27 October 2008

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

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

Medicare ensures that all Australians have access to free or low-cost medical, optometrical and hospital care while being free to choose private health services and in special circumstances allied health services.

Medicare provides access to:

- *free treatment as a public (Medicare) patient in a public hospital*
- *free or subsidised treatment by practitioners such as doctors, including specialists, participating optometrists or dentists (specified services only)*

Australia's public hospital system is jointly funded by the Australian Government and state and territory governments and is administered by state and territory health departments.

Medicare enrolments and medical benefit payments are administered by Medicare Australia through its network of Medicare offices and other information claiming services.

The Medicare Benefits Schedule (MBS) items are developed by committees with specific expertise who consider in detail the health needs of all in the community. It would seem counter productive for particular item numbers in the MBS to be "cherry picked" by some in the community who are pursuing a moral religious construct to financially disadvantage women who have chosen to be cared for by the doctor of their choice in the private health system and then make it necessary for them to access the public system.

In May 2008 a paper was published in Reproductive Health Matters, Reasons for second trimester abortions in England and Wales.[1] This paper outlines the reasons why women present late for termination and suggests ways in which public education, policy development and service provision might be used to bring about change.

RANZCOG believes that termination of pregnancy is a health issue and that women, after consultation with their doctors and family members, must be able to make choices about termination that are appropriate for themselves and their families, taking into consideration their personal medical problems family commitments and socioeconomic circumstances.

The College supports equity in health care and the ability of women to make choices in regard to care at a time in their lives when they are particularly vulnerable. It is hoped that the Government has a commitment to better maternal health outcomes with a focus on the health of Australian families rather than to pursuing issues bought forward by senators with a moral agenda the intention of which is to restrict access to Medicare in the hope that this will reduce the number of mid-trimester terminations of pregnancy being undertaken. Manipulation of the Medicare schedule to limit access to a lawful procedure is unacceptable.

Rates of termination of pregnancy in Australia are poorly documented. It is known that 16525 is used for services that manage fetal death in utero, miscarriage and life threatening maternal

disease in the second trimester, it is therefore difficult to extrapolate the use of item 16525 for termination of pregnancy when it is not known if the procedure is induced or spontaneous.

South Australia conducts the only reliable termination of pregnancy data collection, recording all instances of termination of pregnancy. In 2006 SA reported 4,888 terminations of pregnancies (91.1%) that were performed within the first 14 weeks of pregnancy and only 78 (1.5%) that were late terminations (at or after 20 weeks gestation). Fifty-one percent of these late terminations were for major fetal abnormalities[2]. International data[3,4,5] and data from Victoria[6] suggest that termination after 20 weeks gestation amounts to 1% of all terminations performed.

Because of such small numbers the cost to Medicare of providing this care is small.

In Australia most second trimester terminations are performed in public hospitals, for these, the 16525 item is not used but the jurisdictions and indirectly the federal government supports these services in that they fund the public hospital system. Practitioners caring for private patients use this item number when providing services for women in private hospitals or alternatively for private patients being cared for in public hospitals.

The effects of disallowing this item

It would be extraordinary if benefits for the legal and medically indicated management of labour in the second trimester were not payable. The consequences of this would be harmful to women in many ways:

1. They would face higher costs for the service (which is in any case going to be performed, and is often urgently needed) if they wish to continue under the care of a private practitioner who is already known to them, who may have cared for them in previous pregnancies and who has certainly been involved in their care in the current pregnancy.

2. Those women who cannot afford to continue care in the private system will be forced to seek late termination in the public system, placing pressure on public hospitals which are already stretched and under-resourced. These women are already greatly stressed by the events and investigations, including the diagnosis of major fetal abnormality, that have led them to the difficult decision to terminate the pregnancy (or, in the case where the fetus has died in utero, to the knowledge that they will not give birth to a live baby.)

3. Women are likely to experience delays in negotiating the system while seeking the public hospital services they require at a time when they are distressed and vulnerable.

4. Poor health outcomes both psychological and physical will result from the increased stress placed on women, and this will add to the burden on other health services.

5. Families will inevitably suffer due to loss of income, travel and child care expenses.

6. Delays would have adverse health outcomes especially in the presence of infection, antepartum haemorrhage (bleeding from the placental site which frequently accompanies the death of a fetus in utero in the second trimester of pregnancy) and pre-eclampsia. These are all common obstetric complications that may lead to the need to terminate a pregnancy in the second trimester.

7. Indigenous women and women living in rural and remote communities would be especially disadvantaged, with the problems already noted added to their acknowledged geographic and financial disadvantage in accessing termination of pregnancy services.

8. Women would experience added distress knowing that they have paid the Medicare levy from their own and their partners' wages only to be denied benefits for a legal and medically indicated procedure

9. Women may resort to home / backyard attempts at self abortion resulting in the need for additional health services. It is known that the drug misoprostol, which is used, safely and legally in Australian hospitals for the medical termination of pregnancy, is easily accessible on the Internet.

10. It would be discriminatory against women potentially denying them the care that they need.

RANZCOG would like the inquiry to consider promoting the following: -

1. Active public health education campaigns in schools directed at young people on sex education and education about the prevention of sexually transmitted infections.

2. Consideration of the MBS rebate on item 16525 with a view to increasing the rebate

3. Consideration of the initiatives put in place in the Netherlands that have subsequently reduced the need for TOP services and reduced the rate of teen pregnancies to the lowest in Europe[5]

References

1. Ingham R, Lee E, Clements SJ, Stone N. Reasons for second trimester abortions in England and Wales. Reprod Health Matters. 2008 May;16(31 Suppl):18-29. Centre for Sexual Health Research, School of Psychology, University of Southampton, Southampton, UK. ri@soton.ac.uk

2. Pregnancy Outcome Unit, 'Pregnancy outcome in South Australia 2006' Government of South Australia, Health Department 2007.

3. The facts on late abortions in Canada http://www.arcc-cdac.ca/action/bill_c338.html#facts

4. Department of Health UK, Abortion statistics: England and Wales: 2007

5. Q & A Abortion A Guide to Dutch Policy
http://www.nlembassy.org.yu/downloads/ethical/abortion_policy.pdf

6. The Consultative Council on Obstetric and Paediatric Mortality and Morbidity Annual report for 2006 Melbourne

Dr Christine Tippett
President
RANZCOG (Royal Australian and New Zealand College of Obstetricians and Gynaecologists)
254-260 Albert St
East Melbourne Victoria 3002
Australia
http://www.ranzcog.edu.au