From: Ellwood, David
Subject: RE: Inquiry into Medicare item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007

My responses to your questions are as follows,

1.Evidence has been received that the descriptors of item 16525 should be changed to "intrauterine death, lethal abnormality, or an unequivocal risk to the life of the mother" – Would changing the descriptors have an effect on how the item **currently** operates?

I doubt if this change would have much effect on how this item number was used as this indication is an infrequent one. However, I would argue that this kind of certainty (implied by the use of the word unequivocal) is rarely able to be achieved in clinical situations. What test would be used to ensure that the indication was indeed an 'unequivocal risk to the life of the mother'? . It is likley to be very subjective.

2. It has been suggested that babies that are born alive, are "simply left to die" – can you comment on this suggestion?

I discussed this in some detail in my evidence. Some babies, particular'y at more advanced gestaions, may be born alive and cared for after birth in a 'palliative care' mode. i.e. no neonatal intensive care is initiated but the baby is simply wrapped (kept warm) and then usually spends the short time it is alive for with the mother. This would only apply in situations where intra-cardiac potassium chloride has not been given and the baby is of an age where it is able to be born alive (usually 23-24 weeks). It is unusual for younger babies to be born alive after induction of labour.

3. It has been suggested that somehow accessing breast augmentation is more stringent than the processes and regulations in place for terminations that access item no. 16525 – What is your view of this suggestion? Please outline the hospital processes/regulations/guidelines and supervision that occurs when a decision is taken that utilises item no. 16525?

I have no knowledge or insight into the processes for accessing the item number for breast augmentation so have no way of making a meaningful comparison. The hospital processes/regulations/guidelines anad supervision will vary between different jurisdictions (as the laws vary) but also individual hospitals have different approaches. I am very familiar with that of my own hospital and described this in detail to the committee in my verbal evidence. Essentially a multi-professional 'ethics committee' meets to consider each case individually and then makes it's recommendation to the clinician who has brought the case to them. I believe the processes in lace in the ACT are extremeley rigorous and require a detailed review of the indications for requesting termination of pregnancy.

I trust these answers will augment the detailed evidence I have already given'

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