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

7 October 2008

Dear Ms McDonald

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

Thank you for your invitation to provide a submission to this inquiry. Women's Forum Australia (WFA) is an independent women's think tank that conducts research, education and public policy development about social, economic, health and cultural issues that affect women.

WFA advocates an evidence based approach to the issue of abortion, with a focus on the significance of abortion for women. In 2005 we published a research paper, *Women and Abortion: an Evidence Based Review* which is a critical appraisal of the international research about the reasons women have abortions and the associated physical and psychological health impacts. We seek social policy initiatives that might support women who are pregnant in difficult circumstances and offer them choices other than abortion.

We note that item 16525 relates to the management of second trimester labour, including intrauterine fetal death. We note the objective of Senator's Barnett's Motion of Disallowance which prompted this Inquiry is to prohibit Medicare funding for second trimester and late term abortions which are also funded under item 16525.

Summary of this submission

This submission is in two parts:

In Part 1 we examine the impact of abortion on women. We outline the research about the negative health impacts of abortion on women including late term abortion. We are also concerned about industry practices relating to abortion provision, with significant evidence of lack of information for women considering abortion, inadequate counselling, pressure and coercion. We question the practice of abortion for fetal abnormality. Because of documented adverse

impacts on women, WFA seeks strategies that would reduce the rate of abortion – including second trimester and late term abortion.

In Part 2 we suggest some strategies that might reduce abortion and in particular we argue for a response to which recognises the conditions that often lead women to undergo abortion and seeks to address those. Our research leads us to conclude that women who have second trimester and late term abortions do so under difficult circumstances, including concerns about suspected fetal abnormality, relationship breakdown, psychological distress and disturbance, and lack of financial and personal support.

Any response to the issue of second trimester and late term abortion must acknowledge these personal, economic and social conditions that militate against genuine choice for many women. Thus we call for an examination of the practical ways the Legislature and the community can support women and families in these situations and restore women's freedom to choose motherhood.

1. The Impact of Abortion on Women

Health risks

Evidence is well established that abortion causes negative health outcomes for significant numbers of women. There are demonstrable physical and psychological risks associated with termination procedures.

In 2005 WFA published *Women and Abortion: An Evidence-Based Review*[1], a comprehensive evaluation of the international medical literature on the health impacts of abortion on women.

Our research found:

- There appear to be more deaths from all causes, including suicide and homicide, after abortion compared with childbirth.
- Abortion is associated with a variety of significant physical risks, including premature delivery, infection (which may lead to infertility, particularly in the presence of genital infection), uterine perforation, placenta previa, and possibly miscarriage and low birth weight in future pregnancies.

There is also substantial evidence of psychological harm associated with abortion:

- Ten to twenty percent of women suffer from severe negative psychological complications after abortion.
- Women experience a range of negative emotions after abortion including sadness, loneliness, shame, guilt, grief, doubt and regret.
- Depression and anxiety are experienced by substantial numbers of women after abortion.
- After abortion women have an increased risk of psychiatric problems including bipolar disorder, neurotic depression, depressive psychosis and schizophrenia.
- Women who have experienced abortion also have an increased risk of substance abuse and self-harm. This is particularly true during a subsequent pregnancy.

[1] Ewing, *Women and Abortion: an evidence-based review* (Sydney: Women's Forum Australia, 2005).

- Abortion for fetal disability is particularly traumatic and can be psychologically damaging for women.
- It is possible to identify a list of risk factors which put women at increased risk of psychological harm from abortion, for example a lack of emotional and social support, ambivalence and difficulty making the decision to abort, relationship violence, and a history of psychiatric illness.
- Clinical case studies and stories written and told by many women confirm these empirical findings regarding the psychological harms of abortion.

The body of international research demonstrating the harms of abortion to women continues to grow. A 2006 New Zealand study[2] tracked young women from birth to 25 years. It found that young women who had abortions were significantly more likely to experience subsequent depression, suicidal behaviour and substance abuse, even after the researchers controlled for previous mental health problems.

The Royal College of Psychiatrists in the UK has recently issued a statement that the evidence of these risks is such that women should be properly advised of it in pre-procedure counselling. They also urged proper acknowledgement of the risks to better provide for women who do have such reactions. [3]

Lack of information, inadequate counselling, pressure, coercion

Many women are poorly informed of these risks. A strong body of research has indicated that pressure and coercion, even violence, are real issues for many women considering terminations.[4] Strong ambivalence and a number of other factors have been found in the research to be associated with higher risks of serious psychological difficulties after termination.[5]

Lack of proper counselling and informed consent procedures, non presentation of alternatives and options and overall lack of safeguards to protect the health and safety of women have also been documented.[6]

Many women have not been afforded appropriate, accurate information and assistance to understand the nature of the procedure, physical and psychological risks and possible alternatives and sources of support. Women have been denied the opportunity for careful

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[2] D. M. Fergusson et al, 'Abortion in young women and subsequent mental health', *Journal of Child Psychology and Psychiatry* 47:1 (2006): 16-24.

[3] *Position Statement of the Royal College of Psychiatry UK on Women's Mental Health in Relation to Induced Abortion*, 14 March, 2008. The College highlights the risks indicating the importance of this evidence for informed consent and appropriate follow-up care.

[4] Ewing, *Women and Abortion*, discusses research on the reasons or motivations behind women who seek terminations and found that issues of pressure and coercion played an influential part for some. Anecdotal reporting of experiences of coercion and pressure are documented in Melinda Tankard Reist, *Giving Sorrow Words: Women's Stories of Grief after Abortion (*Sydney: Duffy & Snellgrove, 2000) and *Defiant Birth: Women who Resist Medical Eugenics* (Spinifex Press Australia 2006) and in a growing body of articles. Pregnancy loss counsellors report women seeking help for significant and sometimes even quite disabling psychological difficulties in Australia. The United States-based Justice Foundation's Operation Outcry has collected 3000 legally admissible affidavits from women in the US who testify to a range of negative experiences associated with their terminations. Included in these testimonies is frequent reference to pressure and coercion from family, partners or others. See www.justicefoundation.org.

[5] Ewing, *Women and Abortion*, 5-6.

[6] Tankard Reist, *Giving Sorrow Words* and *Defiant Birth.*

reflection or independent counselling assistance, separate from the abortion provider, to help with decision-making. [7]

The ability of women to access non-directive, unbiased counselling, in what is essentially a for-profit and unaccountable industry, is extremely limited. Pregnancy 'counselling' by abortion clinics, along with some family planning and related agencies, has often been more concerned with perfunctory appearances than with the genuine needs of women. A referral is not required and many clinics offer a walk-in, walk-out same day service. Potential negative ramifications for a woman's health are often minimised. There is no register to record adverse events.[8]

Lack of accountability and scrutiny

It is our position, based on strong evidence, that the practice of abortion in Australia lacks scrutiny. It is mostly an unregulated, unaccountable industry which does not act in the best interests of women in denying them information relevant to their future health and wellbeing. Abortion providers, even those with questionable records and operating outside medical and ethical requirements, have benefitted from Medicare funding. Some practitioners have been accused of rorting Medicare for early and late-term abortions. [9] This requires full investigation because it appears that the cases that have been reported on are not isolated incidents.

There has been a long-held but false assumption that providers are "regulated". The evidence provided by women themselves demonstrates that there appears to be very little real regulation and these providers are able to operate with impunity, except in the very rare instances where a woman takes legal action against them for injury and failure to warn.[10]

In 2004, WFA Director Melinda Tankard Reist documented the case of 16-year-old "Sarah" from Queensland, who required emergency life-saving treatment after an abortion at the Planned Parenthood clinic in Bowen Hills, Brisbane. She suffered a severed fallopian tube, a fist-sized hole in her uterus requiring 200 stitches, a torn bladder and bowel and had three inches of intestine emerging from her body when she arrived at hospital. Body parts – including the baby girl's head - had to be removed. Sarah's mother alleged her daughter had not been warned of any possible side effects from the procedure[11]

A more recent case involved a young Sydney woman who, after being administered abortion drugs to terminate her pregnancy at 23-weeks, delivered a live baby boy into a toilet. He died five hours later. It was alleged Dr Suman Sood did not inform the woman of the risks of this procedure, nor warn her of the possibility of a live birth. It emerged that many women had previously complained about botched and incomplete abortions, failure to warn of abortion risks or to provide counselling or trained staff. Sood's patients described an uncaring doctor who ran a substandard practice, with dirty beds and little or no follow-up care.[12]

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[7] Tankard Reist, *Giving Sorrow Words*.

[8] Tankard Reist, *Giving Sorrow Words*.

[9] 'Abortion clinic owner on trial over fee fraud'. *Sydney Morning Herald* 10 February, 2005. http://www.smh.com.au/news/National/Abortion-clinic-owner-on-trial-over-fee-fraud/2005/02/09/1107890274372.html; Revealed: the dark past of a guilty abortion doctor: History of misconduct, alleged kickbacks and malpractice claims, *Sydney Morning Herald* August 24, 2008, p.1

[10] A list of malpractice actions can be found in the references section of *Giving Sorrow Words:* 275-277.

[11] Melinda Tankard Reist. 'One mum's nightmare won't go away'. *Canberra Sunday Times* 14 November, 2004, p.30.

[12] Melinda Tankard Reist. 'Are abortionists a protected species?' *On Line Opinion* 18 December, 2006. http://www.onlineopinion.com.au/view.asp?article=4908

'Ellen' won an out of court settlement in 1998 for psychological trauma suffered following a late-term abortion at Melbourne's Royal Women's Hospital. She had returned home following the termination and delivered a dead baby into a toilet. [13]

Late term Abortion and Abortion for Fetal Abnormality

In *Defiant Birth*, Tankard Reist records the personal accounts of 19 women from around the world who resisted pressure to terminate on the basis of fetal abnormality. In a number of accounts, women refused medical advice to terminate and their babies were later born without any abnormalities or with less serious conditions than had been diagnosed. The book includes other accounts, including from women who underwent later-term abortions for eugenic reasons, and the subsequent trauma they experienced.

The book also cites significant research on the negative mental health consequences for women undergoing termination - especially late termination - on grounds of fetal disability. A 1993 study found that "women who terminate pregnancies for fetal anomalies experience grief as intense as those who experience spontaneous perinatal loss, and they may require similar clinical management."[14] Further negative impacts of abortion for foetal abnormality are documented in *Women and Abortion: An Evidence-Based Review*.[15]

Melbourne woman Natalie Withers was not prepared for what she would go through with the late termination of her fourth daughter. The baby had been diagnosed with heart problems and a condition causing her stomach and liver to reverse. Ms Withers said the procedure had only been discussed with her on the day she was due to be induced. She was told there would be two pills put into her cervix to induce labour and that it could take a few hours. Natalie says she ended up being administered eight to ten pills. Labour began on a Monday, and the baby was not delivered until Wednesday.[16]

It was only when she was in labour that it was explained to her that the baby might either be stillborn or might take a breath immediately after the birth. She recalls:

"I didn't realise at 20 weeks I would be handed a little person…The nurse said, 'do you want to look because it's not that nice [due to the damage done to the body during the induced labour]?' They put clothes on her but didn't wipe the blood off first, the clothes were stuck to the blood. A quick glimpse, and they took her away. Had we been encouraged to, we would have held her. We said no to an autopsy because we didn't want them to touch her. Against our wishes, they did an autopsy and I had to go in to the hospital for the post-mortem report."[17]

In retrospect Natalie realised she had "massive reservations" about an abortion but wasn't given time or space to air them. "A big part of the weight I carried was that we had to sign her life away. I would still have grieved at her dying [if we didn't abort and she died after birth], but I wouldn't be carrying the same weight. The burden you carry is too great," she said. Natalie has since learnt more about her daughter's condition and discovered that children with it can survive and do well with the right care.[18]

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[13] Tankard Reist, *Giving Sorrow Words,* 249.

[14] Zenah, et al. 'Do women grieve after termination pregnancies because of fetal anomalies?: a controlled investigation'. *Obstetrics and Gynaecology* 82, (1993): 270.

[15] Ewing, *Women and Abortion, 23-25.*

[16] Tankard Reist, *Giving Sorrow Words,* 12. Nathalie Withers, 'A mother's grief' *ABC Unleashed.* http://www.abc.net.au/unleashed/stories/s2359113.htm

[17] Tankard Reist, *Defiant Birth, 12.*

[18] Ibid.

Natalie Withers wrote about her distressing experience recently on *ABC Unleashed*.[19]

Who Defines Gross Fetal Abnormality?

Item number 16525 allows Medicare payments for "Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease". It is disturbing that "gross fetal abnormality" has never been defined. In Australia, most babies with Down's Syndrome are terminated.[20] .Down syndrome is not generally understood as a "gross fetal abnormality". Those with short stature also don't see themselves as having a "gross abnormality"[21], though babies suspected to have the condition have been terminated - even at 32-weeks gestation.[22]

It is known that terminations have been performed on babies with missing fingers, and even for correctible conditions such as cleft palate and hair lip.[23] . For example, n 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 conditions.[24]

Live Birth

Because women are not made aware that delivery of a live fetus can be a possibility in late-term abortion, the trauma of discovering this has happened can only compound the trauma of a termination at that stage.

One of the most prominent cases in recent times was that of 'Baby J' a female born alive after an abortion at 22 weeks performed in Darwin Private Hospital. She lived for 80 minutes.[25] Another case involved one described earlier, of a baby boy delivered alive into a toilet, following an abortion by Dr Suman Sood (who was also de-frauding Medicare).[26]

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[19]Withers, 'A mother's grief'. http://www.abc.net.au/unleashed/stories/s2359113.htm

[20] Samanthi Abeywardana and Elizabeth A. Sullivan, 'Congenital anomalies in Australia 2002-2003*'. Birth Anomalies Series* 3 (Sydney: AIHW National Perinatal Statistics Unit, 2008), 140. Also see 'QLD researchers claim down syndrome breakthrough', Radio Australia, 14 December, 2003. http://www.abc.net.au/ra/innovations/stories/s1010025.htm '...a survey in a Melbourne hospital shows that of 179 women diagnosed with Down Syndrome babies in utero, only 3 continued with their pregnancies. That translates to a termination rate of 98 percent.'

[21] Leisa Whitaker, 'I wouldn't swap them for anything' in Tankard Reist *Defiant Birth,* 212; Francis Allen, 'Shortness is not a death sentence', *The Age*, Letter to the editor, Melbourne 7 July, 2000, p.9.

[22] It is worth noting that Dr Lachlan de Crespigny, who performed the termination by injecting poison into the baby's heart before labour was induced, has been a prominent defender of doctors who perform late-term abortions. See Melinda Tankard Reist, 'No amount of hand-wringing can bring dead babies back after an abortion', *On Line Opinion,* 22 September, 2004. http://www.onlineopinion.com.au/view.asp?article=2560

[23]Melinda Tankard Reist, 'So what if the aborted baby cried', *On Line Opinion,* 9 November, 2004. http://www.onlineopinion.com.au/view.asp?article=2724

[24] M.Riley and J. Halliday, Birth defects in Victoria 2003-2004 (Melbourne: Victorian Perinatal data collection unit, Public health, Department of human services Victoria, 2006). http://www.health.vic.gov.au/perinatal/downloads/bdr_report0304.pdf See also, Queensland Legislative Assembly, *Hansard* (31 October 1995): 682, in which it is stated that Brisbane abortionist Dr. David Grundmann aborted a 23-week baby with cleft lip and palate.

[25] Findings of the Northern Territory Coroner: http://www.nt.gov.au/justice/courtsupp/coroner/findings/other/babyj.pdf

[26]Tankard Reist, 'Are abortionists a protected species?'. http://www.onlineopinion.com.au/view.asp?article=4908

2. Strategies to Support Women Faced With Pregnancies in Difficult Circumstances

Given the negative impacts of abortion on women outlined in Part 1 above, WFA supports the objective of reducing the rate of abortion. Any Legislature which wants to address the rate of abortion and claims to care about women and which also wishes to find the best ways of allocating public monies, must understand the reasons women have abortions in the first place.

Why do women have abortions?

Research has established some of the motivations underlying abortion decisions. We refer the Committee to pages 2 – 11 of *Women and Abortion: An Evidence Based Review* which details these findings:[27]

- Many abortion decisions are motivated by a lack of emotional, social and material support.
- Research does not support the idea that abortion is always for 'unintended' or 'unwanted' pregnancies.
- Financial concerns are one of the most common motivators for abortion.
- Many women believe that continuing with a pregnancy will jeopardise their plans for work and study. This suggests that schools, universities and workplaces are generally unsupportive of pregnant women and mothers.
- Women have concerns about becoming single mothers, suggesting a lack of support from men in many cases, and a lack of community support for single motherhood.
- In the case of suspected fetal abnormality, the commonly noted lack of support for carers of people with disabilities
- Abortion is strongly associated with domestic violence and abuse of women.
- Poor-quality intimate relationships motivate many women to seek abortion.
- Depression and other types of mental illness during pregnancy which can affect decision making capacity

In sum, the research demonstrates that many women believe abortion is their only choice because their real needs remain unaddressed.

We recommend the Committee consider the circumstances which often compel women to undergo termination, such as discrimination, violence, lack of support, paid leave, child care, work flexibility, addressing financial pressures and providing more support for relationships, which would make a real and significant difference in the lives of many women.

In the case of suspected fetal disability, we would also recommend specific initiatives to assist pregnant women and families facing these difficult circumstances and to support the option of completing the pregnancies:

- Additional Medicare items to cover extended counselling sessions with a range of specialist health providers such as health professionals who care for children with the diagnosed condition, to enable couples to have a better understanding of the condition and what is required to assist.. Anecdotally, Women's Forum Australia has heard from doctors who express frustration with the reality that GPs can't afford the time to counsel women properly in these situations.

[27] Ewing, *Women and Abortion.*

- Women and couples should be able to access Medicare for a second medical opinion and independent counselling by professionals. They also deserve and have a right to expect information about alternatives to abortion, the opportunity to meet parents who are bringing up children with the same condition and contact details for disability support groups.

- Generally there is growing community awareness of the pressing need for increased practical support and resources for people with a disability and those who care for them. Many families of children with disabilities report long waiting lists for supported accommodation and respite care. Governments need to do more to provide for families with a disabled or sick family member.

Thank you for the opportunity to comment. We look forward to the Committee's final report.

Yours sincerely

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Enclosures:
- *Women and Abortion: An Evidence-Based Review*