Submission to

The Senate Standing Committee on Finance and Public Administration

Inquiry

Into

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

From

Dr Sally Cockburn MBBS
1 October 2008

CONTENTS

B. BACKGROUND

Since 1974 Australia has had a national universal health scheme. Medicare, as it is now called, is the Commonwealth funded health insurance scheme that provides free or subsidised health care services to the Australian population. It does this through funding free hospital services for public patients in public hospitals through the Australian Health Care agreements with the States, subsidising private patients for hospital services (75 per cent of the Schedule fee) and providing benefits for out-of-hospital medical services such as consultations with GPs or specialists (85 per cent of the Schedule fee).[1] This inquiry focuses on one aspect of the private arm of Medicare .

According to Medicare's website, *its objective is to assist in improving health outcomes in Australia.*[2]

The business and administration of Medicare is governed under the Medicare Act 1973 and this is administered by the Minister for Human Services. Importantly for this inquiry, the Medicare Act 1973 does not cover the clinical aspects of Medicare, such as which services might be covered by Medicare, or what fees these might attract. Instead, the clinical aspects of Medicare Australia are governed by The Health Insurance Act 1973 and its accompanying Regulations. It is the latter that sets out clinical descriptions of services and the fees they attract which are then published in the Medicare Benefits Schedule (MBS). The Health Insurance Act 1973 is administered by The Minister for Health and Aging.

In terms of Senate Committee responsibility I understand that Health and Ageing falls into the portfolio of The Senate Standing Committee on Community Affairs whereas Human Services falls under the auspice of The Senate Standing Committee on Finance and Public Administration.

In early September 2008 Senator for Tasmania, Guy Barnett, announced that he intended to introduce a motion of disallowance into the Senate to remove item 16525 from the MBS in order to remove funding of second trimester abortions under Medicare. However, on 16 September 2008 the Senate referred the matter of the disallowance motion to the Senate Standing Committee on Finance and Public Administration Committee for inquiry and report on and not before 13 November 2008. Senator Barnett withdrew his motion but has said he will reintroduce his motion after the committee has completed its inquiry.

Along with the matter of the disallowance motion the other parts of terms of reference for the inquiry are 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] Medicare - Background Brief http://www.aph.gov.au/library/intguide/SP/medicare.htm issued May 2003 (updated 2004) accessed 22 September 2008

[2] http://www.medicareaustralia.gov.au/about/index.jsp

Given these terms of reference and the fact that this matter has been referred to the Finance and Administration Committee and, notably, not to the Community Affairs Committee it seems that this inquiry is not about the health policy issues relating the MBS item number under inquiry, but rather the financial and administrative aspects of it. However some clinical issues need to be explained in order to clarify the financial and administrative matters. My understanding, however, is that this is not an inquiry into the morals or lawfulness of abortion.

C. RESPONSES TO THE INDIVIDUAL TERMS OF REFERENCE:

(a) The terms of item 16525 of Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007

i) Background on the MBS and how item numbers come to be included on it

The MBS contains three lists of so called item numbers that correspond to certain clinical services approved for funding under Medicare for benefits payable to patients who undergo these services. These lists of item numbers are called

- the General Medical Services Table (GMST)
- the Diagnostic Imaging Services Table and
- the Pathology Services Table.

There are hundreds of item numbers on the MBS, but this inquiry is concentrating only one item (16525) on the GMST.

Item numbers are included on the GMST in the MBS after an extensive expert analysis process. They are referred to the Minister for Health and proposed for inclusion in MBS in the Health Insurance Regulations. The schedule is updated each November and sometimes in between... After which, the updated MBS is published for providers to use when billing patients.

Patients are able to claim a prescribed rebate from Medicare for the MBS listed services so long as their doctor provides them with an invoice for services that have claimable MBS item numbers. MBS item numbers only apply to private patients and are not applicable to public patients in public hospitals.

The prescribed (or schedule) fee does not necessarily reflect the value of the service or cost to the patient but it is merely the amount the Commonwealth is willing contribute to the patient's expenses. Where a service is "bulk billed" this means the practitioner bills Medicare directly for the service and the patient is not out of pocket. The fee paid by Medicare for a service like item 16525 is 75% of the schedule fee

The evaluation process for the services included on the MBS is overseen by Department of Health and Aging (DoHA) with constructive consultative arrangements with the medical profession. This is done mainly through the Medicare Benefits Consultative Committee (MBCC) which considers submissions and reviews evidence regarding the operation of Medicare schedule items referred to it. The MBCC, comprises representatives of DoHA, Medicare Australia, the Australian Medical Association (AMA) and relevant professional bodies. The Medical Services Advisory Committee (MSAC) complements the MBCC by evaluating new and existing medical services and technologies to ensure they are safe, effective and cost-effective. These rigorous and evidence based processes keeps the MBS current and relevant.

It would be unusual for the Minister responsible to go against the advice of these expert committees. And, although it is certainly within the rights of an individual Senator to put a motion of disallowance against any MBS item, I suspect it would be a precedent for such a motion to be passed without having first sought advice from the MBCC, or such a motion completely bypassed the responsible Minister. Passing such a motion would, no doubt, also raise concerns amongst the medical profession and the Australian people about the validity of the processes and protocols already in place to watch over the integrity of the MBS and also raise questions about the relevance and value in taking part in these expert panels.

While I seek to reassure the Committee that MBS item number 16525 is safe and clinically relevant -

Recommendation 1 – Should the Committee be concerned that MBS item number 16525 is not safe or not clinically relevant it is only proper that the matter be referred to the Medicare Benefits Consultative Committee for evaluation prior to a vote on a disallowance motion.

ii) The Details of MBS Item 16525

According to Part 3 of Schedule 1 to the Health Insurance (GMST) Regulations 2007 Item number 16525 applies to the following services:

> *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.)*

*It attracts a schedule fee of $267.00 (*Benefit: 75% = $200.25 85% = $226.95)

For the sake of clarification, *Item* 35643 relates to the services of

> *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.)*

This means that Medicare will pay a rebate of $200.25 to patients who an invoice for item 16525 from their doctor following private inpatient care. If they also have private insurance they may receive a payment from those companies covering the remaining amount up to the Schedule fee (in this case the gap to $267) and in some cases maybe more.

The GMST under Section T4.4 ***Labour and Delivery (Items 16515, 16518, 16519, 16525)*** contains some descriptive notes that also apply to this item number describing in more detail some other technical issues relating to the service, in particular:

> *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);*
> * *Episiotomy or repair of tears.*

In lay terms labour is the physical process where contractions of the uterus work to expel the products of conception (foetus and placenta) through the vagina. The process of labour normally starts spontaneously when the foetus is fully developed and ready to be born but sometimes tragically, labour commences early for various reasons. Often the cause is unknown and although medical science does have useful interventions, sometimes, despite all efforts, labour cannot be stopped. The outcome depends largely upon how developed the foetus is when delivered.

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

It is important to emphasise that MBS item 16525 only relates to the management of labour in the *second* trimester of pregnancy, that is, from 13 to 27 weeks gestation. And that it covers both spontaneous and induced labour. But moreover is noteworthy that it covers situations where the result is a live baby as well as where there has been a lawful request for abortion.

iii) Medical language can be a problem in data interpretation

At this point it may be helpful to clarify how terminology may lead to some confusion in data interpretation. Induction of premature labour for maternal health reasons may still be termed a "termination of pregnancy" because, medically speaking, the pregnancy is being ended. However, unlike the common interpretation of this term, i.e. abortion, in this case, depending on the gestation, the intention is usually to produce a live infant. Sadly despite the best efforts it the infant may not survive.

Survival of the foetus is linked to gestation. According to a study published this year in the British Medical Journal[3], even with modern neonatal intensive care facilities, otherwise healthy babies born at 24 weeks gestation have only a 40% chance of survival to discharge. Babies born at 23 weeks gestation have a 20% chance of survival. Those born at 22 weeks or earlier sadly have no chance of survival. While there has been some improvement over the years of older gestations, the figures for 23 weeks and under have remained unchanged for over a decade.

If a pregnancy spontaneously ends prior to 20 weeks it is termed a miscarriage. If the gestation is beyond 20 weeks and the baby is born dead it is called a still birth. I understand that it is a legal requirement (at least in Victoria) for the latter to be recorded with the Victorian Register of Births Deaths and Marriages. If the baby is born alive after 20 weeks gestation or is a certain weight but then dies within the first 28 days[4] it must be recorded as a neonatal death.

I realise that this Committee is only concerned with facts but it may be interested to explore further some anecdotes I have heard: Sometimes parents are caught in a terrible situation. The woman could be told that she has such a serious medical condition that if the pregnancy continues

---

[3] **Survival of extremely premature babies in a geographically defined population: prospective cohort study of 1994-9 compared with 2000-5, Field D,et Al** BMJ 2008;336:1221-1223 (31 May), http://www.bmj.com/cgi/content/full/bmj.39555.670718.BE

[4] Australian Institute of Health and Welfare Meta data on line registry – Neonatal Death http://meteor.aihw.gov.au/content/index.phtml/itemId/327250

she will die and that sadly at a gestation below 22 weeks if induced the foetus has no hope of survival due to its prematurity. I have heard in this and some situations of gross foetal abnormality women may have requested to have their pregnancy terminated but asked for it not to be an abortion per se. It is a plea from distressed parents that they may hold their hopelessly premature or abnormal baby before it dies.

Senator Barnett has made some accusations of babies been born alive after abortion and then deliberately killed. This is against the law and I seriously doubt this is happening. I call upon him to make a referral to the police if he has evidence or legitimate suspicion of such activities or cease making such claims. Instead, I wonder whether the description above may shed light on his concerns because a termination of pregnancy is not always an abortion. I wonder whether it is nomenclature not crime that could explain this matter.

The details of the issues and misunderstandings relating to this item number are further discussed below in section (c) and (d) of the Terms of Reference responses.

(b) The Number of Services Receiving Payments Under This Item and The Cost of these Payments

As mentioned earlier, federal funding for health programs under Medicare has several arms. The data under scrutiny for this inquiry are only those relating to the MBS and in particular only MBS item 16525.

i) What is the burden of this item number on the business of Medicare?

Medicare Australia provides an online statistics tool that allows analysis of individual MBS funded services over time and by region[5].

The online data only goes back as far as 1994 but according to this tool, for item 16525 -

- There were 10,182 services processed for the fourteen years from January 1994 to December 2007.
- The total benefit paid for those services over 14 year period was $1,780,584
- In the last available calendar year (2007) there were 790 services processed Australia wide and benefits paid of $157,250
- In the last available financial year (2006-7) there were 802 services processed Australia wide and benefits paid of $156,843

(For detailed state by state data see Appendix 1)

[5] https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml

The Medicare 2006 -7 Annual Report[6] provides a summary of overall key performance statistics for the organization for that financial year. Some of these are shown below in Table 1

Persons enrolled in Medicare* at 30 June 2007	21.1 million
Patient claimed services	**70.0 million**
Total services processed	**257.9 million**
Total benefits paid	**$11.8 billion**

Table 1: selection of Medicare Key Performance Statistics

Using the statistics from the Medicare Annual report, together with the online Medicare statistics tool data (appendix 1), it seems item number 16525 represents 0.0003% of the total Medicare services claimed and 0.0015% of the total Medicare Benefits paid in the financial year 2006-7. Without meaning to minimize the importance of the human issues associated this item number, in pure economic terms, it represents a minute proportion of Medicare's business.

It has been claimed by Senator Guy Barnett, in his online briefing document [7] used to back up his disallowance motion that

> *Since 1994 the Australian taxpayer has paid **abortionists** about $1.7 million to perform over 10,000 second trimester and late term **abortions**.*
>
> *In 2007 the Australian taxpayer paid over $157,250 for 790 procedures under item 16525. Nearly all of these procedures would have been second trimester and late term **abortions.*** (emphasis added)

While the numbers are correct, his claims that these figures relate to abortion only are false and misleading. It is impossible for Senator Barnett, or anyone else for that matter, to know what sub services were provided under this item number, or what gestation they were performed at. It is not possible to break down the data further to learn details of the clinical nature of the service provided within this item number. In this case it is just not possible to know whether the procedure was an abortion or induction of labour to produce a live baby. Nor is it possible to know what gestation the service took place at except that is was between 13 and 27 weeks.

Also, while Medicare has a list of recognised specialists "abortionists" are not on their list nor is this a recognized professional term, I think the committee will find that these services were provided by specialist GP's or RANZCOG fellows. Using inappropriate emotive terms like this does not add to the credibility of Senator Barnett's argument.

To get a feel for the possible quantum of expenditure in the controversial area of 22 weeks gestation and over it is a reasonable comparison to look to British data to give an idea of the

[6] 2006 – 2007 Medicare Annual Report – Section 2 page 25
http://www.medicareaustralia.gov.au/about/governance/reports/06-07/files/2006-7_annual_report_section02.pdf

[7] http://www.guybarnett.com/Articles/downloads/BRIEFING-PAPER.pdf

Australian situation. The British data shows that about 90% of abortions take place in the first trimester, 9% of abortions take place between 13 and 19 weeks, only 1% of terminations take place over 20 weeks and only 0.75% over 22 weeks [8].

Given that the Medicare data show that there were 790 second trimester induction of labour procedures claimed under this Medicare item number in 2007, and even if Senator Barnett's inappropriate leap was true and all had been abortions, it is feasible that in this inquiry we are taking about fewer than 59 procedures claimed Australia wide over 22 weeks gestation Even with this grossly inflated guestimate the annual maximum Medicare expenditure would still be less than $12,000.00.

Indeed it is my belief that it is more likely that the vast majority of these procedures are for foetal death in utero, anyway.

Senator Barnett also referred, in his on line Briefing Document, to *second trimester* and *late term* as if they were two separate categories. Late term abortion is not a medical term and while there is no fixed definition for what it applies to, it is often it is used to describe all abortion over 20 weeks. I would advise caution using this term in this inquiry, and stick to medical terms breaking down foetal development into trimesters or weeks of development. I urge this because some use "late term" it to raise emotional responses and confuse people who may think we are taking about third trimester foetuses or describing the pregnancy right up to term (40 weeks). This item number is not applied to third trimester procedures and only covers up to 27 weeks gestation.

ii) Does the fee adequately reflect the complexity and cost of the procedure?

MBS online states that

> *The fee for any item listed in the MBS is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.*[9]

Although what I am about to point out might be an unexpected point to raise, it is nevertheless within the scope of this inquiry to consider and is something I have realised only since researching for this submission. In order to consider this point properly one must remove all emotional investment and look at this service purely as an accepted MBS service that is lawful and clinically relevant.

Is the rebate amount for Item 16525 adequate? It could be argued that given the complex nature of the procedures covered within MBS item 16525 that it is actually under rebated by Medicare.

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 range from $1100 to $3000.* [10]

---

[8] Abortion time limits, A briefing paper from the BMA
http://www.bma.org.uk/ap.nsf/Content/AbortionTimeLimits~Background~Stats

[9] MBS update 1 July 2008 section 10 *Schedule fee and Medicare benefits*
http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/C77AF9BC0761216DCA25745F002F0ABB/$File/1%20Jul%202008%20-%20Gen%20Expl%20Notes.pdf

[10] *Children by Choice* http://www.childrenbychoice.org.au/nwww/abortion2.htm

The rebate from Medicare for item 16525, however is $200.25. And even after a Medicare rebate and possibly even with Private Health Insurance, patients undergoing these procedures in the private sector, may still be thousands of dollars out of pocket.

The issue of rebate fees is normally the domain of the Medicare Benefits Consultative Committee.

Recommendation 2 : I ask the Senate Committee to consider finding out when the rebate for this item number was last assessed for its value against the cost of the procedure and suggest that this matter be referred to the Medicare Benefits Consultative Committee to assess whether the rebate might indeed be too low for these services.*

* please note - I would not benefit personally from any such increase in benefits.

(c) the basis upon which payments of benefits are made under this item

According to the MBS online version 1 July 2008 MBS supplement

> *Medicare benefits are only claimable for 'clinically relevant' services rendered by an appropriate health practitioner.*
> *A 'clinically relevant' service is one which is generally accepted by the profession in question as necessary for the appropriate treatment of the patient.*
> *When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.*
> *Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws.*[11]

The definition of "clinically relevant" above is consistent with the definition given in the Health Insurance Act 1973 states that [12]

Because MBS item number 16525 includes induced abortion it may be morally offensive to some people. However for the purposes of this inquiry the service must be kept in the perspective of the terms of reference, the Law and Medicare objectives. Not only is moral judgment on this item number not within the scope of the Terms of Reference, it would also not be seen as an evidence based reason to restrict a clinically relevant and lawful procedure by those who do not share the moral stance. Sometimes moral stances are veiled in pseudoscience or jargon and it is particularly important to be on the look out for this.

While disapproval of this item number has been brought up Parliamentary before, the proposal to remove it was been rejected with sound reasoning that still applies today.

Coincidentally, almost exactly 5 years to the day of Senator Barnett's call for its removal, on 15th September 2003, then Senator Brian Harradine expressed a similar concern with the item number by putting a question without notice in the Chamber to the then Minister for Health, Senator Kay Patterson[13].
The Minister replied:

---

[11] 1 July 2008 MBS Supplement - Medicare Benefits Arrangements
http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/C77AF9BC0761216DCA25745F002F0ABB/$File/1%20Jul%202008%20-%20Gen%20Expl%20Notes.pdf

[12] Health Insurance Act 1973 Part 1, Section 3, Interpretation page 3 http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s3.html

[13] Australian Senate Hansard, 15105 15 Sept 2003 http://www.aph.gov.au/hansard/senate/dailys/ds150903.pdf

I am sure that you are aware that legislation relating to the performance of abortions is the responsibility of the state and territory governments and that each jurisdiction has different legislation governing the circumstances for when pregnancies can be terminated. The Commonwealth has no role in the policing of state and territory abortion laws. The Commonwealth, through the HIC, assumes without evidence to the contrary that terminations of pregnancy claimed against Medicare have been performed in accordance with state and territory laws. Assuming the claim was otherwise, valid benefits would normally be paid for termination of pregnancy. Medicare benefits have always been payable for the termination of pregnancy. In 1979 the House of Representatives passed a motion confirming that Medicare benefits should be paid for terminations performed in accordance with state law, and this is still the case.

For the purposes of paying Medicare benefits, the Commonwealth applies the presumption of innocence and assumes, in the absence of a court decision to the contrary, that the termination is performed by a medical practitioner in accordance with the relevant state law. Late-term abortions are not covered under Medicare. Medicare benefits are only payable for evacuation of the gravid uterus, which is only practical in the first trimester or for a second trimester termination where there is gross foetal abnormality or life-threatening maternal disease. It is a matter for a doctor's clinical judgment as to whether a patient's condition meets the second trimester requirements. Medicare benefits, I am advised, are not payable in the third trimester

The Ministers words still ring true. However, this aside, when considering whether MBS item number 16525 is appropriate to remain in the MBS the issues are

i) Is the service lawful?
ii) Is the service safe and clinically relevant?
iii) does the service improve health outcomes for Australians
iv) Is the service cost effective?

i) The service is lawful

Just focusing on the controversial aspect of MBS item 16525, as mentioned in Senator Patterson's speech above, abortion is governed by the State and Territory legislation and is not the domain of the Federal Parliament to police or Medicare to question. Abortion law in Australia is complex. However, while abortion still exists in all state and territories criminal codes except one (ACT), second trimester terminations of pregnancy can be lawfully performed in all Sates and Territories based on common law precedents only Northern Territory poses an upper gestational limit of 14 weeks.

However, there is a bill before the Victorian Parliament at the time of writing this submission to have abortion removed from the Crimes Act 1958 (Vic). This bill has passed the Lower House and is due to be put to the Upper House before the close of this Inquiry. If passed, it will remove abortion from Victoria's Crimes Act 1958. However even if the Victorian Bill fails, common law rulings still mean that the procedures described in this item number can continue to be performed lawfully in Victoria.

Another issue is the term "psycho social" which seems to have been used by some to imply that abortions are happening for trivial or even unlawful reasons. Once again it is impossible from the Medicare data to know whether any services are being done for this purpose but the item number does not use this sort of disease based descriptor, but rather refers to the severity of disease – that is, this item number covers "life threatening maternal disease". It must be kept in mind that that

anything less than a "life threatening maternal disease" does not fall within item's clinical description and so any procedures for conditions of a lesser nature would not be eligible for coverage under this item number. However that doesn't make them illegal.

In medical terminology "psycho social" is a term that does not imply degree of severity and can cover an enormous range of clinical situations some of which could fit into the description under item 16525. Common law rulings in Australia do talk about mental health and social considerations as a lawful reason for termination

Whether such procedures are morally acceptable or should not be lawful or not is not is not within the scope of this inquiry. If the procedures are lawful and within the clinical descriptor, it is difficult to argue against the patients deserving a Medicare rebate.

Senator Barnett and others have made accusations about trivial and possibly unlawful procedures being performed and then claimed under this item number. I think they should be challenged to produce evidence to back up their claims. Unlawful behaviour should be referred to the relevant State police. If there is evidence that the item number has been misused by some practitioners, unless it is widespread misuse, this is no reason to remove the item number, but rather means the practitioners need to be counseled on its proper use.

Recommendation 3 - Even though lawfulness is implicit in the MBS, and it is outside the terms of reference for this Inquiry, and given the complex nature of the laws on abortion maybe a simple, palatable option to solve the issue of federal funding such procedures could be to modify the wording of MBS item number 16525 to –

> **Management of second trimester labour, with or without induction for a termination of pregnancy that is lawful in the State or Territory where the procedure is being carried out, not being a service to which item 35643 applies (Anaes.)**

This way termination of pregnancy is used in the medical sense and abortion is covered by the reference to State laws. Thus even if State laws change the Medicare item number keeps up with the changes. It also removes moral versus political issues in the context of state versus federal jurisdiction.

ii) The service is safe and clinically relevant

While this issue is possibly outside the scope of this inquiry, I have included comment as I suspect issues will be raised in relation to it and it is likely there will be misunderstandings relating during the course of the Inquiry. If it is considered irrelevant I ask the Committee to please only exclude this part of my submission not the whole document.

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 the woman can result. Induction of labour for this purpose is considered a safe procedure even after 24 weeks[14].

It is common practice for women to avail themselves of the offer to have tests during their pregnancy to detect or exclude foetal abnormalities. Women do this for various reasons. Some do it to prepare themselves rather than get a surprise at birth but the vast majority does it knowing they have the option of terminating the pregnancy if there is gross foetal abnormality. While some may find this unpalatable it is nevertheless lawful, normal clinical practice and has wide community acceptance.

Some of these abnormalities can be detected early in the pregnancy through screening tests like blood tests and ultrasound but they often need to be confirmed using Chorionic Villus Sampling [15] which is usually done at 10 -12 weeks. This could mean, given that women may want time to decide what they wish to do, that abortions even for these early detected abnormalities might fall into the second trimester, and the territory of MBS item 16525.

However some abnormalities can not be diagnosed until later in the pregnancy and routine ultrasound at 18 – 20 weeks may pick up the first sign of a serious malformation[16]. Sometimes it is even later before the first sign of a serious abnormality can be diagnosed. Having the MBS item 16525 where these procedures are covered up until 27 weeks, applies to these situations.

The clinical relevance of these procedures is obvious. At the risk of repeating myself ad nauseum, this must not be confused with moral distaste.

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

The sustained and continual usage of item 16525 and its longevity on the MBS could also be seen testimony to its clinical relevance. It has been on the MBS for over 30 years.

Then again, I am surprised that this Inquiry has happened in the way it has since there is an established and more definitive way to assess the safety and clinical relevance of this, or any other item number. The Health Insurance Act 1973 provides for the Minister for Health to establish committees to evaluate and advise the Minister on such matters as safety and clinical relevance of services included in the Medicare Benefits Schedule (MBS). These independent expert panels look carefully at new and existing services that are referred to them and make recommendations to the Minister for Health and Aging. The current committee that fulfills this role is the Medicare Benefits Consultative Committee (see page 3 for description of MBCC). I can find no record of any recommendations from this committee for removal of this item number. Why has this matter not been referred to the MBCC? **See recommendation 1**

[14] **Management of late intrauterine death using a combination of mifepristone and misoprostol—experience of two regimens.** European Journal of Obstetrics & Gynecology and Reproductive Biology , Volume 118 , Issue 1 , Pages 28 - 31 T . Fairley , M . Mackenzie , P . Owen , F . Mackenzie

[15] http://www.thewomens.org.au/ChorionicVillusSamplingCVS

[16] http://www.monashultrasound.com.au/library/factsheets_18-20.html

iii) The service improves health outcomes for Australians

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 choice. In doing so it would reduce the stress in an otherwise difficult time for families.

iv)The benefit is cost effective

While not all services covered by this item number are abortions, and it may not be a palatable thought, second trimester abortions are, and will continue to be a reality whether this item number exists or not, so long as they are clinically relevant and lawful. A call to remove the item number based on numbers of services is not equitable to those women who require these services.

Trends, however, in the Medicare data show that the number of services claimed under the item number over the last 14 years has been fairly constant (see table 2) indicating a consistent clinical need for this item number and given the minute percentage of Medicare dollars it uses there is certainly no financial incentive for its removal.

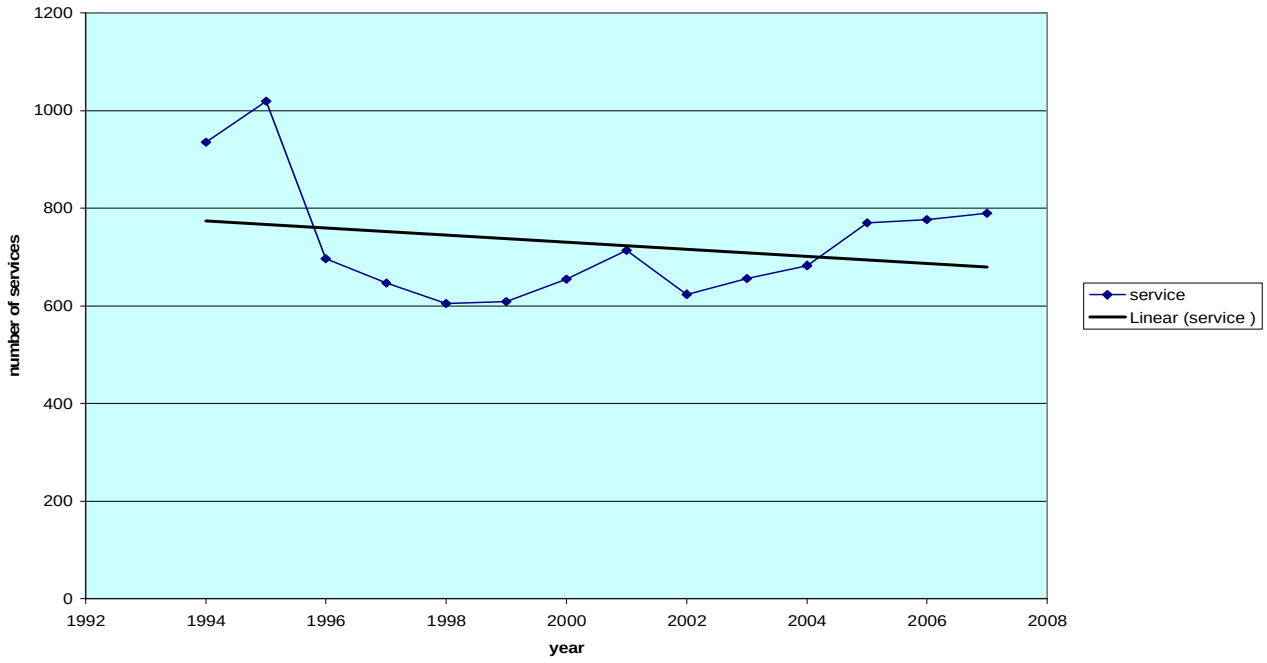

Table 2: item 16525 - number of services processed over 14 year period

Not only this but, not all services described under MBS item 16525 are captured by the item number. These procedures are also performed in public hospitals on public patients where Medicare rebates do not apply, however Medicare will still be paying for these through health service agreements.

Consequently Medicare MBS data may not reflect the true number of procedures taking place or cost. Given the probably underfunding of the procedure one must draw the conclusion that this item number is cost effective to Medicare.

(d) The effects of disallowing this item

To remove any part of this or any other MBS item number through a disallowance motion in the Senate for moral rather than evidence based reasons and without first taking advice from the MBCC, would undermine the integrity of Australia's National Health Insurance Programs.
Such action would send a message to the Australian people that the Federal Parliament has little regard for State laws and believes it is more qualified in clinical practice than the time honoured and trusted expert committees set up for the purpose of assessing Medicare item numbers.

However, along with political fallout there health effects, and these will be considered in the context of the three possible scenarios for disallowance:

- Completely removing the item number from the MBS
- Removing the abortion component only
- Altering the abortion component

1. All three scenarios would also would also have serious personal and clinical consequences for vulnerable women and their families and potentially have serious clinical consequences. They also make no moral or financial sense. They would all have

i) No effect to reduce abortion numbers

It is safe to assume that the aim of those seeking to disallow item number 16525 is to reduce the number of second trimester abortions in this country. However their method is ill conceived and even if they are successful in removing the item number they will fail to meet their goal of reducing abortion numbers. 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. The only people touched by such a disallowance will the women and their families who would have otherwise been able to claim a rebate under this item number. They will still need their procedures but now they will be hit with a financial slap from the federal parliament during arguably the most tragic time of their life.

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.

ii) No positive impact on Medicare's MBS bottom line

MBS item number 16525 accounts for a tiny portion of Medicare's business. Removing it from the MBS will not improve Medicare's bottom line. Cancelling this item number would be nothing more than a cost shifting exercise

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.

iii) The effect to restrict choice of hospital and doctor.

Disallowance or alteration of this item number would restrict the choices of Australians to have a procedure done in a hospital of their choice using the doctor of their choice. Restricting of freedom of choice is contrary to the platforms of most major political parties and the ethos of Australian culture.

iv)The effect to cause disadvantage to certain Australian women and their families

Disallowance or alteration of this item number would disadvantage certain Australian women financially and psychologically. At the moment those who choose to have the procedure in private sector receive a Medicare rebate to assist with the financial burden during a stressful time in their life. Removing this would add to the stress they are already under.

Those who subscribe to private insurance would be disadvantaged as some private health insurers use the MBS schedule as a guide to what they will or won't cover so there is a chance that by disallowing the item these women who pay private insurance will get no rebate at all.

Then there are those who might have afforded to pay for the procedure when the Medicare rebate existed. They will be disadvantaged and may then need to wait in line in the over stretched public sector.

Not only this, but, it is possible that women in rural areas would be particularly disadvantaged by disallowance of the item number. 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.

v)The effect to possibly increase maternal morbidity and mortality

Removing the options for services under this item number will adversely affect women's mental and physical health. Removing the Medicare rebate could, in the short tem 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.

2. Removing the abortion component only from this item number is unconscionable. In addition to the points this is be cause

i) It would deny equitable access to lawful clinical procedures.

Given that procedures under this item number are lawful and clinically relevant, and thinking objectively, it is unfathomable how it could be seen as justifiable to remove the rebate for one group of women over another.

ii) Women might die as a result

While it is more likely that women will still get their life saving abortions in the public sector, complete removal of the abortion component would include removing the benefit for abortion to save a woman's life. This would be unconscionable and effectively tells the Australian people that the Federal Parliament believes that it is preferable to let a woman die rather than perform a life saving abortion.

iii) Women may be forced to carry grossly abnormal foetuses to term against their will.

Again, in the event of cancellation of the item number these procedures would most likely be transferred to the public sector but the message to the Australian people is that Federal Parliamentarians believe that a woman should be forced, against her will, to carry a grossly 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 are incompatible with life outside the uterus or may die shortly after birth. Is it the intention of federal parliamentarians to prolong the agony for these families? Surely not.

3. There is no clinical financial or legal argument for this item number being more restrictive that state laws allow. Along with all the aforementioned effects and with the assumption that the services under this item number are lawful and clinically relevant it makes no sense to restrict them further since State and common laws dictate the lawfulness or otherwise of abortion in this country. Indeed it appears there is a move around the country to remove abortion from the Crimes Act and or change the law to reflect current clinical practice. To guard against Medicare getting left up in such issues **(see recommendation 3)**

C. CONCLUSION

There is no evidence to support the case for removing or restricting MBS Item Number 16525.

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 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.

Is this the message parliamentarians want to give to their constituents?

D. SUMMARY OF RECOMMENDATIONS

Recommendation 1 (Page 5) **– Should the Committee be concerned that MBS item number 16525 is not safe or not clinically relevant it is only proper that the matter be referred to the Medicare Benefits Consultative Committee for evaluation prior to a vote on a disallowance motion.**

Recommendation 2 (Page 9) **– I ask the Senate Committee to consider finding out when the rebate for this item number was last assessed for its value against the cost of the procedure and suggest that this matter be referred to the Medicare Benefits Consultative Committee to assess whether the rebate might be too low for these services. `**

Recommendation 3 (Page 12) – **Even though lawfulness is implicit in the MBS, maybe a simple, palatable option to solve the issue before the Committee could be to modify the wording of MBS item number 16525 to –**

> ***Management of second trimester labour, with or without induction for a termination of pregnancy that is lawful in the State or Territory where the procedure is being carried out, not being a service to which item 35643 applies (Anaes.)***

E. BIOGRAPHICAL STATEMENT FROM DR SALLY COCKBURN:

I am a registered Medical Practitioner in Victoria working part time in General Practice. I am also a media health commentator and health educator. I sit on the board of The Victorian Health Promotion Unit – Vic Health, and am Chair of Family Planning Victoria. I also sit as a volunteer on the National Medical Advisory Committee for Marie Stopes International. I make this submission in my professional capacity as a GP who does not work in obstetrics, a woman and the mother of a daughter. I do not speak on behalf or make representation for any of the organisations I am associated with. I have never performed the procedures listed in item 16525 or 35643, do not or stand to gain directly or indirectly from their inclusion or exclusion from the MBS. I have no vested interest in the outcome of this inquiry other than better health outcomes for the community. However I am familiar with the issues under inquiry.

My intention is to assist the Committee by clarifying clinical and other misunderstood issues in this very sensitive area of health care that is often dominated by minority opinion driven by deep seated moral positions rather then sound clinical judgment. I respect the right of people to believe abortion is wrong, but, where abortion is lawful and clinically relevant, these people have no right to disadvantage the health outcomes of others by imposing their moral views upon them. I would be pleased to appear before the Committee to further clarify any of the points raised in my submission.

APPENDIX 1: DETAILED MEDICARE DATA FOR MBS ITEM 16525:

Requested Medicare items processed from January 1994 to December 2007

	State								Total
	NSW Services	VIC Services	QLD Services	SA Services	WA Services	TAS Services	ACT Services	NT Services	Services
Item 16525	3,100	3,120	1,808	784	906	220	135	109	10,182

The total Benefits paid from January 1994 to December 2007

	State								Total
	NSW $Benefit	VIC $Benefit	QLD $Benefit	SA $Benefit	WA $Benefit	TAS $Benefit	ACT $Benefit	NT $Benefit	$Benefit
Item 16525	543,990	546,941	315,585	136,764	155,751	38,744	23,723	19,087	1,780,584

Benefits paid in 2007 calendar year

	State								Total
	NSW $Benefit	VIC $Benefit	QLD $Benefit	SA $Benefit	WA $Benefit	TAS $Benefit	ACT $Benefit	NT $Benefit	$Benefit
Item 16525	47,332	56,556	22,337	10,825	10,774	4,320	2,748	2,360	157,250

Benefits paid in 2006-7 financial year

	State								Total
	NSW $Benefit	VIC $Benefit	QLD $Benefit	SA $Benefit	WA $Benefit	TAS $Benefit	ACT $Benefit	NT $Benefit	$Benefit
Item 16525	43,037	55,587	24,639	13,005	11,473	3,871	2,700	2,531	156,843

Services processed in 2007 calendar_year

	State								Total
	NSW Services	VIC Services	QLD Services	SA Services	WA Services	TAS Services	ACT Services	NT Services	Services
Item 16525	233	285	114	55	55	22	14	12	790

Services processed in 2006-7 financial year

	State								Total
	NSW Services	VIC Services	QLD Services	SA Services	WA Services	TAS Services	ACT Services	NT Services	Services
Item 16525	220	286	123	67	59	20	14	13	802

Benefit paid By State/ Territory and Year from 1994 – 2007

Item	Calendar Year	State								Total
		NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
		$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit	$Benefit
	1994	38,258	43,973	25,195	9,060	23,756	2,211	1,743	1,591	145,786
	1995	40,032	45,397	33,202	9,603	32,530	2,273	3,207	2,005	168,248
	1996	37,109	32,416	19,832	7,817	11,494	2,606	845	1,651	113,768
	1997	35,715	27,435	19,160	8,832	9,638	2,120	1,002	1,466	105,366
	1998	34,564	22,133	19,748	8,288	9,770	3,482	1,513	853	100,349
	1999	30,409	29,493	20,018	9,588	8,897	2,188	1,009	841	102,443
	2000	35,537	37,710	17,833	8,901	7,188	2,502	1,024	1,024	111,719
	2001	38,832	41,616	20,069	11,124	7,368	2,075	1,211	691	122,986
16525										
	2002	40,479	29,477	19,808	10,537	5,464	882	1,386	1,401	109,435
	2003	37,656	29,494	29,530	10,085	5,589	2,527	1,259	1,803	117,942
	2004	39,770	43,627	22,529	8,672	6,095	2,032	2,404	1,290	126,418
	2005	47,711	53,775	23,225	10,760	6,037	4,340	1,502	941	148,291
	2006	40,584	53,840	23,101	12,673	11,153	5,187	2,872	1,173	150,583
	2007	47,332	56,556	22,337	10,825	10,774	4,320	2,748	2,360	157,250
	Total	**543,990**	**546,941**	**315,585**	**136,764**	**155,751**	**38,744**	**23,723**	**19,087**	**1,780,584**

Medicare item 16525 services processed from January 1994 to December 2007

Item	Calendar Year	State								Total
		NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
		Services	Services	Services	Services	Services	Services	Services	Services	Services
16525	**1994**	245	280	165	57	154	14	11	10	936
	1995	248	282	197	60	186	14	20	12	1,019
	1996	228	199	121	48	70	16	5	10	697
	1997	219	169	118	54	59	13	6	9	647
	1998	208	134	119	50	59	21	9	5	605
	1999	181	175	119	57	53	13	6	5	609
	2000	208	222	104	52	42	15	6	6	655
	2001	225	242	116	65	43	12	7	4	714
	2002	231	168	113	60	31	5	8	8	624
	2003	210	164	164	56	31	14	7	10	656
	2004	214	236	122	47	33	11	13	7	683
	2005	241	284	120	57	32	23	8	5	770
	2006	209	280	116	66	58	27	15	6	777
	2007	233	285	114	55	55	22	14	12	790
	Total	**3,100**	**3,120**	**1,808**	**784**	**906**	**220**	**135**	**109**	**10,182**