Committee Secretary
Senate Finance and Public Administration Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600Australia

fpa.sen@aph.gov.au

**Ms Kaisu Vartto**
**CEO**
**SHine SA**
64c Woodville Road Woodville SA 5011
PO Box 76 Woodville SA 5011
Tel: (08) 8300 5345 Fax: (08) 8300 5399
e-mail kaisu.Vartto@health.sa.gov.au
www.shinesa.org.au

Dear Secretary,

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

Please accept this submission. We are responding to the motion to disallow item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007, as proposed by Senator Guy Barnett.

The proposal to remove item 16525 , approved nearly 30 years ago, would disadvantage those women who attend as a private patient in a public or private hospital or clinic for a second trimester termination of pregnancy. These women are already experiencing a personal health crisis, having made the difficult decision to terminate their pregnancy in the second trimester because of serious maternal health issues, intrauterine foetal death or gross foetal abnormalities.

### 1. Organisation making submission

SHine SA Inc (Sexual Health information networking and education South Australia), formerly the Family Planning Association of SA, is the lead sexual health agency in South Australia providing one to one clinical and counselling services as well as community and workforce education programs, research, clinical practice training, resource development and community participation programs. SHine SA advocates for South Australians to have access to age appropriate relationships and sexual health education before they become sexually active; access to contraception and publicly funded safe medical abortion for women who have decided on this option.

### 2. Abortion in Australia and South Australia

Australia does not have an agreed national abortion reporting system. Abortions are provided in public and private health facilities which varies from state to state. There is no accurate data on the number of abortions in Australia, at any pregnancy trimester. Notification of abortion has been mandatory in South Australia since 1970 and is acknowledged as the main source of comprehensive information on abortion which is often extrapolated into abortion data at a national level.

In 2006 in South Australia almost 97% of abortions are performed in public hospitals; 92.3% of terminations were performed under 14 weeks gestation (first trimester) and 7.7% 15 to 27 weeks

gestation (second trimester). Mental health of the woman represented 0.7% of terminations over 20 weeks gestation [1].

Terminations for maternal mental health reasons are not performed beyond 22 weeks gestation unless for a pre existing condition. All terminations at 23 weeks gestation or later in South Australia (therefore including all "late term" terminations) are performed in teaching hospitals, by induction of labour. The method of "Partial birth abortions" described in Senator Barnett's briefing paper of June 2008, is NOT performed. Terminations at 26 weeks gestation or later are extremely rare.

## Medicare data and abortions

Health Insurance Commission data on Medicare-funded procedures which may result in an abortive outcome are derived from two procedures which may include both spontaneous abortions (or miscarriages), and medical or induced abortions.

Medicare benefits can be claimed for two items representing these procedures:

item 35643: evacuation of the gravid uterus by curettage or suction curettage (a procedure considered only suitable in the first trimester)

item 16525: management of second trimester labour, with or without induction, for intrauterine foetal death, gross foetal abnormality or life threatening maternal disease in the second trimester. This item number can only be utilised by private medical practitioners providing care to patients in private hospitals or private patients in public hospitals.

A precise calculation of the proportion of Medicare claims for these item numbers that are pregnancy terminations is impossible, since Medicare claims for actual abortions cannot be disaggregated from the other procedures claimed under these item numbers.

National data collection and coding

The number of Medicare claims processed for the two relevant items on the MBS (ie those that may result in an abortive outcome) is commonly cited in the public debate as the number of 'Medicare funded abortions'. This is misleading.
MBS items which may result in abortive outcomes also apply to procedures which are not pregnancy terminations, such as those undertaken as a result of miscarriage or foetal death, or other gynaecological conditions not necessarily related to pregnancy. Therefore Medicare claims data on these item numbers includes claims for procedures which are not pregnancy terminations per se.

We would support the recommendation by Chan and Sage (2005) [3] that there be a de-identified national collection system, coordinated through the Australian Institute of Health and Welfare, with data items from two sources:

1. Hospitals

National hospital morbidity statistics for public and private hospitals are already held by the Australian Institute of Health and Welfare. Provision should be made for using coding specifications to capture abortions performed at ≥ 20 weeks and for including any hospitals not currently included.

2. Private clinics.

The same information could be collected, by agreement, from private clinics, either directly or through the Abortion Providers Federation of Australia.

## Testing for foetal abnormality

Pregnant women receiving care in the public and private health systems are routinely offered antenatal genetic screening, consisting of a combination of ultrasound and blood testing, followed by amniocentesis where a pregnancy is determined to be at higher risk of foetal abnormality (primarily neural tube defects and Down's Syndrome) [2]. Uptake of this screening is extremely common and has become a normal feature of antenatal care.

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 their 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.

## Use of Item 16525

- Medicare Item 16525 recognises the medical care provided to pregnant women in their second trimester (14 -26 weeks) who experience diagnosis of intrauterine foetal death, gross foetal abnormality and life threatening maternal health conditions.

- Management of second trimester labour with induction is internationally recognised as appropriate, evidence based and life-saving medical specialist treatment for women with high risk obstetric conditions.

- Removal of the Medicare item number will not affect these services when provided in public hospitals. It is a cynical attempt that will punish pregnant women accessing care outside of the public hospital system and delay their access to services. It may place unnecessary pressure on public hospitals at a time when there services are under heavy demand.

- Much misinformation surrounds the use of Item No. 16525. It is <u>not</u> used by medical practitioners for the provision of surgical termination of pregnancy in the second trimester as has been claimed.

- 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.

  [Cait Calcutt Children by Choice is acknowledged as the author of above information - Use of Item 16525]

## Conclusion

It is not the role of politicians to determine the best medical treatment for women. This is the role of doctors in consultation with their patients, based on the best international evidence. This Medicare item number exists to enable doctors to provide the specialist care that pregnant women in this situation may require. Women deserve access to this basic health care intervention whether they receive care in the public or private health care systems in Australia. Anything less is inequitable, inhumane and would put excessive burdens on the under-resourced public sector.

## References

[1] Annual Report of the South Australian Abortion Reporting Committee 2006. Parliament of South Australia 2008.
[2] Maternal, Perinatal and Infant Mortality in South Australia 2006. Government of South Australia Department of Health 2007.
[3] Chan A., Sage L., Estimating Australia's Abortion Rates 1985-2003. Australian Medical Journal, MJA 2005; 182 (9): 447-452
http://www.mja.com.au/public/issues/182_09_020505/cha10829_fm.html