Submission

on

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

to the

Senate Finance and Public Administration Committee

Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

Telephone: 02 6277 3530
Facsimile: 02 6277 5859

Email:fpa.sen@aph.gov.au

Website: www.aph.gov.au/senate/committee/fapa_ctte

by

FamilyVoice Australia

4th Floor, 68 Grenfell St, Adelaide SA 5000

Telephone: 1300 365 965

Facsimile: 08 8223 5850

Email: office@fava.org.au

Website: www.fava.org.au

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TABLE OF CONTENTS

1. Introduction 1

2. The terms of item 16525 1

   2.1 Not a service to which item 35643 applies 1

   2.2 Management of second trimester labour, with or without induction 2

   2.3 Intrauterine fetal death 2

   2.4 Abortion methods in the second trimester: Dilatation and evacuation (D&E) 3

   2.5 Abortion methods in the second trimester: Partial birth abortion 3

   2.6 Abortion methods in the second trimester: Feticide 4

   2.7 Abortion methods in the second trimester: Leaving the baby to die 4

   2.8 "Gross fetal abnormality" 4

   2.9 "Life-threatening maternal disease" 6

3. Number of services and cost 6

4. The basis upon which payments of benefits are made 7

   4.1 Eugenic abortion 7

   4.2 Abortion and women's mental health 8

5. The effects of disallowing item 16525 9

   5.1 Ending official approval of second trimester abortion 9

   5.2 Affirming the value of human life 9

   5.3 Ending discrimination on the grounds of disability 9

   5.4 Improving women's health 9

   5.5 Second trimester abortions will still be available 9

   5.6 New item for intrauterine fetal death 10

6. Time to act 10

7. Endnotes 10

1. Introduction

The Senate Finance and Public Administration Committee is inquiring into item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007 pursuant to a reference from the Senate on 16 September 2008.

In particular the Committee is to 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.

The Committee has invited written submissions which are due by 2 October 2008. The Committee is due to report on 13 November 2008.

2. The terms of item 16525

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

> "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.)" [1]

Item 35643 is in the following terms:

> "Evacuation of the contents of the gravid uterus by curettage or suction curettage not being a service to which item 35639 or 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.)" [2]

2.1 Not a service to which item 35643 applies

Item 16525 does not apply to "a service to which item 35643 applies".

Item 35643 covers "Evacuation of the contents of the gravid uterus by curettage or suction curettage not being a service to which item 35639 or 35640 applies." Items 35639 and 35640 cover curettage for purposes including "incomplete miscarriage" by someone other than a specialist and by a specialist respectively. [3]

From time to time it is claimed that item 35643 covers curettage for incomplete miscarriage. [4] Any medical practitioner claiming under this item for curettage for incomplete miscarriage would be committing Medicare fraud. The aim of those making this assertion seems to be to minimise or create confusion as to the number of abortions paid for by Medicare and to protect Medicare funding for abortion by implying that the abortion related items, including item 35643, cover procedures other than abortion.

Item 35643 refers to "evacuation of the contents of the gravid uterus". "Gravid" simply means "pregnant".

"Suction curettage" is the most common abortion method used in Australia. For example, 95.4% of all abortions performed in Western Australia in 2005 were performed using this method.[5] Suction curettage can be used between 7 and 15 weeks of pregnancy, according to the Royal College of Obstetricians and Gynaecologists.[6]

"Curettage" other than "suction curettage" means curettage with a sharp instrument rather than a suction tube. It is not recommended by the Royal College of Obstetricians and Gynaecologists at any stage of pregnancy.[7] It is rarely performed in Australia. For example, only 0.1% of all abortions performed in Western Australia in 2005 used dilatation & curettage as the method of abortion.[8]

The exclusion of procedures covered by item 35643 from item 16525 means that this item does not apply to the vast majority of abortions performed in Australia, including those second trimester abortions performed at 14 or 15 weeks by suction curettage.

2.2 Management of second trimester labour, with or without induction

Item 16525 refers to "Management of second trimester labour, with or without induction" for certain indications.

In some circumstances procedures involving management of second trimester labour would be covered under item 16522 of the General Medical Services Table. These would include management of labour and delivery of a "baby with a birth weight less than or equal to 2 500 gm" or where there are conditions that "pose a significant risk of maternal death."[9]

2.3 Intrauterine fetal death

In the tragic circumstances where a baby dies in utero from natural or accidental causes during the second trimester there is clearly no ethical issue raised by the need to induce and manage labour to effect the removal of the dead baby.

If the Senate were to disallow item 16525 the Minister for Health would have a clear responsibility to immediately make a new regulation with an item providing a Medicare benefit for "Management of second trimester labour, with or without induction, for intrauterine fetal death". It would be necessary to distinguish this circumstance clearly from second trimester abortion, and to avoid any possibility of the new item being disallowed, by qualifying this provision with the phrase "other than where fetal death is the result of a procured abortion". Without this phrase the proposed new item could be interpreted as allowing the payment of a benefit for induced labour following fetal death brought about by intracardial injection of potassium chloride or other means.

> ***Recommendation 1:***
>
> ***If item 16525 is disallowed, the Minister for Health should immediately make a new regulation providing a Medicare benefit for "Management of second trimester labour, with or without induction, for intrauterine fetal death other than where fetal death is the result of a procured abortion".***

2.4 Abortion methods in the second trimester: Dilatation and evacuation (D&E)

The Royal Australian and New Zealand College of Obstetricians and Gynecologists reports that "D&E is used for terminations at more advanced gestation, usually after about 14 to 15 weeks, and this requires the cervix to be dilated more widely than for suction curettage… The cervix may be dilated manually (using dilators) if necessary. Products of conception are then removed, usually piecemeal, using forceps. Sometimes the fetus will be passed intact if sufficient cervical dilatation has occurred." [10]

D&E was used for 191 (2.5%) abortions in Western Australia in 2005. [11]

D&E is *not* a form of curettage and so is not covered under item 35643.

Even though it is used for second trimester abortions it does not involve "labour", induced or otherwise, but the "usually piecemeal" removal of the fetus from the uterus using forceps.

Item 16525, therefore, does not appear to cover D&E abortions. However, it is not clear whether or not Medicare payments under item 16525 are in fact being made to medical practitioners who perform this procedure.

2.5 Abortion methods in the second trimester: Partial birth abortion

Partial birth abortion is also known as intact dilatation and evacuation (intact D&E) or as dilatation and extraction (D&X).

"In this procedure the doctor extracts the fetus intact or largely intact with only a few passes, pulling out its entire body instead of ripping it apart. In order to allow the head to pass through the cervix the doctor typically pierces or crushes the skull." [12]

It appears that partial birth abortions in the second trimester may attract a benefit under item 16525. [13]

> **Senator HARRADINE**—Are you aware of Dr Grundmann's description of one late-term abortion technique for four to six months—the dilation and breach extraction DNX? Dr Grundmann on a ABC 7.30 Report once described the technique as essentially a breach delivery where the foetus is delivered feet first and then, when the head of the foetus is brought down into the top of the cervical canal, it is decompressed with a puncturing instrument so that it fits then through the cervical opening. Am I to understand that that barbaric method is paid for through HIC?
>
> **Mr Maskell-Knight**—If it is done under the terms of the item, then yes, it is.

This method of abortion has been banned by the United States Congress on the grounds that "A moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion -- an abortion in which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the dead infant -- is a gruesome and inhumane procedure that is never medically necessary and should be prohibited." [14]

The *Partial-Birth Abortion Ban Act of 2003* was held to be constitutional by the United States Supreme Court in the 2007 decision in *Gonzalez v Carhart.* [15]

It is profoundly disturbing to many Australians that this procedure is not merely permitted in Australia but that the abortionist willing to perform this procedure may be paid Medicare benefits under item 16525 for doing so on babies as well-developed as 26 weeks of pregnancy.

Recommendation 2:

As item 16525 may be paid to an abortionist who carries out the 'gruesome and inhumane procedure' known as partial birth abortion it should be disallowed.

2.6 Abortion methods in the second trimester: Feticide

The Royal College of Obstetricians and Gynaecologists recommends feticide before inducing labour for a second trimester abortion. Injection of potassium chloride into the fetal body, amniotic sac or umbilical cord is the usual method of feticide. [16]

This method avoids the possibility of a live born baby.

However, the method also makes it clear that what is taking place is the direct killing of a living unborn child. It is unconscionable that a Medicare benefit should be paid to an abortionist for poisoning a living child in this way.

Recommendation 3:

As item 16525 may be paid to an abortionist who poisons and kills an unborn child by injecting potassium chloride it should be disallowed.

2.7 Abortion methods in the second trimester: Leaving the baby to die

The latest available figures from Victoria indicate that 42 out of 298 (14%) post-20 week abortions performed in 2006 resulted in the delivery of a live born child who died shortly after delivery. [17]

It is hard to imagine the cruelty and inhumanity involved in intentionally delivering a 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.

It is wrong for Medicare to be funding such procedures.

Recommendation 4:

As item 16525 may be paid to an abortionist who delivers a live born child and leaves it to die it should be disallowed.

2.8 "Gross fetal abnormality"

Item 16525 refers to "Management of second trimester labour, with or without induction, for … gross fetal abnormality".

The meaning of this term has been the subject of discussion at Senate estimates hearings in November 2001: [18]

Senator Harradine asked:

The Medicare Benefits Schedule (MBS) provides for benefits to be paid for the "Management of second trimester labour, with or without induction, for intrauterine foetal death, gross foetal abnormality or life threatening maternal disease."

(a) Does the Department have a definition of "gross foetal abnormality"?

(b) If not, who defines it?

(c) Does the Department consider dwarfism "gross foetal abnormality?"

(d) Does the abortion of the baby in Victoria on the grounds of suspected dwarfism violate anti-discrimination laws?

Answer:

(a) No.

(b) It is a clinical decision for the practitioner.

(c) The Department considers the question of whether a patient's condition constitutes "gross foetal abnormality" as a clinical decision for the practitioner.

(d) This is a matter for the Attorney-General.

A similar position was expressed in answers to estimates questions in 2004:

Senator Harridine [sic] **asked:**

Please explain the Department's understanding of "gross foetal abnormality" for the purposes of a Medicare refund in second trimester abortion and whether this includes correctable conditions like cleft palate, hair lip or whether it includes conditions like missing fingers or dwarfism.

Answer:

The item descriptors used in the Medicare Benefits Schedule are developed in close consultation with the medical profession through the Medicare Benefits Consultative Committee (MBCC). The current item descriptor for item 16525 is based on advice from the Royal Australian College of Obstetricians and Gynaecologists (RACOG).

The interpretation of the term "gross foetal abnormality" is a matter for the doctor's concerned clinical judgment.

Abortions are performed in Australia for such correctable conditions. For example, in 2003-04 at least three babies were aborted in Victoria after 20 weeks gestation solely because they had cleft lip or cleft palate and lip with no other disabilities. [19]

Australia has recently signed the United Nations Convention on the Rights of Persons with Disabilities and is currently considering ratifying it. [20] Article 10 of the Convention provides that:

"States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others."

Any abortion performed on the grounds that an unborn child is "abnormal" is an exercise in depriving a person with a disability of the inherent right to life simply because that person is disabled.

Recommendation 5:

As item 16525 provides for abortion on the basis of disability it is discriminatory against persons with disabilities and therefore should be disallowed.

2.9 "Life-threatening maternal disease"

Like the other terms in item 16525 it appears that the meaning of the phrase "life-threatening maternal disease" is left to the individual medical practitioner to interpret.

Over 50% of all post-20 week abortions (150 out of 298) performed in Victoria in 2006 were for maternal psychosocial indications. [21] Ninety eight abortions for maternal psychosocial indications were performed at 23 weeks gestation or later, that is after fetal viability. [22]

Significantly, there were *no* recorded terminations for maternal physical health risks.

This is not surprising because due to advances in modern medicine there are now few, if any, circumstances in which a maternal medical condition during pregnancy cannot be managed successfully to preserve the life and health of both the mother and her child.

Conditions that genuinely "pose a significant risk of maternal death" and that may require induced delivery and careful management of labour appear to be better covered under item 16522 (j) of the General Medical Services Table.

Recommendation 6:

As item 16525 is being used to pay Medicare benefits for second trimester abortions for maternal psychosocial indications it should be disallowed.

3. Number of services and cost

The online statistical service for the Medicare Benefit Schedule[23] provides data from 1994 onwards.

The table below gives the number of services for which benefits were paid under item 16525 for each calendar year from 1994-2007. This has fluctuated between a low of 605 (1998) and a high of 1019 (1995). The current trend is a steady annual increase from 624 (2002) to 790 (2007).

Data available as at 24 September 2008 for the 2008 calendar year shows that there have been 476 services for which payments have been made from January-July 2008. Extrapolating this seven-month data over a calendar year some 816 services could be expected to be funded. This would make the upward trend a six year trend.

Year	Number of services for which benefits were paid under item 16525
1994	936
1995	1,019
1996	697
1997	647
1998	605

1999	609
2000	655
2001	714
2002	624
2003	656
2004	683
2005	770
2006	777
2007 ***2008***	790 *816*[24]

The scheduled fee for item 16525 is presently $267. The benefit paid for each service is 85% of the scheduled fee or $226.59.

The total amount paid from January 1994 to July 2008 is $1,880,901. In 2007 the total amount paid was $157,250.

The benefit of $226.59 is relatively low compared to the actual cost of a second trimester abortion. For example, Marie Stopes International in Midland, Western Australia performs abortions up to 20 weeks. A second trimester abortion (pre-20 weeks) at this facility would cost $1285 in addition to the Medicare benefit. [25]

Post-20 week abortions in Victoria are reported to cost more than $4000.

4. The basis upon which payments of benefits are made

As discussed at 2.8 and 2.9 above the two indicators that authorise the payment of a benefit under item 16525 for a second trimester abortion - gross fetal abnormality and life-threatening maternal disease – are subject to very broad interpretation by the individual medical practitioner.

4.1 Eugenic abortion

The payment to abortionists of Medicare benefits under item 16525 for abortions performed for eugenic reasons, to eliminate a child with a disability, including trivial and correctable disabilities such as missing fingers or cleft palate, and disabilities perfectly compatible with a happy life such as dwarfism and Down's syndrome is inappropriate and should cease.

On dwarfism, Senator Alan Eggleston's (Lib, WA) reminiscence of a happy boyhood should suffice to allow every Senator to come to the obvious conclusion that the payment of Medicare benefits to abortionist who kill unborn children for being short statured is intolerable.

> "It doesn't affect intelligence or your ability to get on with life. From the time I was a boy growing up in a country town, I have never thought of myself as disabled. I did all the things boys did – swimming, sailing, doing bombies off the diving board at the pool… I have always had the approach that life is there to live." [26]

On Down syndrome a recent report notes that:

> "Quality of life for most people with Down syndrome in many wealthy nations has improved dramatically over the past 40 years. The additional chromosome is still there, but the support provided them by their communities has changed. Their medical needs are mostly well

understood. Knowledgeable medical care has raised average life expectancy for people with Down syndrome born in many developed countries today to 60 years (up from 12 years in 1949) and increasing numbers now live beyond 70 years.

"More young people with Down syndrome are gaining access to effective education and therapies and achieving better levels of literacy and improved communication skills. More adults with Down syndrome are gaining useful and rewarding employment and exercising greater control over their lives. There is much still to do and for an important minority significant additional challenges remain, but the progress people with Down syndrome have made is remarkable." [27]

4.2 Abortion and women's mental health

Given that payment of benefits under item 16525 is being made for abortions performed for maternal psychosocial indications it is appropriate to consider whether abortion on such grounds is likely to be of any *health* benefit to a woman.

Ample evidence has been published in reputable medical journals indicating that abortions carried out for psychological reasons are likely to increase psychological distress rather than alleviate it.

In January 2006 the results of research headed by Professor David Fergusson, psychologist and epidemiologist at the Christchurch School of Medicine and Health Sciences were published in the Journal of Child Psychiatry and Psychology. [28]

This showed that women who have abortions are more likely to become severely depressed. The study concluded that "*Those having an abortion had elevated rates of subsequent mental health problems, including depression, anxiety, suicidal behaviors and substance use disorders. This association persisted after adjustment for confounding factors*."

According to the study, 42 percent of the women who had abortions had experienced major depression within the last four years, almost double the rate of women who never became pregnant. The risk of anxiety disorders also doubled. Women who had abortions 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.

Professor Fergusson, who describes himself as "*an atheist, a rationalist and pro-choice*", believes "*the findings tipped the balance of scientific evidence towards the conclusion that abortion increased psychological distress rather than alleviating it.*"

A paper published in the European Journal of Public Health, reporting a 13-year study of the entire population of women in Finland, found that deaths from suicide, accidents and homicide were 248% higher among women in the year following an abortion, than for women who had not been pregnant in the prior year. [29]

The study also found that a majority of the extra deaths among women who had abortions were due to suicide. The suicide rate among women who had abortions was six times higher than that of women who had given birth in the prior year and double that of women who had miscarriages.

In addition, researchers examining death records linked to medical payments for birth and abortion for 173,000 California women found that aborting women were 62 percent more likely to die than delivering women over the eight year period examined. [30] That study also found that the increased risk of death was most prominent from suicides and accidents, with a 154 percent higher risk of death from suicide and an 82 percent higher risk of death from accidental injuries.

In the light of this evidence it is inappropriate for Medicare to continue to fund second trimester abortions for maternal psychosocial indications.

5. The effects of disallowing item 16525

5.1 Ending official approval of second trimester abortion

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.[31]

5.2 Affirming the value of human life

Disallowing item 16525 would acknowledge the humanity of the unborn child who is fully developed in the second trimester.

The new technology of 4-D ultrasound gives a window into the womb through which the unborn child can be seen living, moving and playing. Viewing these images at medical websites such as Harley Street's Create Health Clinic disposes once and for all with the notion of the unborn child in the second trimester as a merely a bunch of cells. [32]

5.3 Ending discrimination on the grounds of disability

Disallowing item 16525 would give effect to Australia's commitment to end discrimination on the grounds of disability, as expressed by the Rudd government in its signing of the United Nations Convention on the Rights of Persons with Disabilities.

This would be in accordance with the best Australian tradition and sentiment of a "fair go for all".

5.4 Improving women's health

Abortion is harmful for women (see 4.2 above). Discouragement of second trimester abortions through disallowing funding for such abortions under item 16525 may lead some women to think more carefully before pursuing a second trimester abortion. This would have positive health outcomes for such women.

5.5 Second trimester abortions will still be available

Disallowing item 16525 would not, of course, stop the performance of second trimester abortions. The legality of abortion is a matter for the States and Territories.

Second trimester abortions performed on public patients in public hospitals would not be affected by the disallowance of item 16525.

As mentioned in section 3 above, the cost of a second trimester abortion is between $1200 and $4000 after Medicare benefits are paid. It seems unlikely that the withdrawal of a benefit of $226.59 would be a decisive economic factor in whether a woman decides to have a second trimester abortion or not.

5.6 New item for intrauterine fetal death

As discussed at 2.3 above, if item 16525 is disallowed the Minister for Health should immediately make a new regulation providing a Medicare benefit for "Management of second trimester labour, with or without induction, for intrauterine fetal death other than where fetal death is the result of a procured abortion".

6. Time to act

For over thirty years the Senate has allowed item 16525 (or its predecessor items) to sit on the table unchallenged.

In the light of new scientific developments such as 4-D ultrasound, *in utero* fetal surgery and improved survival of premature babies; of a renewed commitment to end discrimination on the grounds of disability; and of recent research demonstrating adverse outcomes for women who undergo abortion, it is past time for the Senate to disallow an item which allows the payment of a Medicare benefit for the abortion of babies as old as 26 weeks.

7. Endnotes

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1. *Health Insurance (General Medical Services Table) Regulations 2007,* p 252; http://www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrument1.nsf/0/6ECDAD9C9EC4C548CA2573780025AC0D/$file/0712628A070907EV.pdf.

2. *Ibid,*. p 386.

3. *Ibid.*

4. For example, the Australian Reproductive Health Alliance claimed in a so-called Fact Sheet dated November 2004 that "The Health Insurance Commission (HIC) collects information on the number of Medicare claims for procedures done under the benefits schedule item referring to *evacuation of the contents of the gravid uterus by curettage or suction curettage (first trimester)* (item number 35643). This service includes curettes that are part of a pregnancy termination, as well as curettes for miscarriages", p.1; http://www.arha.org.au/factSheets/abortionaustralianew.pdf.

5. *Induced Abortions in Western Australia, 1999-2005*, Department of Health, p.13, table 12; http://www.health.wa.gov.au/ICAM/publications/pubdocs/AbortionReport1999-2005FINAL(4).pdf.

6. *The Care of Women Requesting Induced Abortion*, Royal College of Obstetricians and Gynaecologists, 2004, p 47; http://www.rcog.org.uk/resources/Public/pdf/induced_abortionfull.pdf.

7. *Ibid.*

8. *Induced Abortions in Western Australia, 1999-2005*, Department of Health, p.13, table 12; http://www.health.wa.gov.au/ICAM/publications/pubdocs/AbortionReport1999-2005FINAL(4).pdf.

9. *Health Insurance (General Medical Services Table) Regulations 2007,* p.252; http://www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrument1.nsf/0/6ECDAD9C9EC4C548CA2573780025AC0D/$file/0712628A070907EV.pdf.

10. *Termination of pregnancy: a resource for health professionals*, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2005, p 14; http://www.ranzcog.edu.au/womenshealth/pdfs/Termination-of-pregnancy.pdf.

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12. *Gonzalez v Carhart*, United States Supreme Court, April 2007, p 1; http://www.supremecourtus.gov/opinions/06pdf/05-380.pdf.

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14. *Partial-Birth Abortion Ban Act of 2003;* http://news.findlaw.com/hdocs/docs/abortion/2003s3.html.

15. http://www.supremecourtus.gov/opinions/06pdf/05-380.pdf.

16. *The Care of Women Requesting Induced Abortion*, Royal College of Obstetricians and Gynaecologists, 2004, p 43; http://www.rcog.org.uk/resources/Public/pdf/induced_abortionfull.pdf.

17. *The Consultative Council on Obstetric and Paediatric Mortality and Morbidity's Annual Report for the Year 2006 incorporating the 45th Survey of Perinatal Deaths in Victoria, p 12;* http://www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep06.pdf.

18. Senate Community Affairs Legislation Committee, Answers To Estimates Questions On Notice Health And Aged Care Portfolio, Supplementary Budget Estimates 2000-2001 22 November 2000 Outcome 2: Access To Health Services Question: E015, p.47; http://www.aph.gov.au/senate/committee/clac_ctte/estimates/bud_0001/vol5_feb01.pdf.

19. Riley, M. and Halliday J. *Birth Defects in Victoria 2003–2004,* Victorian Perinatal Data Collection Unit, Public Health, Department of Human Services Victoria, 2006; http://www.health.vic.gov.au/perinatal/downloads/bdr_report0304.pdf.

20. http://www.un.org/esa/socdev/enable/documents/tccconve.pdf.

21. The Consultative Council on Obstetric and Paediatric Mortality and Morbidity's Annual Report for the Year 2006 incorporating the 45th Survey of Perinatal Deaths in Victoria, p 12; http://www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep06.pdf.

22. *Ibid.*, p 13.

23. https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

24. Data extrapolated from January-July data showing 476 services.

25. Personal communication, 24 September 2008.

26. *Sunday Herald Sun,* 9/7/2000.

27. Buckley, F and Buckley, S. "Wrongful deaths and rightful lives – screening for Down syndrome", *Down Syndrome Research and Practice*, Vol. 12, issue 2, October 2008, p 79-86, p 84; http://www.down-syndrome.org/editorials/2087/.

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29. M. Gissler et. al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European Journal of Public Health,* 15(5):459-63 (2005).

30. DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women," *Southern Medical Journal*, 95(8):834-41 (2002).

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