SUBMISSION TO THE SENATE FINANCE AND PUBLIC ADMINISTRATION COMMITTEE

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

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Executive Summary

The Australian Christian Lobby (ACL) supports the motion to disallow Medicare funding of second trimester and late-term abortions. In removing this provision, ACL are mindful of the need to introduce additional consequential protections to ensure continued provision for those very rare cases of lethal fetal abnormality, unequivocal risk to the life of the mother or intrauterine death.

ACL contends that life begins at conception and, therefore, abortion at any stage of pregnancy deprives the unborn child of life. However, many of those who accept 'a woman's 'right to choose' abortion in the early stages of pregnancy, become less and less accepting of that choice as the pregnancy progresses, and the unborn child becomes recognisably human and capable of surviving outside the womb.

Australians hold conflicting views about abortion, but few support public funding of abortion at any stage of pregnancy. One survey found that 67% of Australians oppose Medicare funding of abortion in the second trimester of pregnancy[1].

Advances in ultrasound technology mean that many Australians have seen children in the womb and have recognised their humanity. Recent developments in fetal surgery have enhanced this recognition. The well-known operation on a 21-week-old fetus, who was pictured reaching out his tiny hand to grasp the surgeon's finger[2], underscores the obvious humanity of the unborn child.

The humanity of the unborn child, therefore, is no longer in any real doubt, but, ironically, its right to life is still questioned. This seems doubly wrong at a point when the child is capable of surviving outside the womb. Put simply, after a certain stage of pregnancy, when the child can be delivered alive, there is no longer any need to weigh the 'right to choose' against the 'right to life'.

The States and Territories are responsible for determining their laws on when abortions can legally be performed, but the Federal Government is responsible for the Medicare scheme. Removing Medicare funding of second-trimester or late-term abortions would save the lives

[1] National Opinion Poll on Abortion in Australia, Market Facts (Qld), November 2005, p.48

[2] http://www.michaelclancy.com/story.html

of many children who are capable of independently living outside the womb, and who deserve a fighting chance of life.

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

Item 16525 of the Medicare General Services Table[3] provides for the payment of a Medicare benefit of $267.00 to a doctor who carries out "Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease." The second trimester covers weeks 14 to 26 of pregnancy.

The use of this Item has been stretched beyond its original intent. Whilst there are some terribly distressing cases of lethal fetal abnormality or genuine risk to the mother's life, a high proportion of second-trimester abortions take place for psychosocial reasons alone, not for the medical reasons listed in this Item number. These concerns will be explored further below.

Facing the facts of late-term abortion

It is worth pausing to consider what is involved in a late-term abortion. Partial birth abortion is a brutal method used to terminate pregnancies during the second trimester of pregnancy. Although banned in the United States, this horrific method of abortion may attract a Medicare benefit.

Partial birth abortion involves the breech delivery of the live child, except for the head. The abortionist then stabs scissors into the base of the baby's skull and widens the scissors to enlarge the opening. A suction catheter is then inserted into the gap to suck the brains out, causing the skull to collapse. The head of the now dead child can then be delivered. This is an absolutely abhorrent assault on a viable child.

Australian Dr David Grundmann, who performs abortions using the partial birth abortion method, has said that he has carried out such abortions for reasons including "major changes in socio-economic circumstances".[4]

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[3] http://www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrumentCompilation1.nsf/0/A94276861701D254CA2574D50023F435/$file/HlthInsurGenMedSerTab2007.pdf p. 244

[4] David Grundmann "Abortion After Twenty Weeks in Clinical Practice: Practical, Ethical and Legal Issues" in John McKie (ed), *Ethical Issues in Prenatal Diagnosis and the Termination of Pregnancy*,

Other forms of second trimester and late term abortion can result in the birth of a living child, who is then left to die. Forty-seven out of 309 (15%) post-20 week abortions performed in Victoria in 2005 resulted in the delivery a live born child, who was then tragically left to die[5]. The line between late term abortion and infanticide is a very blurred one.

As part of the debate on this disallowance motion, ACL arranged for federal and state politicians to hear from Gianna Jessen. Gianna was born alive after her mother underwent a saline abortion in the third trimester of pregnancy. Despite being burned for approximately 18 hours in the womb from the saline solution, Gianna was delivered alive in a Los Angeles County abortion clinic. Her medical records state: "born during saline abortion". Thankfully for Gianna, the abortionist was not present at the unintended birth (though later compelled to sign her birth certificate!) and the nurse refused to follow the practice of the time, which was to cause the child's death by strangulation, suffocation or neglect[6]. Instead, Gianna was transferred from the abortion clinic to the hospital. Gianna is now in her early thirties.

As Gianna states, "If abortion is merely about women's rights, ladies and gentlemen, then what were mine? There was not a radical feminist standing up and yelling about how my rights were being violated that day. In fact my life was being snuffed out in the name of women's rights.[7]"

Fetal pain

Research is shedding light on pain perception in unborn children. The neuro-scientific orthodoxy for more than 50 years has been that all conscious awareness comes from the cerebral cortex. It is said that if there is activation of other portions of the nervous system but they do not reach the cortex, then there can be no conscious awareness. There is good scientific evidence to suggest that connections between the body, the lower brain and the cortex only start to be established at 24-26 weeks of gestation. Therefore the orthodox reasoning is that there can be no conscious awareness of pain before this stage of development.

This view has been strongly defended and promoted by supporters of abortion on demand. However there are several lines of evidence that challenge the orthodox position:

Monash University Centre for Human Bioethics, 1994.

[5] The Consultative Council on Obstetric and Paediatric Mortality and Morbidity's Annual Report for the Year 2005, incorporating the 44th Survey of Perinatal Deaths in Victoria

[6] ACL understands that, in the US, this practice only ceased in 2002 with the passage of the Born Alive Infants Protection Act.

[7] Gianna Jessen, Address given at Queen's Hall, Parliament of Victoria, 8th September 2008

1. The strongest evidence is that extremely premature babies of 23 - 26 weeks gestation show every sign of pain perception and awareness. A research group at University College in London has used a range of techniques to show that the brain is activated by painful stimuli even in the most extreme infants. Thus there is *prima facie* evidence to suggest that fetuses of the same gestational age would have similar pain perception. This has been countered by suggesting that the placenta provides some form of pain suppression and therefore the experiences of newborn babies are different. However there is no real evidence to support this.

2. There is good evidence that stress hormones are released during invasive procedures on fetuses down to 18 weeks gestation or earlier[8]. Hence fetuses do seem to be able to respond appropriately to what would be painful procedures.

3. There is evidence that lower brain centres such as the thalamus play a critical role in pain perception and therefore may provide conscious awareness of pain even if the cortex is not wired up. The thalamus develops much earlier in gestation than the cortex. Also parts of the brain called the subplate neurons may play a role in pain perception.

4. There is clinical evidence that anencephalic babies who don't have a cerebral cortex still seem to have some form of pain perception and response.

In summary, though the science is not conclusive, there is enough evidence to challenge the simplistic idea that fetuses cannot feel pain until 24-26 weeks gestation.

It is also important to draw a distinction between the scientific approach, which is to seek certainty, and the clinical approach, which is to "play safe". Even if certainty is not yet established, we should take an ethical position of playing safe and assuming that fetuses are capable of experiencing pain from mid-gestation[9].

This seems to be recognised when surgery is being performed on the fetus. Though not yet common, amazing treatments have been given to unborn children in the womb to correct problems such as spina bifida or potential loss of limbs. Indeed, the National Institute of

[8] Gitau R, Fisk NM, Cameron A, Teixeira J, Glover V. (2001). 'Fetal HPA stress responses to invasive procedures are independent of maternal responses', *Journal of Clinical Endocrinology and Metabolism*. 86, pp104-109

[9] Glover V, Fisk N, 'We don't know: better to err on the safe side from mid-gestation,' *British Medical Journal*, 1996, 313: 796, 28 September.

Child Health and Development predicts routine diagnosis and in utero treatment of congenital malformations by 2020.

Interestingly, analgesia is provided for many of the procedures performed on the fetus in utero, in recognition of the possibility that the procedure will cause it distress. However, the double-standard remains. Great efforts are made to treat wanted babies, either in the womb or when born prematurely, and attempts are made to alleviate any pain or distress they may experience. Yet an unborn child of the same gestational age, whose parents have chosen abortion, is offered no pain relief, presumably because this would bring the reality of what is being done to a defenceless human being into too sharp a focus.

Testifying before one of the US trials to determine the constitutionality of a ban on partial birth abortion, Oxford and Harvard trained neonatal paediatrician Professor Knawljeet Anand, certainly not a conventional pro-life activist, stated that: *"If the foetus is beyond 20 weeks of gestation, I would assume that there will be pain caused to the foetus. And I believe it will be severe and excruciating pain."*[10]

The number of services receiving payments under this item and the cost of these payments

Statistics show 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[11]. Given the comparatively small number of intra-uterine fetal deaths, nearly all of these procedures would have been second trimester and late term abortions.

The basis upon which payments of benefits are made under this item

As noted above, ACL is concerned that the Item is being interpreted far more broadly than originally intended. The Item is intended to cover the management of second trimester labour with or without induction, for three specific reasons, namely:

[10] Evidence supplied by Dr. Anand is summarised from page 196 of the Carhart v Ashcroft court ruling.
[11] Medicare Benefits Schedule (MBS) Item Statistics Reports at:
http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml
services under Item 16525 from 1994-2007 by State

- intrauterine fetal death;
- gross fetal abnormality; or
- life threatening maternal disease.

The first is relatively clear-cut. If the child dies in the womb then of course it must be delivered to protect the mother. This is not abortion, but rather management of a terribly sad event. However, ACL is concerned about the wide interpretations of the second two reasons covered by the Item. Though not officially included under the Item number, there is good evidence that many late abortions are being performed for psychosocial reasons alone.

Gross fetal abnormality

Gross fetal abnormality is an ill-defined term and its application seems left to the discretion of each individual abortionist. There is evidence that the term is being used to abort children with minor abnormalities that can be corrected with surgery. For example, research shows that correctable conditions like cleft palate or hair lip or conditions which are compatible with a reasonable quality of life such as missing fingers, Down Syndrome, or dwarfism are being treated as 'gross fetal abnormalities' and used as grounds for abortion under this Item[12]. 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[13].

The unspoken philosophy behind allowing abortion for reasons of abnormality is one of eugenics: a less than perfect baby should not be born. ACL utterly opposes this philosophy, believing that all people are of inherent and equal moral value, irrespective of their physical or mental state.

However, where a fetus has a lethal abnormality and would not be expected to survive once born, we would accept a new Medicare Item number to provide funding for abortions in these very rare circumstances though we would still also wish to see support for parents who wished to continue the pregnancy and deliver their child.

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[12] 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; Senate Community Affairs Legislation Committee Answers To Estimates Questions On Notice Health And Ageing Portfolio Supplementary Budget Estimates 2004-2005, November 2004 Question: E04-043

[13] Riley, M. and Halliday J. *Birth Defects in Victoria 2003–2004*, Victorian Perinatal Data Collection Unit, Public Health, Department of Human Services Victoria, 2000. http://www.health.vic.gov.au/perinatal/downloads/bdr_report0304.pdf

Life-threatening maternal disease

ACL considers the loss of the unborn child through medical intervention acceptable in those very rare cases where there is a genuine and unavoidable choice to be made between the life of the mother and the life of the child. The intent here is not to terminate the life of the fetus but to preserve the life of the mother: better one life saved than two lives lost. ACL would support the introduction of a new Medicare Item number to cover this exceptional circumstance where there is a genuine and unequivocal risk to the life of the mother and the only way of saving her is to end the life of her unborn child.

However, it must be noted that, particularly later in pregnancy, it is very rarely necessary to make this terrible choice. The baby can be delivered alive, protecting both mother and child. The child's survival may not be assured if it is born very prematurely but it should at least be given every opportunity to live.

Sadly, 'life threatening maternal disease' is far too easily used to claim Medicare funding for abortions performed for psychosocial reasons, including economic reasons. Indeed, the Victorian data reveals that there were no terminations performed for reasons of the mother's physical health.

Late abortions for psychosocial reasons

Alarmingly, it seems that, despite the terms of the Item, the reality is that late-term abortion is often available for any reason.

At 23-27 weeks of pregnancy, *the age at which other premature babies are being routinely cared for in the hospital nursery*, the Victorian records for 2005 show 108 healthy babies terminated for 'psychosocial' reasons – and only 23 terminated for congenital abnormality[14].

The term 'psychosocial' means there is no medical problem with the mother or the baby, but the parents request abortion because of economic or emotional stress. Victorian data shows that the majority of late abortions are for 'psychosocial' reasons, not fetal abnormality or maternal health.

We know about this practice from many sources. The most recent data is from the Victorian Health Department's 2005 survey of perinatal deaths.[15] Importantly, this report shows that

[14] Consultative Council on Obstetric and Paediatric Mortality and Morbidity, p13 http://www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep05.pdf

public hospitals almost never perform late abortion for 'psychosocial' reasons. Since 2001, of the 581 late abortions done for psychosocial reasons, only 4 were done in a public hospital; the rest were performed by private operators, whose primary motivation is to make a profit from abortions, not to secure the welfare of the mother or child.

Therefore, the current Medicare provision mandates that the public pay, with their taxes, for private operators, principally abortion clinics, to abort healthy babies of healthy mothers, beyond the age at which these babies could have been cared for in our hospital nurseries. Remember, the age at which prematurely born babies can survive is as early as 23 weeks, with the youngest known survivor born under 22 weeks. Our supporters object most strongly to this abhorrent practice.

The effects of disallowing this item

The effect of this motion, if it is successful, will be to end taxpayer funding of second trimester and late term abortions through Medicare. It is already the case that Medicare does not provide funding for third trimester abortions (abortions after 26 weeks of pregnancy), though they are lawful under certain conditions in some States.

It is important to note that it is the public funding of late term abortions that will end, not the availability itself. If permitted under state laws, late term abortion will still be available but at personal, not public, cost. The public signal will be that abortion beyond a certain date is not considered acceptable enough to be publicly subsidised, though it will remain available if state parliaments permit it, and if pregnant women choose to fund it themselves.

We acknowledge concerns about unintended consequences of disallowing this Item – that it might affect funding for cases of medical conditions in the mother requiring induction of labour prior to 26 weeks, or cases of tragic lethal conditions in the baby such as anencephaly.

As noted throughout this submission, ACL is conscious of some unintended consequences if Medicare funding is removed for all abortions in the second trimester. We therefore accept the introduction of tightly worded and enforced new Item numbers to address situations of:

- lethal fetal abnormality;

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[15] Consultative Council on Obstetric and Paediatric Mortality and Morbidity. See section "Perinatal Mortality Review 2005" especially pp 1,3,13 and following, at http://www.health.vic.gov.au/perinatal/downloads/ccopmm_annrep05.pdf

- unequivocal risk to the life of the mother;
- intrauterine death.

We would hope that such exceptions could be provided for in new Item numbers concurrently, or as quickly as possible after the disallowance motion is passed.

Conclusion

In conclusion, ACL strongly supports the motion to disallow Medicare funding of second-trimester and late-term abortions, though we accept the need for the introduction of new Item numbers to cover those very rare cases outlined above.

We maintain that there are very, very few scenarios where the only option is to end the life of the unborn child. Psychosocial reasons are being used to justify hundreds of abortions per year of healthy babies of healthy mothers. These children deserve their chance of life, irrespective of a change in their parents' circumstances or the discovery of a potential abnormality. The age of viability is steadily reducing as developments in neonatal medicine mean that many very premature babies can survive outside the womb. Many Australian couples are also waiting to adopt, meaning that this option should be pursued for parents who decide, late in pregnancy, that they cannot raise a child themselves.

We must cease to accept the fallacy that an unborn child deserves recognition if its parents want it but can be aborted with public money if its parents so choose. Ending Medicare funding of second-trimester or late-term abortions, whilst introducing new item numbers to cover very rare cases of genuine need, would send such a signal.

ACL National Office
October 2008