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

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

Submission from:

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Item: 16525 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.) $267.00

This submission focuses on (d) the effects of disallowing this item.

1 Background

We live in a sophisticated medical and obstetric country where people request, expect and are advised about pregnancy screening and pregnancy and family planning options, including pregnancy termination.

We live in an egalitarian and developed society where our government is expected to honour its duty of care in providing health care to all its citizens via Medicare. This is especially so when it comes to accessing essential health care, including prenatal testing and termination of pregnancy.

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).

Abortion is lawful (given specified circumstances) in all Australian jurisdictions.

Grayson, Hargreaves & Sullivan (2005) and Chan & Sage (2005) estimate that 84,000 induced abortions occurred in Australia in 2003, and that less than 6% (less than 5,000) abortions occurred after 13 weeks gestation, and less than 0.7% (less than 600) occurred after 20 weeks gestation. These estimates are consistent with Straton, Godman & Gee (2005).

Services for MBS-item 16525 are almost entirely provided to patients admitted to public or private hospitals (Grayson et al, 2005).

Like Grayson et al (2005), The Public Health Association (2005) report, *Abortion in Australia: Public Health Perspectives*, points out that "an unknown number of 35643 and 16525 claims are performed for procedures other than termination of pregnancy, for example, treatment of miscarriage" (p. 3) .

As discussed below, rather than removing MBS-item 16525, we would welcome the Committee considering how small the MBS-item 16525 rebate is, and recommend increasing the rebate to ensure a more equitable access to this vital medical service for women from differing socioeconomic backgrounds.

The current proposal to disallow MBS-item 16525 may be rooted in a radical philosophical or religious belief of a senator or senators that the government should not fund therapeutic abortions. The current proposal may be part of a long term plan to gradually restrict Medicare

funding for all abortions. In 1997, the Health Insurance Commission (HIC) advised that it would no longer accept claims for MBS-item 35500 (gynaecological examination under anaesthetic) when laminaria tents were inserted on the first day of second trimester abortions performed using this two stage (two day) abortion procedure. The use of MBS-item 35500 for this service had been commonplace for years, and no substitute item was provided. This directive increased the financial burden on women accessing this method of post twelve-week pregnancy termination. Approximately two years ago, when most abortions were covered by MBS-item 35643, that is, irrespective of gestation, the Health Insurance Commission introduced MBS-item 16525 to be used for all terminations post 12 weeks gestation. As a blanket withdrawal of Medicare funding for abortions would likely be rejected by the Australian people, the introduction of gestation specific MBS items allows the opportunity to more specifically and gradually peg back the Medicare coverage for abortion. We view this proposal as an example of a planned and gradual process of curtailing women's abortion rights by stealth.

We respectfully suggest that those who oppose others accessing abortion should address this issue through state and territory law, not by introducing discriminatory funding.

In contrast to extreme and radical views, our discussion below highlights that disallowing MBS-item 16525, without providing alternative Medicare coverage, is not consistent with our society's religious or secular values of compassion, social justice and duty of care. We would only support such a move if this meant that the HIC returned to allowing MBS-item 35643 for all abortions, irrespective of gestation.

2 Effects of Disallowing MBS-Item 16525

The range of possible effects of removing the Medicare item number for 2nd trimester terminations are discussed below. Case examples are provided from our clinical experience:

2.1 Nil effect in economic savings

The financial savings will be negligible and may be severely outweighed by additional costs (see 2.3 below). The number of services receiving payments under this item and the cost of these payments are small. In addition, as discussed in 2.3 below, any savings may be offset, indeed far outweighed, by additional costs.

2.2 Reduction in essential services to women

2.2.1 Intrauterine fetal death

Untreated intrauterine fetal death risks complications including infection and clotting disorders potentially causing serious sequelae. Disallowing MBS-item 16525 runs the risk of causing a serious risk to the health, and potentially the life, of pregnant women.

2.2.2 Gross fetal abnormality

Terminations for fetal abnormality are nearly all performed in the second trimester. Removing MBS-item 16525 runs the risk of causing serious harm to the physical and mental health of the pregnant women.

Case example: Fiona was almost 20 weeks' pregnant when doctors discovered inoperable fetal heart tumours. The fetus would die, either before or shortly after birth, and Fiona and her husband felt it would be too cruel to proceed. She was referred for abortion at 21 weeks.

The hospital refused to perform the procedure, instead referring her case to its committee and repeating tests. After almost 2 weeks without a date set for the termination, Fiona was secretly given details of a private abortion clinic by a hospital staff member. She had the procedure done at 24 weeks, costing her about $4000.

Fiona, who suffers from depression, said the ordeal caused her to have a nervous breakdown.

2.2.3 Life threatening maternal disease

Removing MBS-item 16525 would deny Medicare benefits to a pregnant woman who needed a second trimester pregnancy termination for life- threatening maternal disease.

Case example: A married mother of two children with a planned and wanted pregnancy. At fourteen weeks gestation an aggressive breast cancer was diagnosed. In addition to surgery, life-saving treatment meant chemotherapy incompatible with the pregnancy continuing. The decision to terminate the pregnancy was an agonising one for this woman and her husband, but ultimately there in fact was no choice for this woman. Either she would die, with the pregnancy being unviable anyway and leaving her family devastated, or she terminate her pregnancy and receive potentially life-saving treatment.

Exclusion of this woman (and by consequence exclusion of consideration of her family's well-being) from Australia's Medicare system is not consistent with any reasonable religious or secular values or morals. Economically, exclusion of this woman may have further delayed her accessing safe abortion services, increasing the likelihood of complications and heightening demand for other Medicare rebated health care, including mental health items for the entire family.

2.2.4 Other services

"An unknown number of 35643 and 16525 claims are performed for procedures other than termination of pregnancy, for example, treatment of miscarriage" (The Public Health Association, 2005, p3). Disallowance of MBS-item 16525 will also 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.

2.3 Increase in other Medicare services

2.3.1 Early abortions

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.

2.3.2 Home remedy/Backyard attempts at abortion

Where women cannot access safe, timely and affordable abortion, they are at risk of resorting to dangerous methods outside the safe, medically regulated system. These methods can include self-medication/remedies, or interventions by untrained or trained but unregulated practitioners. Reproductive morbidity and mortality is high in such circumstances (WHO). In light of Medicaid funding cessation and other limits on abortion access in the United States, Fried (1997) observed American women turning to unsafe abortion practices, including ingestion of poison and violence, either self-inflicted or inflicted by others.

Removing MBS-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. If this were to occur Australia becomes similar to many developing countries where the safety of an abortion is dependent on a woman's wealth.

2.3.3 Discrimination against women

Women may be denied care to which they are legally entitled if termination is unfunded. Women and their families may pursue compensation.

Current practice is already unfair and discriminatory, given the low Medicare rebate for second trimester abortion and the city-centricity of services.

Removal of funding would be discriminatory against poor and rural women at a time in their lives when they are at their most vulnerable. 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 rearing a disabled child because she wanted, but could not fund, pregnancy termination.

Women are less likely to choose to have a child, or more children, if they are not confident that access is available to both appropriate prenatal testing and abortion if a major abnormality is found, or the pregnancy threatens a woman's life. Governments wishing to encourage women to have children must take away barriers.

2.3.4 Stigma, harm & Duty of Care to Australian Women & Their Families.

The stigma, anguish and harm for women and their families likely to result from removing item 16525, potentially could see an increase in women and their families accessing other physical and mental health Medicare services.

2.3.5 Use of alternative MBS-items

Without a reduction in fetal abnormalities, maternal risk factors and so on, and given our current screening technology, there is unlikely to be lessening of demand for item 16525. Consequently, health practitioners may resort to other item numbers to meet their professional obligations in caring for their patients. Grayson et al (2005, p. 21) consider the Medicare Item numbers which theoretically could be related to induced abortion.

Use of alternative MBS-item numbers may apply to other procedures too (see 2.2.4 above).

3 References

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The Public Health Association of Australia Inc (2005) *Abortion in Australia: Public Health Perspectives*, 3rd edition.

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