her as a mature and responsible person with the capabilities of self determination. The withdrawal of the Medicare rebate will undoubtedly create financial hardship for many women, and a decision by the committee that would make access to a safe and legal abortion more expensive would discriminate against women already economically disadvantaged.[48]

4.37 Associate Professor Lachlan de Crespigny and Dr Susie Allanson argued that rights upheld by human rights conventions to which Australia is a signatory include that of reproductive health:

> Australia is signatory to various United Nations human rights conventions respecting the right of men and women to self-determination, to plan their families and control their fertility including the right to bodily integrity (UN 1966), health, reproductive health, family planning and deciding the number and planning of children (UN 1979; UN Population Fund, 1994).[49]

4.38 Dr Christine Tippett commented on the rights of an unborn child:

> …I think the proposal to put in place legislation for the rights of the unborn child is extremely difficult. The main reason for that is that in many ways then puts the woman in a very difficult situation. There are some countries that are looking at this—and I know that Canada has some proposal on the table. The college in Canada are strongly opposing it, and we would strongly oppose it also. Basically it means that the mother loses her autonomy. So people outside the mother are telling that mother what she should do with her pregnancy.
>
> …The foetus is not autonomous until it is born. The thought of bringing that in without a huge amount of consideration from the point of view of a women's rights issue is extremely problematic. Does that mean that the foetus that comes out whose growth is restricted because of hypertension can sue the mother when it is 30 because she smoked? The implications of such a thing are enormous. There is much written about this but I would not like to see the discussion go down that pathway.[50]

4.39 Dr Tippett concluded:

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47 Australian Reproductive Health Alliance, *Submission 199*, p.12.

48 Family Planning Association of Western Australia, *Submission 194*, p.2.

49 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.2.

50 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, pp88–89.

> It is extremely concerning when the mother's wishes are overridden by a court of law. How do you then quantify when the baby's rights are greater than the mother's? Who decides that?[51]

*Women's physical and mental health*

4.40 A number of submissions including that of YMCA Australia maintained that disallowance of item 16525 would have serious implications for women's mental and physical health.[52] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) argued that disallowance of the item would result in poor psychological and physical health outcomes resulting from the increased stress on women, which in turn will 'add to the burden on other health services'.[53] Family Planning NSW (FPNSW) noted that such a disallowance would increase maternal and infant morbidity and mortality rates:

> FPNSW holds the strong position that disallowance of Item 16525 would cause unnecessary and severe hardship for people at an extremely vulnerable and stressful time in their lives and would increase levels of poverty in Australia through increases in maternal and infant morbidity and mortality. This is contrary [to] the achievement of the Millennium Development Goals (MDGs), to which Australia is a signatory.[54]

4.41 Dr Cockburn elaborated on the potential impact of a disallowance on maternal mortality rates:

> Removing the Medicare rebate could, in the short term at least, lead to overburdening of the public system, and delays in treatment. Delaying the evacuation of the gravid uterus following foetal death in utero increases the risk of maternal bleeding disorders. These can be fatal.[55]

4.42 Similarly, the Royal Australasian College of Physicians argued that disallowance of the item may result in both physical and mental risk to the women in question including 'risk to the woman's life and health because of a medical complication, or to her long term mental and physical health as a result of the pregnancy complication for which she has decided to have the termination'.[56]

4.43 Dr Cockburn maintained that whilst disallowance of the item would ensure that these procedures are transferred to the public sector:

> …the message to the Australian people is that Federal Parliamentarians believe that a woman should be forced, against her will, to carry a grossly

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51 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.89.

52 YWCA Australia, *Submission 180*, p.1.

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

54 Family Planning NSW, *Submission 182*, p.1.

55 Dr Sally Cockburn, *Submission 189*, p.16.

56 Royal Australasian College of Physicians, *Submission 217*, p.1.

> abnormal foetus to term knowing for months on end that she is carrying a foetus that has little chance of the life they had hoped for it. It could be that foetus has abnormalities that are incompatible with life outside the uterus or may die shortly after birth.[57]

4.44 The ARHA also argued that the removal of the item may increase the number of foetuses with severe and/or life threatening abnormalities being carried to term. According to the ARHA, an American Psychological Association review of 20 years of evidence found that women who experience miscarriage, stillbirth, death of a new born or termination of a wanted pregnancy due to fetal abnormality have equivalent negative psychological reactions but that these 'are less than [for] women who deliver a child with a life-threatening abnormality'.[58] Thus, according to the ARHA, removal of item 16525 'looks set to *increase* the likelihood of mental health issues in women who are pregnant.'[59]

*Accessibility and affordability of appropriate medical services*

4.45 A number of submissions held the view that disallowance of item 16525 would disadvantage women who attend as a private patient in a public or private hospital, or private practice.[60] As one case in point, the Women's Hospitals Australasia maintained that abortion after the first trimester is 'an essential component of women's health care' and removal of item 16525 would discriminate against women 'because it undermines access to affordable, accessible health care'.[61]

4.46 The Royal Women's Hospital held that:

> Should item 16525 be disallowed, it would reduce the options for care for those women needing this service. A woman who has booked for private antenatal care may need to transfer away from a known and preferred provider, in this already distressing situation, if the care she needs is not covered by Medicare benefits.[62]

4.47 Similarly, the Health Services Commissioner, Victoria argued that removal of the item would place restrictions on the ability of women to have the procedure carried out in a hospital of their choice by a doctor of their choice:

> We need to make sure women who require these services have the option of having the procedure done with the doctor of their own choice locally

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57 Dr Sally Cockburn, *Submission 189*, p.17.

58 Australian Reproductive Health Alliance, *Submission 199*, p.11.

59 Australian Reproductive Health Alliance, *Submission 199*, p.11.

60 SHine SA, *Submission 92*; Family Planning Queensland, *Submission 201*; Dr Sally Cockburn, *Submission 189*; Women's Hospitals Australasia, *Submission 209;* Family Planning NSW, *Submission 182*, p. 3; Health Services Commissioner, Victoria, *Submission 205*, p.3.

61 Women's Hospitals Australasia, *Submission 209*, p. 1.

62 The Royal Women's Hospital, *Submission 196*, p.2.

> where family and support systems are available. The removal of this service from Medicare benefits could cause many to have to travel long distances on a very lonely and stressful journey. There is an emotional aspect to these services which must be taken into account.[63]

4.48 Moreover, Dr Cockburn stated:

> Aside from the obvious clinical benefits like saving women's lives, this item number provides services that improve health outcomes for women by allowing them the option of timely access to safe induction of second trimester labour in private hospitals with doctors of their own choice. In doing so it would reduce the stress in an otherwise difficult time for families.[64]

4.49 The Rural Doctors Association of Australia maintained that withdrawal of item 16525 would impact upon 'those private hospitals that use the number to cover induction for fetal death in utero even though they do not support genetic pregnancy terminations'.[65]

4.50 According to the ARHA, anecdotal evidence suggests that there has been a decline in the availability of termination services of public hospitals and that removing the financial support currently made available to private medical providers will 'place further pressure on the dwindling public services available'.[66] Citing evidence from the Victorian Law Commission which established that approximately two-thirds of abortions in Victoria are provided in private clinics, the Women's Hospitals Australasia argued that disallowance of the item would shift demand from the private sector to state funded services requiring increased resources for the state and territory systems.[67]

4.51 The view that removal of the item from the Schedule would place an additional strain on state public hospitals which would then require more resources was held by the Rural Doctors Association of Australia, Health Services Commissioner, Victoria, and Royal Women's Hospital.[68] As one case in point, Dr Cockburn maintained that removal of item 16525 would not significantly reduce Medicare's financial burden given that it amounts to a relatively small portion of its business, but would instead constitute a cost-shifting exercise to the states.[69]

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63 Health Services Commissioner, Victoria, *Submission 205*, pp3–4.

64 Dr Sally Cockburn, *Submission 189*, p.14.

65 Rural Doctors Association of Australia, *Submission 426*, p.2.

66 Australian Reproductive Health Alliance, *Submission 199*, p.11.

67 Women's Hospitals Australasia, *Submission 209*, p.3.

68 Rural Doctors Association of Australia, *Submission 426*, p.2; The Royal Women's Hospital, *Submission 196*, p.2; Health Services Commissioner, Victoria, *Submission 205*, p.4.

69 Dr Sally Cockburn, *Submission 189*, p.15.

4.52 Greater demand on termination services in public hospitals and increased waiting time for women seeking to access such services has the potential to increase the number of second trimester terminations according to the AHRA, 'as women are forced to wait longer because of their economic inability to access private termination services'.[70] Similarly, Catholic Health Australia held that disallowance of the item would reduce the scope of private providers (usually clinics) to provide such services and likely lead to greater demand for such services in public hospitals, 'resulting in an adverse impact on acute care facilities, without reducing the demand on the incidence of abortion in Australia'.[71]

4.53 SHine SA argued that disallowance of the item will 'punish pregnant women accessing care outside of the public hospital system and delay their access to services' whilst placing 'unnecessary pressure on public hospitals at a time when there services are under heavy demand'.[72] This view was supported by RANZOG which maintained that:

> Women are likely to experience delays in negotiating the system while seeking public hospital services they require at a time when they are distressed and vulnerable.[73]

4.54 Dr Cockburn held that:

> If this item number ceased to exist the procedures would move across to the already overstretched public hospitals and most likely extra funding would be sought by State and Territory Health Ministers through the public arm of Medicare and the State Health Service Agreements. Indeed the Commonwealth may end up paying even more when the States put in the bill for the true cost of these complex procedures in their public hospitals.[74]

4.55 This view was also supported by Family Planning Queensland who questioned the equity of such changes for women experiencing financial difficulty and those in regional and remote settings.[75]

*Continuity of care*

4.56 The issue of continuity of care for women undergoing second trimester services under item 16525 was raised in evidence. Professor Ellwood of the Women's Hospitals Australasia stated before the committee:

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70 Australian Reproductive Health Alliance, *Submission 199*, p.11.

71 Catholic Health Australia, *Submission 190*, p.3.

72 SHine SA, *Submission 92*, p. 3. SHine SA is the acronym for Sexual Health information networking and education South Australia.

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

74 Dr Sally Cockburn, *Submission 189*, p.15.

75 Family Planning Queensland, *Submission 201*, p.1.

> The use of this item number allows continuity of care by private providers working within the public system. Many women access tertiary services in prenatal diagnosis and in late termination of pregnancy through the public sector. Enabling continuity of care for private providers is an important part of services to women. For that reason, we believe that the removal of this item number would be discriminatory.[76]

*Women in rural and regional areas*

4.57 The disallowance of item 16525 was recognised as an added disadvantage to women in rural and regional areas who are already faced with existing inequalities in access to health services. The Rural Doctors Association of Australia explained:

> Rural women's ability to access this procedure is already constrained by distance, continuing rural hospital downgrades and closures that limit reproductive health interventions and shortages of appropriately credentialed medical practitioners. Nor do they have the same access to services like preconception counselling and sophisticated diagnostic testing as women who live in or close to a major city. Yet the acknowledged lower health and socio-economic status of rural populations suggests that they are particularly vulnerable to financial pressures which limit their access to essential health services even further.[77]

4.58 Of the situation for women in rural and remote areas, Dr Cockburn stated:

> What about a scenario where the only close hospital is a private facility and the nearest public hospital is a long distance away? By disallowing or restricting this item number it could mean that a woman who would have otherwise had the procedure with a doctor of her choice in a local facility close to her family and support systems, may now need to travel great distances to have the procedure in a public facility far from her loved ones by a doctor she doesn't know. The cost in financial terms of travel and time off work is one thing, but the human cost associated with the emotional fall out of such a situation could be enormous.[78]

4.59 Similarly, Associate Professor de Crespigny and Dr Allanson maintained that removal of item 16525 would be discriminatory to poor and rural women:

> Access to prenatal testing and termination of pregnancy should not depend on her personal resources or where a woman happens to live. Rural women already face much higher costs because of needing to fund travel and accommodation. A woman might feel forced to take on the emotional, physical and financial costs of continuing with an unwanted pregnancy and

76 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.100.

77 Rural Doctors Association of Australia, *Submission 426*, p.2.

78 Dr Sally Cockburn, *Submission 189*, p.16.

> rearing a disabled child because she wants, but could not fund, pregnancy termination.[79]

4.60 The Rural Doctors Association of Australia further noted that whilst women would still be able to access item 16525 procedures without charge in their local public hospital if the item were disallowed, in jurisdictions such as Western Australia, where regional funding is managed differently, women would have no other option but to travel to Perth:

> This means many rural women will face economic hardship on top of the costs of their travelling to another centre for the procedure and their separation from their families and local health care providers at a very difficult time. Some many have to delay their journey, prolonging the distress of their situation.[80]

*Resort to methods outside the medically regulated system*

4.61 The question of whether the inability to access safe, timely and affordable second trimester termination services would result in a greater number of women resorting to dangerous methods outside of the medically regulated system was raised before the committee. Citing evidence from the United States where funding cessation and other limits on abortion led to the utilisation of unsafe abortion practices, Associate Professor de Crespigny and Dr Allanson held that the removal of item 16525 may lead to 'a small number of women desperately turning to dangerous self-or other-administered methods, with a resulting need for additional health treatment'.[81]

4.62 This view was supported by RANZCOG which stated:

> Women may resort to home / backyard attempts at self abortion resulting in the need for additional health services. It is known that the drug misoprostol, which is used, safely and legally in Australian hospitals for the medical termination of pregnancy, is easily accessible on the Internet.[82]

***Potential financial effect of a disallowance***

4.63 The Australian Medical Association noted that disallowance of the item would have the effect of 'removing any financial assistance for appropriate medical care for women for all of the clinical circumstances covered by the item…'[83] YMCA Australia argued that removal of funding for services under the item 'will have the

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79 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

80 Rural Doctors Association of Australia, *Submission 426*, p.2.

81 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

82 RANZCOG, *Submission 523*, p.3.

83 Australian Medical Association, *Submission 191*, p.1.

greatest impact on poorer women, who may be forced to continue carrying a dead or dying baby against medical advice'.[84]

4.64 Of the potential financial impact of the disallowance of the item on women's health, the Department of Health and Ageing stated:

> If a woman was faced with higher charges, it would have some disincentive effective on the woman's decision as to whether or not to proceed with the service. To the extent it might thus cause women to defer or avoid a service considered medically necessary, it would be likely to result in negative health consequences for those women.[85]

4.65 Ms Amy Naivasha held the view that removing funding for item 16525 services would 'foster an environment of decision-making based on financial capacity and not on the physical and/or mental health of the pregnant woman and her foetus'.[86]

4.66 RANZCOG and the Rural Doctors Association of Australia argued that removing the rebate to women facing severe emotional and financial stress would be inequitable and would only add to such stress.[87] RANZCOG maintained that involved families will suffer due to loss of income, travel and child care expenses and that:

> Women would experience added stress knowing that they have paid the Medicare levy from their own and their partners' wages only to be denied benefits for a legal and medically indicated procedure.[88]

*Adequacy of the rebate*

4.67 A number of submitters took the view that the procedures under item 16525 are under-funded.[89] Dr Cockburn continues:

> These are expensive procedures for patients to have in the private sector. According to one website a termination at 16 weeks' gestation may cost as much as $1100. At 19 weeks the cost can arrange from $1100 to $3000.
>
> The rebate from Medicare for item 16525, however is $200.25. And even after a Medicare rebate and possibly even with Private Health Insurance,

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84 YMCA Australia, *Submission 180*, p.1.

85 Department of Health and Aging, *Submission 218*, p.4.

86 Ms Amy Naivasha, *Submission 509*, p.1.

87 RANZCOG, *Submission 523*, p.2; Rural Doctors Association of Australia, *Submission 426*, p.1; See also Dr Sally Cockburn, *Submission 189*, p.4; Health Services Commissioner, Victoria, *Submission 205*, p.4.

88 RANZCOG, *Submission 523*, p.2; see also Dr Christine Tippett, RANZCOG, *Committee Hansard*, p.81.

89 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.2; Health Services Commissioner, Victoria, *Submission 205*, p.3; Dr Sally Cockburn, *Submission 189*, p.9.

> patients undergoing these procedures in the private sector, may still be thousands of dollars out of pocket.[90]

4.68 Associate Professor de Crespigny and Dr Allanson argued that the rebate should be increased to 'ensure a more equitable access to this vital medical service for women from differing socioeconomic backgrounds'.[91] Similarly, RANZCOG expressed the view that the rebate be increased.[92]

***Potential effect on second trimester abortion numbers***

4.69 A number of submitters argued that removal of item 16526 from the Schedule would not reduce the number of second trimester abortions in Australia.[93] Amongst them, Dr Cockburn held that:

> No matter what proportion of the services are abortions, the procedures described in this item number are lawful and clinically relevant, so they will continue to be performed. Only the venue and/or funding mode will change…
>
> For those who believe that there are illegal abortions happening in Australia, removing this item number won't affect that either. It would be hard to imagine an illegal "abortionist" being bold enough to try to allow someone to claim their work under Medicare.[94]

4.70 Children by Choice suggested that if the objective of removing item 16525 is to restrict termination of second trimester pregnancies, it is unwarranted:

> If the aim of removal of Item no. 16525 is to restrict termination of pregnancy over 20 weeks it is unnecessary and unwarranted. Second trimester medical termination for foetal abnormality over 20 weeks gestation is generally heavily regulated via legal restrictions, hospital review panels and committees, along with doctors working in team consultation with their colleagues.[95]

4.71 Dr Cockburn argued that removal of the item will not eradicate the procedures carried out under the item as the need for them will continue:

> Removing or restricting it might take the issues off the Federal Parliamentary agenda in the short term, but it will not improve maternal health outcomes, make gross foetal abnormalities go away, and importantly, nor will it reduce abortion numbers. It will only add to the financial and emotional burden already facing people requiring the procedures currently

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90 Dr Sally Cockburn, *Submission 189*, pp9–10.

91 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.2.

92 RANZCOG, *Submission 523*, p.3.

93 Health Services Commissioner, Victoria, *Submission 205*, p.3.

94 Dr Sally Cockburn, *Submission 189*, p.15l; see also, *Committee Hansard,* 30.10.08, p.55.

95 Children by Choice, *Submission 437*, p.1.

> covered by this item number. Disallowance of this MBS item number would be nothing more than a cost shifting exercise that makes little sense other than to allow some people to turn a blind eye to a set of lawful and clinically relevant services that they find morally repugnant.[96]

4.72 Similarly, the Rural Doctors Association of Australia stated that it is unaware of any evidence that disallowance of the item will lead to a decrease in second trimester termination of pregnancy and noted that:

> …second trimester terminations are usually undertaken in circumstances and for imperatives that are not susceptible to policy change. In other words, they will be undertaken in any case.[97]

4.73 Associate Professor Lachlan de Crespigny and Dr Susie Allanson suggested that removal of item 16525 from the Schedule may in fact result in a greater number of women terminating earlier in their pregnancy:

> Reliable screening does not occur in early pregnancy but occurs at later gestation, may require repeat tests and may involve the woman and her family taking time to make a decision. If women face additional hardship impacting on their pregnancy choices in second trimester, more women may decide precipitously to terminate a pregnancy in early stages (where a rebate is available) when they have a concern about the health or viability of the pregnancy.[98]

### *Medicare responsible for providing equal access to health care*

4.74 A number of submitters in support of continued funding for item 16525 such as the ARHC noted that Medicare describes itself as Australia's universal health care system responsible to 'give all Australians, regardless of their personal circumstances, access to health care at an affordable cost or at no cost'.[99] The ARHC took the view that removal of item 16525 is not consistent with the Medicare's stated role:

> The removal of item 16525 from the Health Insurance Regulations ignores the stated intentions of Medicare, denying universal access to affordable and safe termination of a pregnancy, and removing women's right to choose a practitioner based on personal preference, rather than financial circumstance.[100]

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96 Dr Sally Cockburn, *Submission 189*, p.17.

97 Rural Doctors Association of Australia, *Submission 426*, p.1.

98 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

99 Medicare Australia, *The Australian Health Care System,* 28 May 2008, http://www.medicareaustralia.gov.au/about/whatwedo/health-system/index.jsp (Accessed 8.10.08).

100 Australian Reproductive Health Alliance, *Submission 199*, p.10.

4.75 This view was shared by Associate Professor de Crespigny and Dr Allanson and the Rural Doctors Association of Australia who noted of efforts to disallow item 16525:

> Manipulating a system designed to ensure that all Australians have access to free or low-cost medical and hospital care in this way would be repugnant and improper.[101]

4.76 The National Foundation for Australian Women argued that the disallowance of item 16525 would effectively remove a rebate for a lawful medical procedure which would be inconsistent with the availability of rebates for other lawful medical procedures.[102] Similarly, RANZCOG stated that:

> Manipulations of the Medicare schedule to limit access to a lawful procedure is unacceptable.[103]

## Lack of clinical evidence to support disallowance of item 16525

4.77 A number of submitters such the ARHA maintained that the services provided under item 16525 are clinically accepted procedures.[104] Family Planning NSW stated that there is no financial imperative to disallow item 16525 and that the current effort to do so was not evidence based.[105] RANZCOG argued that:

> It would be extraordinary if benefits for the legal and medically indicated management of labour in the second trimester were not payable.[106]

4.78 The Health Services Commissioner, Victoria maintained that disallowance of the item would contradict the 'work of all of the expert committees which included it in the first place…' and that:

> The Parliament, with all due respect, is not as qualified in clinical obstetric practice as the expert committees which set up service 16525 as a Medicare item in the first place.[107]

4.79 This position was also held by the Rural Doctors Association of Australia:

> As the Association is unaware of any clinical reason for removing this item from the Schedule, it presumes that any proposal to do so relates to non-clinical policy or opinion. The Association points out that changes to the

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101 Rural Doctors Association of Australia, *Submission 426*, p.2; Associate Professor de Crespigny and Dr Allanson, *Submission 185*, p.2.

102 National Foundation for Australian Women, *Submission 188*, p.4.

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

104 Ms Kelsey Powell, Australian Reproductive Health Alliance, *Committee Hansard*, 29.10.08, p.73.

105 Family Planning NSW, *Submission 182*, p.3.

106 RANZCOG, *Submission 523*, p.3.

107 Health Services Commissioner, Victoria, *Submission 205*, p.3.

> Schedule should be based on evidence relating to the need for the service and the health impact of these changes.[108]

4.80 The YMCA Australia highlighted that the process by which Medicare item numbers are listed are based on best practice:

> Medicare item numbers are determined by expert panels of Medicare Australia, in line with current best practice in clinical care. We believe moves to disallow or remove Medicare item number 16525 interfere with the integrity of the Medicare Australia processes and will compromise the healthcare of pregnant women.[109]

4.81 Whilst respecting the Senate's right to disallow regulations, the Australian Medical Association held that it was 'more appropriate for the Minister of Health and Ageing to consider the clinical and policy aspects of Medicare funding with the advice of the medical profession'.[110]

**Senator Polley**

**Chair**

108 Rural Doctors Association of Australia, *Submission 426*, p.1.

109 YMCA Australia, *Submission 180*, p.1.

110 Australian Medical Association, *Submission 191*, p.2.

# Additional Comments from Senator Hanson-Young

## Introduction:

Item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007 currently provides a Medicare rebate of $267 to a Medical practitioner for the "Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease."

We support measures to ensure that all women have the right to access legal, free and safe pregnancy termination services. By making the Medicare funding unavailable for second trimester terminations, this motion could result in an increase in terminations later in pregnancy due to the financial burden it consequently places on women.

**It is for this reason, that we do not support any moves to disallow Medicare Item 16525, or any other like Item number.**

## Background:

We are concerned that the result of disallowing this specific Medicare Item number will not only affect women from economically disadvantaged backgrounds, but also women from rural and regional areas. It could also delay women accessing terminations until later in pregnancy, after being forced to find additional monies to cover the gap, as well as the original fee.

The diagnosis and confirmation of fetal abnormality or serious illness in pregnancy is a difficult and very stressful time for women and their families. Removing Medicare item 16525 would place a great financial burden on top of the huge emotional burden of deciding whether or not continue with a pregnancy following a devastating medical diagnosis. All pregnant women should have access to Medicare funded treatment, regardless of the circumstances of their pregnancy.

While we recognise that people have strong and differing opinions on this issue, and respect the right of all Australian's to express their views, this is not a debate about the legality of abortion, but rather a debate about accessibility and cost.

While this inquiry was not investigating the legalities of abortion as a whole, the purpose of pursuing the disallowance of Item 16525 effectively prevents women from accessing second trimester terminations (depending on State and Territory legislation), by making it almost unaffordable for the average woman to even consider.

Much misinformation was circulated around the use of Item No. 16525, during the course of the inquiry, contrary to some recent published comments this item number is not currently used by medical practitioners in private stand alone clinics for the provision of surgical termination of pregnancy in the second trimester.

Second trimester medical termination for fetal abnormality over 20 weeks gestation is generally heavily regulated via legal restrictions, hospital review panels and committees, along with doctors working in team consultation with their colleagues. So if the aim of this motion is to prevent terminations after 20 weeks, it seems entirely unwarranted. More specifically when looking at the statistics, is estimated that in Australia around 94% of terminations occur in the first trimester, with only 0.7% occurring at 20 weeks or later.

## Conclusion:

Too often we have seen legislators in this place find it impossible to avoid interfering in women's reproductive health rights. Women have fought long and hard to be able to make decisions about their health and wellbeing, and we will not be supporting any attempt to turn back the clock on women's reproductive rights.

**Recommendation 1:**
**Disallowance of Medicare Item Number 16525, or any related Item Number should not proceed.**

Sarah Hanson-Young

Senator for South Australia

# Family First

# Additional Comments

# Inquiry into item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007


## Summary

Family First opposes abortion and believes more should be done to help reduce the abortion rate.

Disallowing item 16525 is unlikely to cut the number of abortions, but would send a clear signal that the Parliament is not willing to give financial support to the abortion of unborn children up to 26 weeks gestation.

Item 16525 covers a range of procedures other than second trimester abortion. Family First is concerned that these other legitimate procedures should continue to be offered. It is clear that whether item 16525 continues to exist or not, all of the procedures will be offered at public hospitals.

Claims that abolishing item 16525 will impact unfairly on lower income women are not credible, given the $273 fee covers only a small proportion of the full cost of procedures. In terms of second trimester abortion, a woman would have to cover the balance of the cost, which ranges from $1,250 to $4,000.[1] Clearly low income women would attend a public hospital rather than go to the expense.

Evidence given to the Committee has revealed a disturbing view that unborn children with disabilities should be aborted to save the public purse. This view was even contained in a submission by a group of parliamentarians.[2]

Nobody is perfect. It is exceedingly arrogant for people to both assume the lives of people with disabilities are not worth living and to advocate they not be allowed to be born because their care would cost money. It is clear that the children with disabilities and their parents deserve much more support than is offered by governments and the community.

Family First therefore supports the motion to disallow Medicare item 16525.


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1 Queensland Branch, World Federation of Doctors Who Respect Human Life, submission 211

2 Parliamentary Group on Population and Development, submission 436

## Disallowance motion

The Finance and Public Administration Committee was requested to examine Medicare item 16525 as a result of a disallowance motion proposed in the Senate to abolish this item for second trimester abortion.

It is important to state at the outset that Family First opposes abortion and believes more should be done to help reduce the abortion rate. Family First believes its views are in line with the majority public opinion in Australia:

> The definitive study, conducted by the Southern Cross Bioethics Institute in 2005, Give Women Choice: Australia Speaks on Abortion, showed quite clearly that in spite of a general support for the right to abortion (63%) the community rejects it morally, wishes to reduce its incidence, wants mandatory counselling, and views late-term abortion with abhorrence. Another national poll in 2005 also found that 67% of Australians were opposed to Medicare funding for second trimester terminations.[3]

Family First therefore supports the motion to disallow Medicare item 16525. Family First does not believe second trimester abortions should be allowed to occur in private for-profit abortion clinics.

Disallowing item 16525 is unlikely to cut the number of abortions, but would send a clear signal that the Parliament is not willing to give financial support to the abortion of unborn children up to 26 weeks gestation through Medicare funding:

> The first effect of disallowing item 16525 would be to make a clear statement to the Australian people that the Senate does not approve of the use of taxpayer funds to pay abortionists to kill unborn children in the second trimester of pregnancy through partial birth abortion, potassium chloride injections into the beating heart of the child, live born delivery followed by death by neglect and abandonment or any other means. This would be in line with public opinion. Two out of three (67%) of Australians are opposed to Medicare funding of abortions performed in the second trimester and only 14% support this arrangement.[4]

## The use of item 16525

It was clear from evidence presented to the inquiry that item 16525 covers a broader range of procedures than just second trimester abortion and therefore Family First believes there is a genuine and urgent need to review the other procedures that are covered under item 16525.

Evidence from the Department of Health and Ageing stated clearly the restrictions imposed on abortion providers:

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3 The Australian Family Association, submission 177

4 Family Voice Australia, submission 176

> The second trimester is generally considered to range between 13 and 26 weeks gestation. A Medicare rebate is not available for second trimester labour outside the restrictions of this item. The item restrictions include intrauterine fetal death, gross fetal abnormality or life threatening maternal disease. It is a matter for the doctor's clinical judgement as to whether a patient's condition meets these second trimester requirements. There is no Medicare item for terminations in the third trimester.[5]

It was alarming to hear evidence submitted that many abortions being performed did not fit these descriptors and that they were being misinterpreted by means of loopholes in the current item number:

> It is even more apparent to me having had the benefit of listening to other witnesses than when I made my submission that the term 'gross foetal abnormality' has no fixed definition. We heard from the department of health representatives yesterday that 'gross' in their view means macroscopic, visible to the naked eye. That could include Down syndrome, because there are some external features that can be picked up by ultrasound; a missing digit; and so forth. We were told, though, by other expert witnesses that it never occurred to them that that meaning of gross would be the one to apply in this circumstance and that they interpreted gross in one common dictionary meaning of 'serious or grave'. Others have suggested that gross means something close to lethal or at least incompatible, as one witness said this morning, with a long life. Another witness, who is an expert in prenatal testing, said that gross is not a word he uses in this context and so could not define it.[6]

The Department of Health and Ageing stated that "for a termination to be funded through Medicare it needs to be provided in accordance with State and Territory law",[7] but the Department later stated in the hearings that, despite this statement suggesting there is strict oversight, it takes no role in assessing lawfulness and instead trusts that the law is followed.[8]

## Reasons for second trimester abortions

Dr Lachlan Dunjey gave evidence that from figures released in Victoria that the vast majority of post-20 week abortions were for psychosocial distress and not lethal abnormality:

> 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

5 Department of Health and Ageing, submission 218

6 Mr Egan, Committee Hansard, 30 October 2008, page 36

7 Department of Health and Ageing, submission 218

8 Mr Bridge, Committee Hansard, 29 October 2008, page 17

> 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.[9]
>
> Specifically, the concern with item 16525 is that this item is being used for elective abortion in circumstances where the definition of 'life threatening maternal disease' has come to mean 'psychosocial distress' and 'gross foetal abnormality' has come to mean 'any abnormality or considered defect'.[10]

## Other procedures offered under item 16525

By separating out Medicare item numbers for spontaneous intrauterine death (or miscarriage in lay terms) another item number for lethal foetal abnormality and another for a mother at risk of death from deliberately induced abortion would go a long way to closing these loopholes.

> The introduction of a new Medicare item to cover rare circumstances such as intrauterine foetal death and procedures unequivocally necessary to prevent the death of the mother would ensure that women whose unborn child dies from natural causes in utero continue to receive appropriate care and assistance.[11]

Family First is concerned that these legitimate procedures should continue to be offered. It is clear that whether item 16525 continues to exist or not, the procedures will be offered at public hospitals which a vast number of submitters clearly saw as best practice for these procedures.

> It would be practice in the public hospital system for that woman to be given extensive information and counselling: input from skilled obstetricians, genetic counsellors, paediatricians, social workers—whatever is required to ensure that she is fully informed about what is going on. But in the public hospital system the counselling that is provided is highly skilled and extensive.[12]

## Public hospitals

Family First believes that public hospitals are the only place second trimester abortions should be provided. Private for-profit abortion clinics can be too easily distracted by financial and commercial interests and are not bound by public scrutiny and accountability that is required of public hospitals.

> The point you make about public hospitals is very important because that addresses the obvious concern of those very grave abnormalities which are not lethal. That is a matter for terrible clinical agonising, not to mention parental agonising. The only valid place for such a complex and unclear

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9 Dr Dunjey, Committee Hansard 29 October 2008, page 52

10 Dr Dunjey, Committee Hansard 29 October 2008, page 46

11 Mr Meney, Committee Hansard, 30 October 2008, page 2-3

12 Prof. Ellwood, Committee Hansard, 29 October 2008, page 115

> clinical situation to be considered is in a major institution, a public or private hospital with ethics committees, with specialists. I put it to the committee: that sort of decision is not to be made by a commercial abortion doctor on his own.[13]

These major publicly funded emergency hospitals provide life saving scrutiny in a grey area. This public accountability is ultimately a benefit for women:

> It is our position, based on strong evidence, that the practice of abortion in Australia lacks scrutiny. It is mostly an unregulated, unaccountable industry which does not act in the best interests of women in denying them information relevant to their future health and wellbeing. Abortion providers, even those with questionable records and operating outside medical and ethical requirements, have benefited from Medicare funding. Some practitioners have been accused of rorting Medicare for early and late-term abortions. This requires full investigation because it appears that the cases that have been reported on are not isolated incidents.[14]

## Disability

Family First was concerned that the birth of children with a disability was cited as a reason to keep item 16525:

> The financial cost of caring for a severely disabled individual is high not only for the family, but for the greater community. Removing item 16525 would save the Commonwealth, by some estimates, $181,560 per year based on 2007 utilisation of item 16525. Adequately supporting an individual with high support needs costs the community and families far more than this.[15]

This disturbing attitude was echoed by Dr Weisberg for Family Planning New South Wales:

> You also have to look at what would mean to the community to have an increase in the number of handicapped children who needed assistance, because that would be a far greater cost than this Medicare item.[16]

It is interesting that those defending item 16525 on the basis of the cost of people born with a disability listed the negatives or the expense of a person born with a disability, but failed to acknowledge the benefits each person brings to the world. It is a concern that a person's disability can so dominate our attitude to them that we sometimes cannot see their other characteristics.[17]

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13 Dr van Gend, Committee Hansard 29 October 2008, page 49-50

14 Women's Forum Australia, submission 216

15 Australian Reproductive Health Alliance, submission 199.

16 Dr Weisberg, Committee Hansard, 29 October 2008, page 41.

17 Chipman, P "The moral implications of prenatal genetic testing" *Penn Bioeth J* 2006 Spring; 2(2); pages 13-6.

## Conclusion

Family First therefore supports the disallowance of Medicare item 16525 and does not agree that this will unfairly impact on women. Services provided by this item number will continue to be provided by public hospitals, offering women a safer and more accountable environment.

Senator Steve Fielding

Leader of Family First

# Appendix 1

## Submissions and additional information received

| | |
|---|---|
| 1 | Mr Dwayne and Mrs Jocelyn McMath |
| 2 | Name withheld |
| 3 | Confidential |
| 4 | Ms Janelle Pickering |
| 5 | Ms Jennifer Wood |
| 6 | Mr Paul Botha |
| 7 | Mrs Rosemary and Mr Malcolm Pryor |
| 8 | Ms Gaye Chambers |
| 9 | Mr Andrew and Mrs Jody van Burgel |
| 10 | Ms Marla Jones |
| 11 | Mr John McCarthy |
| 12 | Ms Carmel Sherwood |
| 13 | Mr Wes Taylor |
| 14 | Ms Rachelle Hawkins |
| 15 | Mr George Lee |
| 16 | Mr Adrian and Mrs Kerri Park |
| 17 | Confidential |
| 18 | Mr Geoff and Mrs Lesli Findlay |
| 19 | Ms Sheree Scott |
| 20 | Ms Rita Joseph |
| 21 | Mr David and Mrs Rebecca Field |
| 22 | Ms Barbara Cameron |
| 23 | Name withheld |
| 24 | Mr John and Mrs Colleen Batten |
| 25 | Mr Thomas Harris-Brassil |
| 26 | Ms Esther Dourado |
| 27 | Mr Geoffrey Earl |
| 28 | Mr Tony Woodruff |
| 29 | Mr Jonathan and Mrs Renee Dillon |
| 30 | Ms Brenda Forbath |
| 31 | Ms Irene Shand-Len |
| 32 | Mr John and Mrs Patricia Quinn |
| 33 | Mr Mark and Mrs Ilka Hornshaw |
| 34 | Name withheld |
| 35 | Ms Lois Coetzee |
| 36 | Ms Vanessa Burgess |
| 37 | Mr Wyley Hargraves and Ms Christina Parker |
| 38 | Name withheld |
| 39 | Name withheld |
| 40 | Mr Bruce Hulme |
| 41 | Ms Anne Andrew |
| 42 | Ms Connie Robinson |

43 Confidential
44 Mr Ian Kilminster
45 Mr Michael Hardy
46 Mrs Nancy Thomas
47 Ms Juli Bednall
48 Mr Callum Iles
49 Australian Family Association (NSW)
50 Mr Richard Stevens
51 Mr Vincent P. White
52 Confidential
53 Ms Louise Le Mottee
54 Mr Anthony Woodward
55 Confidential
56 Mr Alex Brookes
57 The Reverend Andrew Grace
58 Ms Fay Alford
59 Mr Denis Colbourn
60 Ms Janet E Sanders
61 Confidential
62 Mr Jason Ashby
63 Mr and Mrs Robert and Elizabeth Alabaster
64 Mr Ryan Cuthbertson
65 Mrs Roslyn Phillips
66 Mr Michael and Mrs Leanne O'Brien
67 Confidential
68 Ms Nola Drum
69 Mr John Ventnor
70 Mr David Pitt
71 Mrs Judith Bond
72 Ms Rachael Stone
73 Mr Peter Rice
74 Ms Anna Johnstone
75 Mr Stewart and Mrs Christina Berry
76 Mr John Bowles
77 Mr James and Mrs Dorothy Hamilton
78 Mr Spencer Gear
79 Ms Vicky Carriage
80 Mr Geoff Germain
81 Mr Bruce Hambour
82 Mr Christopher Eaton
83 Mr James Murnane
84 Mr Kevin Swarts
85 Mr Bryan de Pree
86 Ms Leanne Thomas
87 Mrs Kate-Anne Warren
88 Mrs Judith Beavis
89 Mr R S Thomas

90 Confidential
91 Ms Karen Siegmann
92 SHine SA
93 Ms Elisa Martin
94 Ms Kelly Kohlhardt
95 Ms Mandy Morgan
96 Baptistcare Mental Health Services
97 Ms Michelle Kirkby
98 Mr Willem and Mrs Linda Vanderven
99 Mr Graham and Mrs Lynn Davy
100 Ms Marion Smith AM
101 Mr Barry and Mrs Elke Benz
102 Evangelicals for Life
103 Ms Alison Murray
104 Mr Stuart and Mrs Carolyn Thomson
105 Ms Suzanne Dawson
106 Mr Douglas and Mrs Margaret Martin
107 Mrs Uta Compton
108 Name withheld
109 Mr Dan and Mrs Adeline Keenan
110 Mr Colin Oldfield
111 Mr Bill Andrews
112 St Brendan's Parish, Ganmain
113 Australian Family Association Tasmania
114 Mr Rick and Mrs Danielle Maude
115 Ms Elizabeth Priest
116 Ms Kerrie Davies
117 Ms Nicole Miller
118 Ms Marie Kohlhardt
119 Dr Tim Coyle
120 Mr Max Hilbig
121 Mr Carmel Attard
122 Mr Ed and Mrs Ann Pitt
123 Mr David Shearer
124 Ms Penny Shilling
125 Confidential
126 Mr Norman and Mrs Alecia Rawson
127 Ms Michelle Shave
128 Mr John F Schwerdt
129 Mr Greg Rowe
130 Mr Alan and Mrs Elaine Glen
131 Ms Joy Heylen
132 The Reverend Father Peter Jones OSA
133 Ms Margaret Ruth Middleton
134 Ms Bernice Woodland
135 Mr Robert Bom
136 Name withheld

137 Mrs Rae Howard
138 Mr Allan and Mrs Lorraine Douch
139 Name withheld
140 Mr Trevor Dawes
141 Name withheld
142 Mr Daniel Pask
143 Mrs Anna Shepherd
144 Ms Margaret Middleton
145 Mr Yves Dinel
146 Mr James and Mrs Tricia Button
147 Name withheld
148 Mrs Barbara Hopley
149 Ms Pam Doble
150 Mr Roy Pires
151 Ms Bernice Pannekoek
152 Ms Berniece Schafer
153 Name withheld
154 Confidential
155 Mrs Judith Bond
156 Mr Michael Bourke
157 Mr Frank Bellet
158 Ms Colleen Chandler
159 Mr Rodger Bassham
160 Mrs Alison Ferguson
161 Mrs Patricia Bosel
162 Ms Trisha Ellis
163 Ms Lesley Parker
164 Mr Stephen Wardell-Johnson
165 Ms Jacqui Ratajczak
166 Ms Lina Hadinoto
167 Mr Patrick Arendse
168 Mr David and Mrs June Garratt
169 Confidential
170 Mr Michael Treacey
171 Mr Peter Dolan
172 Mr Russell Young
173 Confidential
174 Confidential
175 Ms Sue Rhodes
176 Family Voice Australia
177 Australian Family Association
178 Family Life International Australia Ltd
179 Medicine With Morality
180 YWCA Australia
181 Catholic Archdiocese of Adelaide
182 Family Planning NSW
183 Atheist Foundation of Australia Inc

184 Endeavour Forum Inc
185 Associate Professor Lachlan de Crespigny and Dr Susie Allanson
186 Pregnancy Help Australia Limited
187 Catholic Women's League, Archdiocese of Sydney
188 National Foundation for Australian Women
189 Dr Sally Cockburn
190 Catholic Health Australia
191 Australian Medical Association
192 Church of God Australia
193 Life, Marriage and Family Centre, Catholic Archdiocese of Sydney
194 Family Planning Association of Western Australia Inc
195 Salvation Army Australian Southern Territory
196 The Royal Women's Hospital
197 Catholic Women's League Australia, Diocese of Armidale
198 Right to Life Australia Inc
199 Australian Reproductive Health Alliance
200 Confidential
201 Family Planning Queensland
202 Australian Family Association (South Australian Branch)
203 Catholic Women's League of Victoria and Wagga Wagga Inc
204 Australian Christian Lobby
205 Health Services Commissioner, Victoria
206 Family Council of Queensland
207 Catholic Medical Guild of St Luke
208 Catholic Women's League Australia Inc
209 Women's Hospitals Australasia
210 National Union of Students
211 Queensland Branch, World Federation of Doctors Who Respect Human Life
212 Dr Thomas McEniery
213 Commission on Social and Bioethical Questions, Lutheran Church of Australia
214 Confidential
215 Dr David Knight
216 Women's Forum Australia
217 The Royal Australasian College of Physicians
218 Department of Health and Ageing
219 Ms Barbara Cameron
220 Children of the World
221 Ms Jane Munro
222 Mr Arthur Hartwig
223 Mr Karne de Boer
224 Concern Australia
225 Ms Johanna Sawyer
226 Ms Heather McEwan
227 Ms Kathryn Cooper
228 Mr Earl and Ms Valmai Bearham
229 Mr Warwick and Mrs Kathy Vincent
230 Confidential

231 Ms Gail Osmak
232 Ms Judith Ann Miller
233 Mr Romano and Mrs Linda Sala Tenna
234 Ms Valda Morse
235 Mrs P W Cherry
236 Mr Dunstan and Mrs Margaret Hartley
237 Mr D'Arcy Watson
238 Mr Rick Martin
239 Mrs Robyn Martin
240 Ms Jo Gavin
241 Mr Ken Meyer
242 Mr H Williamson
243 Name withheld
244 Name withheld
245 Mr Bruce and Mrs Margaret Dunne
246 Mr John and Mrs Carol McIntyre
247 Confidential
248 Mr David Boyd
249 Confidential
250 Dr Lewis and Mrs June Larking
251 Mr Brian and Mrs Pauline Ireland
252 Mr Andrew Copp
253 Mr Eric Frith
254 Mr Francis Connell
255 Mr David Hutchison
256 Ms Arleen Purcell
257 Confidential
258 Ms Ana Garufi
259 Confidential
260 Mrs June Head
261 Ms Daphne Weatherill
262 Mr Dion and Mrs Cath Nohlmans
263 Name withheld
264 Name withheld
265 Mr Jonathan Dillon
266 Mrs Ethel Orr
267 Mr Ken Packer
268 Mr Gerard Purcell
269 Mr Elwyn Sheppard
270 Ms Jenny Margaret Anne Kayal
271 Mr Raymond and Mrs Margaret Ellwood
272 Dr Desmond O Gaffney
273 Murraylands Christian College
274 Mr Dennis Litchfield
275 Ms Margaret Whalley
276 Mr Ian Moncrieff
277 Mrs Bernadette Davies

278 Ms Barbara Paterniti
279 Mrs Lillian Deane
280 Mr Geoff Reid
281 Ms Elizabeth Hecksher
282 Confidential
283 Mr W and Mrs J Kirkpatrick
284 Mr Bill and Mrs Milly Hancock
285 Mr Brian McGregor
286 Mr Kenneth Brunjes
287 Mrs Lyn Manthey
288 Mr John Weymouth
289 Mr Isaac Scot
290 Mr Israel Vogel
291 Mr John Kelly
292 Ms Elizabeth Walker
293 Ms Ruth Cavicchi
294 Mr Stephen Asic
295 Ms Joanne Andrews
296 Ms Stella Ng
297 Mr Dale Shuttleworth
298 Confidential
299 Confidential
300 Confidential
301 Ms Lyn Barr
302 Confidential
303 Dr Natalie Ong
304 Mrs Merle Ross
305 Mr Vincent and Mrs Isabel Manuel
306 Ms Rhonda Avasalu
307 Dr Natalie Bennett
308 Mr Richard Woolland
309 Ms Paulina May
310 Ms Robyn Elliott
311 Mrs Maree Triffett
312 Ms Shirley Potter
313 Ms Helen Wyborn
314 Mr Michael and Mrs Mary Walsh
315 Mrs Sue Meehan
316 Confidential
317 Name withheld
318 Mr John Bridge
319 Mrs Janelle Patch
320 Mr David O Paech
321 Mrs K M Chosich
322 Mrs Lucia Musgrave
323 Ms Amanda Wells
324 Ms Cynthia Barker

325 Dr Margaret Colwell
326 Ms Alison J Sherrington
327 Confidential
328 Mrs Linda Irene Behan
329 Mr Stephen J Fyson
330 Mr David and Dr Belinda Goodwin
331 Mr Hugh Bartley
332 Ms Heather Rutherford
333 Ms K Faye Tassell
334 Dr John Curran
335 Mr Ken and Mrs Adrianne Lowe
336 Mr David Lloyd
337 Mr Adrian Gunton
338 Ms Jo Norton
339 Dr Peter and Mrs Louise Thygesen
340 Mr Robin Madill
341 Dr Dianne Grocott
342 The Reverend Father Anastasios Bozikis and Mrs Maria Bozikis
343 Mrs Kerry Scott
344 Mr Eric and Mrs Eva Hogan
345 Ms Michelle Verkerk
346 Dr Ruth Nicholls
347 Mr Bruce Sinclair
348 Mr Murray Thomas
349 Mey Lim
350 Mr Gerard and Mrs Andrea Calilhanna
351 Confidential
352 Mr Timothy and Mrs Nelly Que
353 Mrs Judith A Cato
354 Ms Stephanie Croft
355 Mr Peter Miller
356 Mr Joseph Tang
357 Confidential
358 Ms Tracey Rupcic
359 Mr Tony and Mrs Karen Fisher
360 Ms Kate Perry
361 Ms Amanda Fairweather
362 Mr Chris Sargeant
363 Mr Kevin Hodges
364 Ms Madeleine Tope
365 Mrs Beth Burns
366 Ms Debra Quinn
367 Mr Ben Everingham
368 Ms Leesa Crossley
369 Mr Adrian and Mrs Wendy Elliott
370 Ms Anne M Finkel
371 Mr Ewan McDonald

372 Mr Damer A Walsh
373 Ms Antoinette Mowbray
374 Mr Mark Whittaker
375 Ms Justine Howard
376 Mrs Cynthia Drane
377 Confidential
378 Ms Bernice McKenna
379 Mr Anthony McKenna
380 Confidential
381 Ms Maria McLaughlin
382 M J Smith
383 Mr Trevor and Mrs Maria Atkinson
384 Mr Bruce and Mrs Judith Morgan
385 F A Smith
386 Ms Elizabeth Stewart
387 Confidential
388 Name withheld
389 Mr Fred Bramich
390 Mr Geoffrey Bullock
391 Ms Mary Burgi
392 Mr Chris Whiting
393 Ms Linda Broekman
394 Mr Gary Atkins
395 Ms Colleen McBride, Ms Esta Caputo and Ms Rita Parker
396 Ms Heather Sharland
397 Dr Julian O'Dea
398 Dr David John Miller
399 Mrs Lynette E. Keane
400 Ms Hazel Elaine Bushby
401 Ms Sylvia Wilcox
402 Dr Donna Purcell
403 Ms Gabrielle Whiting
404 Mr Daryl and Mrs Helen Keen
405 Mr Chris and Mrs Sandi Koshering
406 Mrs Pat O'Brien
407 Mr Colin G Pietzsch
408 Name withheld
409 Mr Peter and Mrs Diane Newland
410 Ms Pam Hine
411 Ms Marcia Tatters
412 Ms Helen Severin
413 Confidential
414 Confidential
415 Mr James Birchley
416 Ms Helen Sullivan
417 Mr Terence Dwyer
418 Dr David Bird

419 Ms Lavinia Andrew
420 Mr Aldis Purins
421 Mr Gerard Spoelstra
422 Mr Daivd Ian Combridge
423 Ms Carmel Charlton-Hancock
424 Pregnancy Problem House
425 Ms Ruth Robertson
426 Rural Doctors Association of Australia
427 National Association of Specialist Obstetricians and Gynaecologists
428 Confidential
429 The Reverend Stefan Slucki
430 Mr Matthew Sakaris
431 Ms Cynthia Taylor
432 Ms Sara Taylor
433 Mrs Judith Bond
434 Name withheld
435 Sexual Health and Family Planning Australia
436 Parliamentary Group on Population and Development
437 Children by Choice
438 Mr Greg Byrne
439 The Reverend Father Doug Harris
440 Ms Sheree Alderton
441 Ms Poli Lim
442 Mr Wayne Crow
443 Mrs L C Hickson
444 Mr William and Mrs Fiona MacCallum
445 Name withheld
446 Ms Lynda Hammond
447 Name withheld
448 Ms Wendy Brown
449 W J Reeves
450 Ms Danielle McKendry
451 Mrs J E Kessler
452 Ms Shirley A Myers
453 Name withheld
454 Mrs Margaret Gillett
455 Ms Val Dyson
456 Ms Anne Butler
457 C V Chandler
458 Name withheld
459 Mr Selwyn and Mrs Bev Mai
460 Mrs Juliet Kirkpatrick
461 Confidential
462 Mr Peter Evans
463 Mr Paul Joseph Miller
464 Ms Jennifer Whately
465 Mrs Mary Johnstone

466 Mrs Mary Harold
467 Ms Phyllis A Pitcher
468 Mr Mark Buhagior
469 Mr Colin and Mrs Leanna Loughridge
470 Ms Patricia Buchiw
471 Mrs Beverley Birznieks
472 Ms Joan Macnaught
473 Mrs M Fawssett
474 Mrs Shirley Fisher
475 Mr Richard Hawke
476 Confidential
477 Ms Anne Butler
478 Mr Colin Clifford
479 Mr Kevin F Reed
480 Mr Alastair McEwen
481 Confidential
482 Mr J G Sertori
483 Women's Health Victoria
484 Australian Family Association Townsville Branch
485 Family Council of Victoria
486 Ms Maria Michasiuk
487 Mr Peter and Mrs Christine Hadfield
488 Mr John and Mrs Pat May
489 Ms Fiona Webb
490 Mr Paul Webb
491 Confidential
492 Ms Deanne Blackman
493 Mr Robert and Mrs Linda Hensel
494 Confidential
495 Mr John and Evelyn Hair
496 Mr Graham Lawn
497 Mr Oliver and Mrs Edith Gellert
498 Mrs Leanne Mordini
499 Mr Kevin Avery
500 Mr John and Mrs Nadia Rysko
501 Mr Paul Kelly
502 Name withheld
503 Mr Christopher Moore
504 Ms Stephanie Hall
505 Ms Angela Smith
506 Ms Lisa Thorpy
507 Ms Melanie Arnost
508 Confidential
509 Ms Amy Naivasha
510 Name withheld
511 Mr Harry Greenwood
512 Ms Katherine Bartley

513 Ms Thomas McMurchy
514 Confidential
515 Ms Laura Jeffery
516 Ms Alison Macgregor
517 Ms Claire McAulay
518 Mr Nicholas Hansen
519 Ms Rebecca Jones
520 Confidential
521 Confidential
522 Mrs Hazel Lambert
523 Royal Australian and New Zealand College of Obstetricians and Gynaecologists
524 Confidential
525 Name withheld
526 Mr John H Cooney
527 Ms Rebekah Rodda
528 Mr Robert Doran
529 Mr James and Mrs Kathleen Duggan

## Additional information received

1 World Federation of Doctors Who Respect Human Life: Tabled document during public hearing, 29 October 2008, Canberra: Attachments to submission
2 Mrs Rita Joseph: Answer to question on notice from public hearing, 29 October 2008, Canberra
3 Family Voice Australia: Paper provided in response to a request from public hearing, 30 October 2008, Canberra
4 Australian Reproductive Health Alliance: Answer to question on notice from public hearing, 29 October 2008, Canberra
5 Right to Life Australia: Paper provided in response to a request from public hearing, 30 October 2008, Canberra
6 Department of Health and Ageing: Answers to questions on notice from public hearing, 29 October 2008, Canberra
7 SHine SA: Annual Report of the South Australian Abortion Reporting Committee 2006; Canadian Medical Association Journal article - 'Wrongful birth litigation and prenatal screening' November 2008
8 Medicare Australia: Answers to questions on notice from public hearing, 29 October 2008, Canberra
9 Women's Hospitals Australasia: Answers to questions on notice
10 Australian Health Insurance Association: Answers to questions on notice

# Appendix 2

## Public hearings

***29 October 2008 – Parliament House, Canberra***

**Catholic Health Australia**

Mr Martin Laverty, Chief Executive Officer

**Department of Health and Ageing**

Mr Michael Ryan, Acting Assistant Secretary, Medicare Benefits Branch

Dr Bronwen Harvey, Medical Adviser, Population Health Division

Mr Tony Kingdon, First Assistant Secretary, Medical Benefits Division

Dr Brian Richards, Executive Manager, Health Technology and Medical Services Group

**Medicare Australia**

Ms Jenny Benjamin, Acting General Manager, Medicare and Associated Government Programs

Mr Colin Bridge, General Manager, Program Review Division

**Family Planning New South Wales**

Ms Ann Brassil, Chief Executive Officer

Dr Edith Weisberg, Director of Research

**SHine SA (Sexual Health Information Networking and Education)**

Ms Anne Nixon, Manager

**World Federation of Doctors Who Respect Human Life**

Dr David van Gend, State Secretary, Queensland Branch

**Medicine with Morality**

Dr Lachlan Dunjey, Convenor

**Dr Thomas McEniery**, Private capacity (*via teleconference*)

**Australian Reproductive Health Alliance**

Ms Kelsey Powell, Director

**Mrs Rita Joseph**, Private capacity

**Australian Christian Lobby**

Mr Lyle Shelton, Chief of Staff

**National Association of Specialist Obstetricians and Gynaecologists**

Dr Andrew Pesce, Chair (and representative of the **Australian Medical Association**)

**Women's Hospitals Australasia**

Professor David Ellwood, President

***30 October 2008 – Parliament House, Canberra***

**Life, Marriage and Family Centre, Catholic Archdiocese of Sydney**

Mr Christopher Meney, Director

**Rural Doctors Association of Australia**

Dr Peter Rischbieth, Immediate Past President (*via teleconference*)

Ms Susan Stratigos, Policy Adviser

**Associate Professor Lachlan de Crespigny**, Private capacity

**Right to Life Australia**

Mrs Margaret Tighe, President

**FamilyVoice Australia**

Mr Richard Egan, National Policy Officer

**Dr Sally Cockburn,** Private capacity

**National Foundation for Australian Women**

Mrs Marie Coleman, Chair, Social Policy Committee

Dr Janet Mould, Representative

**Dr David Knight,** Private capacity

**Dr David Baartz**, Private capacity

**Royal Australian and New Zealand College of Obstetricians and Gynaecologists**

Dr Christine Tippett, President