Chapter 4

Effects of disallowance of item 16525: evidence in support of continued funding

4.1 This chapter considers the effects of a disallowance of item 16525 in Part 3 of the Schedule to the Health Insurance (General Medical Services Table) Regulations 2007 (item 16525) with focus on evidence in support of continued funding.

4.2 Submitters in favour of continued funding under item 16525 stated that services performed under the item were clinically relevant and lawful.[1] Many such witnesses maintained that disallowance of the item would have serious negative health and financial repercussions whilst limiting the accessibility and affordability of publicly funded health services for the 'small proportion of women faced with a difficult and distressing circumstance'.[2]

Services provided under item 16525 in Part 3 of the Schedule

4.3 Services provided under item 16525 relate to both spontaneous abortion (miscarriage) and medical or induced abortion (termination).[3] The National Association of Specialist Obstetricians and Gynaecologists noted that item 16525 would apply to women who 'are spontaneously miscarrying or are in spontaneous premature labour associated with the relevant clinical conditions'.[4]

4.4 The Australian Medical Association (AMA) stated that item 16525 provides a rebate for the 'surgical treatment of non-viable pregnancies' which may be required in a broad range of circumstances. According to the AMA, in all situations for which item 16525 procedures apply, 'the women have lost, or are losing their baby'.[5]

4.5 Dr Sally Cockburn elaborated on the circumstances of the termination services provided under item 16525:

> 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

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1 Rural Doctors Association of Australia, *Submission 426*; Dr Sally Cockburn, *Submission 189*; National Foundation for Australian Women, *Submission 188*; Health Services Commissioner, Victoria, *Submission 205*; RANZCOG, *Submission 523*, p.1.

2 Family Planning Queensland, *Submission 201*, p.2. See also, The Royal Women's Hospital, *Submission 196,* 1; The Royal Australasian College of Physicians, *Submission 217*, p.1; Health Services Commissioner, Victoria, *Submission 205*, pp3–4.

3 Department of Health and Ageing, *Submission 218*, p.2.

4 The National Association of Specialist Obstetricians and Gynaecologists, *Submission 427*, p.3.

5 Australian Medical Association, *Submission 191*, p.1.

> evacuated for reasons of a maternal health crisis or a serious abnormality has been diagnosed in foetal development and the women has requested termination of her pregnancy, obviously in situations permitted under the particular State law.[6]

4.6 The Royal Australasian College of Physicians maintained that second trimester termination was an essential part of antenatal services:

> While in our experience second trimester termination is always a difficult decision, and never undertaken lightly, it is still a service that is essential to the range of antenatal services available to women in order to protect their safety and health.[7]

Intrauterine fetal death

4.7 According to Family Planning NSW in cases where the fetus has died in utero, the pregnancy does not always spontaneously abort and it may be necessary to induce the termination of such a pregnancy.[8] This position is supported by other witnesses before the committee including Dr Cockburn who stated of item 16525:

> 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 a woman can result. Induction of labour for this purpose is considered a safe procedure even after 24 weeks.[9]

4.8 Associate Professor Lachlan de Crespigny and Dr Susie Allanson maintained that untreated intrauterine fetal death risks complications including infection and clotting disorders which can potentially cause serious risk to the health and even the life of the pregnant women involved.[10] Similarly, Dr Cockburn stated that delaying the evaluation of the gravid uterus following fetal death in utero 'increases the risk of maternal bleeding disorders' which can be 'fatal'.[11]

Gross fetal abnormality

4.9 Dr Peter Rischbieth from the Rural Doctors Association of Australia described gross fetal abnormality as a 'situation where there is an abnormality which will be incompatible with a long life':

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6 Dr Sally Cockburn, *Submission 189*, p.6.

7 Royal Australasian College of Physicians, *Submission 217*, p.1.

8 Family Planning NSW, *Submission 182*, p.3.

9 Dr Sally Cockburn, *Submission 189*, pp12–13.

10 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.3.

11 Dr Sally Cockburn, *Submission 189*, p.16.

> They may mean major heart, brain, kidney, stomach and digestive tract organ dysfunction which may be diagnosable using ultrasound techniques during pregnancy. Or significant genetic abnormalities that can be discovered on amniocentesis.[12]

4.10 Professor David Ellwood commented:

> Gross refers to the degree. One of my roles at the Canberra Hospital is chair of the Clinical Ethics Committee. I can say to you with all honesty that virtually all cases of late termination of pregnancy are either for conditions which are incompatible with extra-uterine life or where the foetal condition would be associated with very severe disability after birth.[13]

4.11 A number of submissions highlighted that the nature of fetal abnormalities, screening and diagnostic testing meant that cases of gross fetal abnormality were often not able to be diagnosed until the second trimester.[14] This was explained by Associate Professor de Crespigny and Dr Allanson:

> Reliable screening does not occur in early pregnancy but occurs at late gestation, may require repeat tests and may involve the woman and her family taking time to make a decision.[15]

4.12 SHine SA elaborated further:

> Amniocentesis, which is an invasive diagnostic test, is generally carried out at 15 – 18 weeks gestation and sometimes later. Receiving accurate results from this test generally requires two weeks. Sometimes amniocentesis needs to be repeated if the original sample was inadequate. This leaves women well into the second trimester of pregnancy contemplating a termination of the pregnancy for foetal abnormality, which is a difficult and sad decision to have to make. Women require access to safe services in this situation, whether they are public or private obstetric patients.[16]

4.13 Any delay in diagnosis of fetal abnormality will result in a delay in accessing termination services. Of diagnostic testing, Family Planning NSW stated:

> Women with a family history of genetic abnormality and older women are usually offered the opportunity for testing for chromosomal abnormalities during pregnancy, so that a decision can be made by the couple whether to continue the pregnancy in order to have a healthy baby. In some cases, unexpected sporadic abnormalities come to light on routine antenatal testing during the pregnancy. Of necessity, many of these diagnoses can

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12 Dr Peter Rischbieth, Rural Doctors Association of Australia, *Committee Hansard*, 30.10.08, p.20.

13 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.104.

14 The Royal Women's Hospital, *Submission 196*, p. 2; Dr Sally Cockburn, *Submission 189*, p.13; Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

15 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

16 SHine SA, *Submission 92*, p.3.

> only be made after the first trimester. While some may argue that there is never a reason to terminate a pregnancy, no matter how severe the abnormality, the Australian health care model aims to place the pregnant couple in the best possible position to have a positive outcome for their pregnancy. Careful and considered counselling, correct diagnosis and decision-making takes time. Many diagnoses will not be possible until well into or at the end of the second trimester, making a termination later than 14 weeks the only option for these couples.[17]

4.14 Dr Christine Tippett from RANZCOG also commented that currently in Australia 80 to 90 per cent of women have a mid-trimester ultrasound scan which is funded by Medicare. If an abnormality is detected there is an expectation that 'they will have a choice to terminate the pregnancy or not to continue the pregnancy'. Dr Tippett went on to state:

> Over 85 per cent of women have Down syndrome screening. This is provided and supported by federal and state government funding on the understanding those women may choose to terminate a pregnancy afterwards. On the one hand we are providing women with access to diagnostic imaging and to different diagnostic tests on the expectation that they will have a choice whether or not to continue a pregnancy.
>
> It seems to me to be somewhat contrary to then say, 'We have picked up an abnormality. You have decided that for you and for your family this is a major abnormality that will adversely impact on your child and your child's life and you have decided to terminate the pregnancy. Sorry but we do not think that is right. We have decided that these abnormalities are okay and these are not—so we will fund some and not the others.' I do not think that is very logical.[18]

4.15 Dr Cockburn noted that in some instances of gross fetal abnormality or where a woman's life is threatened by a medical condition if the pregnancy at a gestation below 22 weeks continues, women may request to have their pregnancy terminated but not for an abortion per se. Dr Cockburn explained that this is a 'plea from distressed parents that they may hold their hopelessly premature or abnormal baby before it dies'.[19]

4.16 The Atheist Foundation of Australia took the view that:

> Political assessment of what constitutes severe foetal abnormality is inappropriate. The pregnant female is in the best position to decide, on advice from the medical profession, whether or not to continue with the pregnancy.[20]

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17 Family Planning NSW, *Submission 182*, pp2–3.

18 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.83

19 According to Dr Cockburn, those born at 22 weeks or earlier have no chance of survival. Dr Sally Cockburn, *Submission 189*, pp6–7.

20 Atheist Foundation of Australia Inc, *Submission 183*, p.2.

Life threatening maternal disease

4.17 The Department of Health and Ageing noted in its submission that examples of life threatening maternal conditions that pregnant women may experience include premature rupture of the membranes with infection, severe antepartum haemorrhage, severe pre-eclampsia, pulmonary hypertension and cyanotic heart disease.[21]

4.18 In relation to item 16525 services provided under this category, Dr Cockburn stated:

> It is even more difficult to dispute the clinical relevance of the need to have an MBS item number covering the situation where a woman requires termination of her pregnancy to save her in a serious medical crisis.[22]

Psychosocial indications

4.19 Contrary to the view that 'psychosocial indications' (PS) are commonly utilised as the basis on which medical terminations of pregnancy are carried out under item 16525, a number of submitters held that termination services provided under the item number are carried out primarily for reasons other than psychosocial. President of the Women's Hospitals Australasia, Professor David Ellwood, stated before the committee:

> Many women find themselves making a very difficult choice about termination of pregnancy in the second trimester, for reasons that are beyond their control—primarily to do with the inability to diagnose many serious foetal conditions or, indeed, many serious maternal illnesses until well into the second trimester.[23]

4.20 Professor Ellwood went on to state that 'it is extremely uncommon for there to be a request for termination of pregnancy beyond 20 weeks outside of this qualifier—foetal death, gross foetal abnormality or life-threatening maternal disease'. Furthermore 'about the only circumstance in which second trimester induction of labour is carried out because of life-threatening maternal disease is where it is truly life-threatening'. Professor Ellwood concluded:

> I do not think changing the wording would change practice at all because clinical practice around that qualifier really is limited to life-threatening maternal disease.[24]

4.21 Dr Andrew Pesce from the National Association of Specialist Obstetricians and Gynaecologists, stated in evidence:

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21 Department of Health and Ageing, *Submission 218*, p. 4.

22 Dr Sally Cockburn, *Submission 189*, p.13.

23 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.100.

24 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.105.

> The vast majority of requests for termination of pregnancy at this later stage of pregnancy occur for two reasons. Firstly, there might be an antenatal diagnosis of a significant foetal abnormality. There is increasing use of nuchal translucency and serum screening for Down syndrome, which when offered to women is very, very highly taken up. Probably about 95 per cent of women who are offered it will take the opportunity. Secondly, at the 18- to 20-week ultrasound scan when a woman goes to see how the baby is developing, there may be diagnosis of a major congenital heart problem or a major renal problem—something which sometimes is incompatible with life and sometimes could be compatible with life but with major disability and multiple surgeries. Women agonise about these decisions. They have to think about the children they have and what they are going to be going through and about the multiple surgeries which are required to correct congenital heart problems. I just cannot fathom how people can say that this is just some disorganised bimbo who has decided she is going to have a termination at 20 weeks. I am sure it happens, but the vast majority of the time that is not the case.[25]

4.22 Similarly, Dr Peter Rischbieth of the Rural Doctors Association of Australia held that:

> My understanding is that the decision to go ahead to have a termination is made if the continuation of the pregnancy may cause significant harm to either the foetus or the maternal health. There would be very few areas where the psychosocial aspects would be a key reason for a termination to be sought.[26]

4.23 Furthermore, the National Association of Specialist Obstetricians and Gynaecologists noted in its submission that there are 'no reliable data to determine the extent to which termination of pregnancy for PS indications contributes to the utilisation of 16525'.[27] The Family Planning Association of Western Australia stated in relation to such claims:

> Contrary to the view Senator Barnett made in his speech to the Senate on 24 June 2008, where he stated, "Late abortions are being done for 'maternal psychosocial reasons', which in reality means abortion on request", our experience is that women have to traverse, at times several legal and medical hurdles before they can have an abortion. The phrase 'abortion on request' negates the process a woman goes through when deciding her options and is an emotive phrase used by the anti-choice movement. There is a plethora of evidence that reports women take seriously their decision whether to continue with or terminate their pregnancy. Likewise there is strong evidence that where a woman has access to legal and safe abortion

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25 Dr Andrew Pesce, National Association of Specialist Obstetricians and Gynaecologists, *Committee Hansard*, 29.10.08, p.102.

26 Dr Peter Rischbieth, Rural Doctors Association of Australia, *Committee Hansard*, 30 October 2008, p.17.

27 National Association of Specialist Obstetricians and Gynaecologists, *Submission 427*, p.3.

> and makes her decision voluntarily, there is less immediate or long lasting psychological impact.[28]

4.24 Quoting 2006 data, Ms Letitia Nixon, Manager of SHine SA noted that of post 20 week gestation terminations in South Australia for example:

> There is a very small number—0.7 per cent—that might have been done for psychosocial reasons; primarily it is for maternal health conditions, foetal abnormalities or foetal conditions that are incompatible with life.[29]

4.25 It was also noted that in relation to Victoria, where the number of terminations for psychosocial indications are highest, there were 150 terminations of pregnancy of 20 to 27 weeks gestation for 'maternal psychosocial indications' undertaken in 2006. Of the 150, 90 such procedures (or 60 per cent) were carried out for interstate and overseas residents.[30] Associate Professor Lachlan de Crespigny informed the committee of the Victorian context:

> Data is available from 20 weeks, and that shows that almost three-quarters of the post-20 week terminations on Victorian women are for the diagnosis of foetal abnormality and something a little above a quarter for psychosocial reasons. They are classified as either one or the other. It is a simple classification. The situation is that terminations later in pregnancy, variously defined, are available in a very limited way across the country. So, even when termination is lawful, access can be extremely poor in many parts of the country and many parts of the state as well such that there is a group of women from around the country and even overseas who seek services in Victoria. So I think the Victorian and the non-Victorian figures need to be pulled apart to get any reasonable assessment of that. So, yes, there are psychosocial terminations done post 20 weeks, but it is the minority when one considers Victorian women.[31]

4.26 In relation to the seriousness of conditions under which the classification 'psychosocial' applies under item 16525 of the MBS, Dr Sally Cockburn stated:

> The word 'psychosocial' can be many things but in order to make a claim under this item number the psychosocial condition would have to be life-threatening for the mother.
>
> If you ask, 'What psychosocial conditions could be life-threatening?' some examples could be suicide, homicide—although you would hope you would be able to take her out of that sort of situation—or maybe a severe psychiatric condition that required medication that could be harmful to the foetus. But I think the term 'psychosocial' has been, if I may say so, bandied about as if it might be that I would like to buy a new pair of shoes to wear

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28 Family Planning Association of Western Australia, *Submission 194*, p.1.

29 Ms Letitia Nixon, SHine SA, *Committee Hansard*, 29.10.08, p.36.

30 The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Annual Report for the Year 2006*, p.13.

31 Associate Professor Lachlan de Crespigny, *Committee Hansard*, 30.10.08, p.24.

> to the Cup. I have to say that in my experience in medicine I have never met a woman or seen a woman who would ever decide to terminate her pregnancy for a reason of a trivial nature. I would really like to put that on the record, because these are real people we are talking about, people who are probably watching us right now, and I think that they would be insulted to think that we are saying that maybe they will do it because they do not fit into their dress for the Cup.[32]

Clinically relevant

4.27 A number of witnesses before the committee maintained that services carried out under the item number were 'clinically relevant'. When questioned about the rigour applied to ensure that such services are 'clinically relevant', Mr Colin Bridge of Medicare Australia informed the committee:

> There is a process involving a separate agency, which is the Professional Services Review. Should, in the course of our examination of any medical Medicare item, we develop concerns about that particular issue, our role is to refer it to the Professional Services Review. The Professional Services Review is an agency within the department of health which has a range of powers to undertake investigation of that particular point, including, potentially, peer review.[33]

4.28 Mr Bridge further clarified, that from Medicare Australia's records, 'we have not been able to find any cases of that sort being referred from us or issues we have raised over the last 10 years'.[34]

Termination methods

4.29 Professor David Ellwood commented on termination methods and stated that from his knowledge of practices in the tertiary women's hospitals country, the only method used is one that induces labour. Professor Ellwood went on to note that 'I think the reference to partial birth abortions would be restricted to the private sector and, as far as I am aware, it is restricted to one clinic'.[35]

4.30 Dr Christine Tippett also commented on termination methods:

> I think there is a great deal of misunderstanding, too, about how pregnancy terminations and late pregnancy terminations are undertaken. There has been comment made and pictures shown—once again referring to Victoria—of procedures that I, in 30 years of practice, have never heard of

32 Dr Sally Cockburn, *Committee Hansard*, 30 October 2008, pp59–60.

33 Mr Colin Bridge, Medicare Australia, *Committee Hansard*, 29.10.08, p.22.

34 Mr Colin Bridge, Medicare Australia, *Committee Hansard*, 29.10.08, p.23.

35 Professor David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.104

> being done. I had to inquire as to what they were because I was unfamiliar with them. I have worked for a long time in the public system.[36]

4.31 In relation to practices in private clinics, Dr Tippett commented on one clinic in Victoria where a significant number of late terminations are undertaken and stated:

> That is the most regulated medical clinic in Victoria. There have been case reviews, and it has been looked at very carefully. I have a very good working knowledge of how that clinic works and I think it does provide a service for women. It does mean those women are not in the public system, and I think it provides a very valuable service.[37]

4.32 Dr Tippett also commented on the term 'left to die' and stated:

> I think it is a very unfortunate term, and I feel some disquiet that it has been used so generally here. If a pregnancy is terminated and the baby has the capacity to be born alive, and that can happen any time after 14 or 15 weeks, those babies will die if they are not given supportive care. As you get closer to 24 weeks they will take longer to die than if the pregnancy is terminated sooner.
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> Those babies will die from hypoxia because they cannot breathe, they cannot get oxygen to their brain and although we think there is no difference in the way foetuses or babies of this gestation experience pain, in fact those babies are hypoxic just like an adult who becomes hypoxic and effectively unconscious and unaware of what is going on around them. I think one can be confident that these babies do not suffer.
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> Secondly, where those babies are cared for will depend on the parents. Usually we tell parents that the baby may be born alive and if the parents say they do not want that to happen, the baby will be given an injection prior to or during the termination so that the baby is not born alive.[38]

4.33 Professor Ellwood made some comments concerning fetal pain:

> I am familiar with a lot of the scientific literature on foetal pain and I am aware that there is a lot of controversy around the gestational age at which the foetus is able to experience pain. I am not sure that the science has yet progressed to the point where you can answer the question honestly and say at a certain gestational age the foetus is able to feel pain and below it the foetus cannot.[39]

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36 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.84.

37 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.86.

38 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.87.

39 Professor David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.109.

The effects of disallowing item 16525

Discriminatory to women

4.34 A number of submissions including the Rural Doctors Association of Australia considered the potential disallowance of item 16525 as discriminatory to women particularly of low socio-economic backgrounds, Indigenous women and women living in rural and remote areas.[40] The Australian Reproductive Health Alliance (ARHA) and Royal Women's Hospital argued that disallowance would amount to an erosion of access to adequate health care for women.[41] Others including the Health Services Commissioner, Victoria and Dr Cockburn held that withdrawing the item could in fact increase maternal morbidity and mortality for those reasons.[42]

4.35 The ARHA highlighted that procedures undertaken under item 16525 include not only termination of pregnancy, but also procedures undertaken in the event of spontaneous miscarriage or premature labour. According to the ARHA, removing funding from this item would therefore remove funding from 'a series of legal and required medical procedures, denying women in this situation the access to funded healthcare afforded to other members of Australian society'.[43] This view was supported by Associate Professor de Crespigny and Dr Allanson who maintained that a disallowance will result in 'financial hardship, delay in service, or denial of appropriate medical care for some women suffering miscarriages or requiring other procedures for which this item is currently used'.[44]

4.36 The ARHA stated that removing the item has the potential to violate the human rights of women of reproductive age given that it would be 'tantamount to the government deciding who may give birth and who may not'.[45] This view was supported by the Parliamentary Group on Population and Development.[46] According to the ARHA, such a course of action would effectively result in one category of pregnant women denied government health and payment programs that are offered to

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40 Rural Doctors Association of Australia, *Submission 426*, p. 1. See also RANZCOG, *Submission 523*, p.2 and National Union of Students, *Submission 210*, p.1.

41 Australian Reproductive Health Alliance, *Submission 199*; Royal Women's Hospital, *Submission 196*. See also, Health Services Commissioner, Victoria, *Submission 205*; Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*; National Union of Students Women's Department, *Submission 210*.

42 Health Services Commissioner, Victoria, *Submission 205*, p.4; Dr Sally Cockburn, *Submission 189*, p.16. See also, Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.3.

43 Australian Reproductive Health Alliance, *Submission 199*, p.10.

44 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.4.

45 Australian Reproductive Health Alliance, *Submission 199*, p.12.

46 Parliamentary Group on Population and Development, *Submission 436*, p.4.

other pregnant women.[47] The Family Planning Association of Western Australia held that:

> The United Nations Committee on the Elimination of all forms of Discrimination Against Women (CEDAW), recognizes women's rights and equal citizenship. Underlying this is the right of the woman to choose what is best for her, situating her as a mature and responsible person with the capabilities of self determination. The withdrawal of the Medicare rebate will undoubtedly create financial hardship for many women, and a decision by the committee that would make access to a safe and legal abortion more expensive would discriminate against women already economically disadvantaged.[48]

4.37 Associate Professor Lachlan de Crespigny and Dr Susie Allanson argued that rights upheld by human rights conventions to which Australia is a signatory include that of reproductive health:

> Australia is signatory to various United Nations human rights conventions respecting the right of men and women to self-determination, to plan their families and control their fertility including the right to bodily integrity (UN 1966), health, reproductive health, family planning and deciding the number and planning of children (UN 1979; UN Population Fund, 1994).[49]

4.38 Dr Christine Tippett commented on the rights of an unborn child:

> …I think the proposal to put in place legislation for the rights of the unborn child is extremely difficult. The main reason for that is that in many ways then puts the woman in a very difficult situation. There are some countries that are looking at this—and I know that Canada has some proposal on the table. The college in Canada are strongly opposing it, and we would strongly oppose it also. Basically it means that the mother loses her autonomy. So people outside the mother are telling that mother what she should do with her pregnancy.
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> …The foetus is not autonomous until it is born. The thought of bringing that in without a huge amount of consideration from the point of view of a women's rights issue is extremely problematic. Does that mean that the foetus that comes out whose growth is restricted because of hypertension can sue the mother when it is 30 because she smoked? The implications of such a thing are enormous. There is much written about this but I would not like to see the discussion go down that pathway.[50]

4.39 Dr Tippett concluded:

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47 Australian Reproductive Health Alliance, *Submission 199*, p.12.

48 Family Planning Association of Western Australia, *Submission 194*, p.2.

49 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.2.

50 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, pp88–89.

> It is extremely concerning when the mother's wishes are overridden by a court of law. How do you then quantify when the baby's rights are greater than the mother's? Who decides that?[51]

Women's physical and mental health

4.40 A number of submissions including that of YMCA Australia maintained that disallowance of item 16525 would have serious implications for women's mental and physical health.[52] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) argued that disallowance of the item would result in poor psychological and physical health outcomes resulting from the increased stress on women, which in turn will 'add to the burden on other health services'.[53] Family Planning NSW (FPNSW) noted that such a disallowance would increase maternal and infant morbidity and mortality rates:

> FPNSW holds the strong position that disallowance of Item 16525 would cause unnecessary and severe hardship for people at an extremely vulnerable and stressful time in their lives and would increase levels of poverty in Australia through increases in maternal and infant morbidity and mortality. This is contrary [to] the achievement of the Millennium Development Goals (MDGs), to which Australia is a signatory.[54]

4.41 Dr Cockburn elaborated on the potential impact of a disallowance on maternal mortality rates:

> Removing the Medicare rebate could, in the short term 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.[55]

4.42 Similarly, the Royal Australasian College of Physicians argued that disallowance of the item may result in both physical and mental risk to the women in question including 'risk to the woman's life and health because of a medical complication, or to her long term mental and physical health as a result of the pregnancy complication for which she has decided to have the termination'.[56]

4.43 Dr Cockburn maintained that whilst disallowance of the item would ensure that these procedures are transferred to the public sector:

> …the message to the Australian people is that Federal Parliamentarians believe that a woman should be forced, against her will, to carry a grossly

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51 Dr Christine Tippett, RANZCOG, *Committee Hansard*, 30.10.08, p.89.

52 YWCA Australia, *Submission 180*, p.1.

53 RANZCOG, *Submission 523*, p.2.

54 Family Planning NSW, *Submission 182*, p.1.

55 Dr Sally Cockburn, *Submission 189*, p.16.

56 Royal Australasian College of Physicians, *Submission 217*, p.1.

> 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 that are incompatible with life outside the uterus or may die shortly after birth.[57]

4.44 The ARHA also argued that the removal of the item may increase the number of foetuses with severe and/or life threatening abnormalities being carried to term. According to the ARHA, an American Psychological Association review of 20 years of evidence found that women who experience miscarriage, stillbirth, death of a new born or termination of a wanted pregnancy due to fetal abnormality have equivalent negative psychological reactions but that these 'are less than [for] women who deliver a child with a life-threatening abnormality'.[58] Thus, according to the ARHA, removal of item 16525 'looks set to *increase* the likelihood of mental health issues in women who are pregnant.'[59]

Accessibility and affordability of appropriate medical services

4.45 A number of submissions held the view that disallowance of item 16525 would disadvantage women who attend as a private patient in a public or private hospital, or private practice.[60] As one case in point, the Women's Hospitals Australasia maintained that abortion after the first trimester is 'an essential component of women's health care' and removal of item 16525 would discriminate against women 'because it undermines access to affordable, accessible health care'.[61]

4.46 The Royal Women's Hospital held that:

> Should item 16525 be disallowed, it would reduce the options for care for those women needing this service. A woman who has booked for private antenatal care may need to transfer away from a known and preferred provider, in this already distressing situation, if the care she needs is not covered by Medicare benefits.[62]

4.47 Similarly, the Health Services Commissioner, Victoria argued that removal of the item would place restrictions on the ability of women to have the procedure carried out in a hospital of their choice by a doctor of their choice:

> We need to make sure women who require these services have the option of having the procedure done with the doctor of their own choice locally

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57 Dr Sally Cockburn, *Submission 189*, p.17.

58 Australian Reproductive Health Alliance, *Submission 199*, p.11.

59 Australian Reproductive Health Alliance, *Submission 199*, p.11.

60 SHine SA, *Submission 92*; Family Planning Queensland, *Submission 201*; Dr Sally Cockburn, *Submission 189*; Women's Hospitals Australasia, *Submission 209;* Family Planning NSW, *Submission 182*, p. 3; Health Services Commissioner, Victoria, *Submission 205*, p.3.

61 Women's Hospitals Australasia, *Submission 209*, p. 1.

62 The Royal Women's Hospital, *Submission 196*, p.2.

> where family and support systems are available. The removal of this service from Medicare benefits could cause many to have to travel long distances on a very lonely and stressful journey. There is an emotional aspect to these services which must be taken into account.[63]

4.48 Moreover, Dr Cockburn stated:

> 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 own choice. In doing so it would reduce the stress in an otherwise difficult time for families.[64]

4.49 The Rural Doctors Association of Australia maintained that withdrawal of item 16525 would impact upon 'those private hospitals that use the number to cover induction for fetal death in utero even though they do not support genetic pregnancy terminations'.[65]

4.50 According to the ARHA, anecdotal evidence suggests that there has been a decline in the availability of termination services of public hospitals and that removing the financial support currently made available to private medical providers will 'place further pressure on the dwindling public services available'.[66] Citing evidence from the Victorian Law Commission which established that approximately two-thirds of abortions in Victoria are provided in private clinics, the Women's Hospitals Australasia argued that disallowance of the item would shift demand from the private sector to state funded services requiring increased resources for the state and territory systems.[67]

4.51 The view that removal of the item from the Schedule would place an additional strain on state public hospitals which would then require more resources was held by the Rural Doctors Association of Australia, Health Services Commissioner, Victoria, and Royal Women's Hospital.[68] As one case in point, Dr Cockburn maintained that removal of item 16525 would not significantly reduce Medicare's financial burden given that it amounts to a relatively small portion of its business, but would instead constitute a cost-shifting exercise to the states.[69]

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63 Health Services Commissioner, Victoria, *Submission 205*, pp3–4.

64 Dr Sally Cockburn, *Submission 189*, p.14.

65 Rural Doctors Association of Australia, *Submission 426*, p.2.

66 Australian Reproductive Health Alliance, *Submission 199*, p.11.

67 Women's Hospitals Australasia, *Submission 209*, p.3.

68 Rural Doctors Association of Australia, *Submission 426*, p.2; The Royal Women's Hospital, *Submission 196*, p.2; Health Services Commissioner, Victoria, *Submission 205*, p.4.

69 Dr Sally Cockburn, *Submission 189*, p.15.

4.52 Greater demand on termination services in public hospitals and increased waiting time for women seeking to access such services has the potential to increase the number of second trimester terminations according to the AHRA, 'as women are forced to wait longer because of their economic inability to access private termination services'.[70] Similarly, Catholic Health Australia held that disallowance of the item would reduce the scope of private providers (usually clinics) to provide such services and likely lead to greater demand for such services in public hospitals, 'resulting in an adverse impact on acute care facilities, without reducing the demand on the incidence of abortion in Australia'.[71]

4.53 SHine SA argued that disallowance of the item will 'punish pregnant women accessing care outside of the public hospital system and delay their access to services' whilst placing 'unnecessary pressure on public hospitals at a time when there services are under heavy demand'.[72] This view was supported by RANZOG which maintained that:

> Women are likely to experience delays in negotiating the system while seeking public hospital services they require at a time when they are distressed and vulnerable.[73]

4.54 Dr Cockburn held that:

> 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.[74]

4.55 This view was also supported by Family Planning Queensland who questioned the equity of such changes for women experiencing financial difficulty and those in regional and remote settings.[75]

Continuity of care

4.56 The issue of continuity of care for women undergoing second trimester services under item 16525 was raised in evidence. Professor Ellwood of the Women's Hospitals Australasia stated before the committee:

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70 Australian Reproductive Health Alliance, *Submission 199*, p.11.

71 Catholic Health Australia, *Submission 190*, p.3.

72 SHine SA, *Submission 92*, p. 3. SHine SA is the acronym for Sexual Health information networking and education South Australia.

73 RANZCOG, *Submission 523*, p.2.

74 Dr Sally Cockburn, *Submission 189*, p.15.

75 Family Planning Queensland, *Submission 201*, p.1.

> The use of this item number allows continuity of care by private providers working within the public system. Many women access tertiary services in prenatal diagnosis and in late termination of pregnancy through the public sector. Enabling continuity of care for private providers is an important part of services to women. For that reason, we believe that the removal of this item number would be discriminatory.[76]

Women in rural and regional areas

4.57 The disallowance of item 16525 was recognised as an added disadvantage to women in rural and regional areas who are already faced with existing inequalities in access to health services. The Rural Doctors Association of Australia explained:

> Rural women's ability to access this procedure is already constrained by distance, continuing rural hospital downgrades and closures that limit reproductive health interventions and shortages of appropriately credentialed medical practitioners. Nor do they have the same access to services like preconception counselling and sophisticated diagnostic testing as women who live in or close to a major city. Yet the acknowledged lower health and socio-economic status of rural populations suggests that they are particularly vulnerable to financial pressures which limit their access to essential health services even further.[77]

4.58 Of the situation for women in rural and remote areas, Dr Cockburn stated:

> 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.[78]

4.59 Similarly, Associate Professor de Crespigny and Dr Allanson maintained that removal of item 16525 would be discriminatory to poor and rural women:

> Access to prenatal testing and termination of pregnancy should not depend on her personal resources or where a woman happens to live. Rural women already face much higher costs because of needing to fund travel and accommodation. A woman might feel forced to take on the emotional, physical and financial costs of continuing with an unwanted pregnancy and

76 Prof David Ellwood, Women's Hospitals Australasia, *Committee Hansard*, 29.10.08, p.100.

77 Rural Doctors Association of Australia, *Submission 426*, p.2.

78 Dr Sally Cockburn, *Submission 189*, p.16.

> rearing a disabled child because she wants, but could not fund, pregnancy termination.[79]

4.60 The Rural Doctors Association of Australia further noted that whilst women would still be able to access item 16525 procedures without charge in their local public hospital if the item were disallowed, in jurisdictions such as Western Australia, where regional funding is managed differently, women would have no other option but to travel to Perth:

> This means many rural women will face economic hardship on top of the costs of their travelling to another centre for the procedure and their separation from their families and local health care providers at a very difficult time. Some many have to delay their journey, prolonging the distress of their situation.[80]

Resort to methods outside the medically regulated system

4.61 The question of whether the inability to access safe, timely and affordable second trimester termination services would result in a greater number of women resorting to dangerous methods outside of the medically regulated system was raised before the committee. Citing evidence from the United States where funding cessation and other limits on abortion led to the utilisation of unsafe abortion practices, Associate Professor de Crespigny and Dr Allanson held that the removal of item 16525 may lead to 'a small number of women desperately turning to dangerous self-or other-administered methods, with a resulting need for additional health treatment'.[81]

4.62 This view was supported by RANZCOG which stated:

> 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.[82]

Potential financial effect of a disallowance

4.63 The Australian Medical Association noted that disallowance of the item would have the effect of 'removing any financial assistance for appropriate medical care for women for all of the clinical circumstances covered by the item…'[83] YMCA Australia argued that removal of funding for services under the item 'will have the

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79 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

80 Rural Doctors Association of Australia, *Submission 426*, p.2.

81 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

82 RANZCOG, *Submission 523*, p.3.

83 Australian Medical Association, *Submission 191*, p.1.

greatest impact on poorer women, who may be forced to continue carrying a dead or dying baby against medical advice'.[84]

4.64 Of the potential financial impact of the disallowance of the item on women's health, the Department of Health and Ageing stated:

> If a woman was faced with higher charges, it would have some disincentive effective on the woman's decision as to whether or not to proceed with the service. To the extent it might thus cause women to defer or avoid a service considered medically necessary, it would be likely to result in negative health consequences for those women.[85]

4.65 Ms Amy Naivasha held the view that removing funding for item 16525 services would 'foster an environment of decision-making based on financial capacity and not on the physical and/or mental health of the pregnant woman and her foetus'.[86]

4.66 RANZCOG and the Rural Doctors Association of Australia argued that removing the rebate to women facing severe emotional and financial stress would be inequitable and would only add to such stress.[87] RANZCOG maintained that involved families will suffer due to loss of income, travel and child care expenses and that:

> Women would experience added stress 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.[88]

Adequacy of the rebate

4.67 A number of submitters took the view that the procedures under item 16525 are under-funded.[89] Dr Cockburn continues:

> 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 arrange from $1100 to $3000.
>
> The rebate from Medicare for item 16525, however is $200.25. And even after a Medicare rebate and possibly even with Private Health Insurance,

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84 YMCA Australia, *Submission 180*, p.1.

85 Department of Health and Aging, *Submission 218*, p.4.

86 Ms Amy Naivasha, *Submission 509*, p.1.

87 RANZCOG, *Submission 523*, p.2; Rural Doctors Association of Australia, *Submission 426*, p.1; See also Dr Sally Cockburn, *Submission 189*, p.4; Health Services Commissioner, Victoria, *Submission 205*, p.4.

88 RANZCOG, *Submission 523*, p.2; see also Dr Christine Tippett, RANZCOG, *Committee Hansard*, p.81.

89 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.2; Health Services Commissioner, Victoria, *Submission 205*, p.3; Dr Sally Cockburn, *Submission 189*, p.9.

> patients undergoing these procedures in the private sector, may still be thousands of dollars out of pocket.[90]

4.68 Associate Professor de Crespigny and Dr Allanson argued that the rebate should be increased to 'ensure a more equitable access to this vital medical service for women from differing socioeconomic backgrounds'.[91] Similarly, RANZCOG expressed the view that the rebate be increased.[92]

Potential effect on second trimester abortion numbers

4.69 A number of submitters argued that removal of item 16526 from the Schedule would not reduce the number of second trimester abortions in Australia.[93] Amongst them, Dr Cockburn held that:

> 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…
>
> 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.[94]

4.70 Children by Choice suggested that if the objective of removing item 16525 is to restrict termination of second trimester pregnancies, it is unwarranted:

> If the aim of removal of Item no. 16525 is to restrict termination of pregnancy over 20 weeks it is unnecessary and unwarranted. Second trimester medical termination for foetal abnormality over 20 weeks gestation is generally heavily regulated via legal restrictions, hospital review panels and committees, along with doctors working in team consultation with their colleagues.[95]

4.71 Dr Cockburn argued that removal of the item will not eradicate the procedures carried out under the item as the need for them will continue:

> 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

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90 Dr Sally Cockburn, *Submission 189*, pp9–10.

91 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.2.

92 RANZCOG, *Submission 523*, p.3.

93 Health Services Commissioner, Victoria, *Submission 205*, p.3.

94 Dr Sally Cockburn, *Submission 189*, p.15l; see also, *Committee Hansard,* 30.10.08, p.55.

95 Children by Choice, *Submission 437*, p.1.

> 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.[96]

4.72 Similarly, the Rural Doctors Association of Australia stated that it is unaware of any evidence that disallowance of the item will lead to a decrease in second trimester termination of pregnancy and noted that:

> …second trimester terminations are usually undertaken in circumstances and for imperatives that are not susceptible to policy change. In other words, they will be undertaken in any case.[97]

4.73 Associate Professor Lachlan de Crespigny and Dr Susie Allanson suggested that removal of item 16525 from the Schedule may in fact result in a greater number of women terminating earlier in their pregnancy:

> Reliable screening does not occur in early pregnancy but occurs at later gestation, may require repeat tests and may involve the woman and her family taking time to make a decision. If women face additional hardship impacting on their pregnancy choices in second trimester, more women may decide precipitously to terminate a pregnancy in early stages (where a rebate is available) when they have a concern about the health or viability of the pregnancy.[98]

Medicare responsible for providing equal access to health care

4.74 A number of submitters in support of continued funding for item 16525 such as the ARHC noted that Medicare describes itself as Australia's universal health care system responsible to 'give all Australians, regardless of their personal circumstances, access to health care at an affordable cost or at no cost'.[99] The ARHC took the view that removal of item 16525 is not consistent with the Medicare's stated role:

> The removal of item 16525 from the Health Insurance Regulations ignores the stated intentions of Medicare, denying universal access to affordable and safe termination of a pregnancy, and removing women's right to choose a practitioner based on personal preference, rather than financial circumstance.[100]

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96 Dr Sally Cockburn, *Submission 189*, p.17.

97 Rural Doctors Association of Australia, *Submission 426*, p.1.

98 Associate Professor Lachlan de Crespigny and Dr Susie Allanson, *Submission 185*, p.5.

99 Medicare Australia, *The Australian Health Care System,* 28 May 2008, http://www.medicareaustralia.gov.au/about/whatwedo/health-system/index.jsp (Accessed 8.10.08).

100 Australian Reproductive Health Alliance, *Submission 199*, p.10.

4.75 This view was shared by Associate Professor de Crespigny and Dr Allanson and the Rural Doctors Association of Australia who noted of efforts to disallow item 16525:

> Manipulating a system designed to ensure that all Australians have access to free or low-cost medical and hospital care in this way would be repugnant and improper.[101]

4.76 The National Foundation for Australian Women argued that the disallowance of item 16525 would effectively remove a rebate for a lawful medical procedure which would be inconsistent with the availability of rebates for other lawful medical procedures.[102] Similarly, RANZCOG stated that:

> Manipulations of the Medicare schedule to limit access to a lawful procedure is unacceptable.[103]

Lack of clinical evidence to support disallowance of item 16525

4.77 A number of submitters such the ARHA maintained that the services provided under item 16525 are clinically accepted procedures.[104] Family Planning NSW stated that there is no financial imperative to disallow item 16525 and that the current effort to do so was not evidence based.[105] RANZCOG argued that:

> It would be extraordinary if benefits for the legal and medically indicated management of labour in the second trimester were not payable.[106]

4.78 The Health Services Commissioner, Victoria maintained that disallowance of the item would contradict the 'work of all of the expert committees which included it in the first place…' and that:

> The Parliament, with all due respect, is not as qualified in clinical obstetric practice as the expert committees which set up service 16525 as a Medicare item in the first place.[107]

4.79 This position was also held by the Rural Doctors Association of Australia:

> As the Association is unaware of any clinical reason for removing this item from the Schedule, it presumes that any proposal to do so relates to non-clinical policy or opinion. The Association points out that changes to the

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101 Rural Doctors Association of Australia, *Submission 426*, p.2; Associate Professor de Crespigny and Dr Allanson, *Submission 185*, p.2.

102 National Foundation for Australian Women, *Submission 188*, p.4.

103 RANZCOG, *Submission 523*, p.1.

104 Ms Kelsey Powell, Australian Reproductive Health Alliance, *Committee Hansard*, 29.10.08, p.73.

105 Family Planning NSW, *Submission 182*, p.3.

106 RANZCOG, *Submission 523*, p.3.

107 Health Services Commissioner, Victoria, *Submission 205*, p.3.

> Schedule should be based on evidence relating to the need for the service and the health impact of these changes.[108]

4.80 The YMCA Australia highlighted that the process by which Medicare item numbers are listed are based on best practice:

> Medicare item numbers are determined by expert panels of Medicare Australia, in line with current best practice in clinical care. We believe moves to disallow or remove Medicare item number 16525 interfere with the integrity of the Medicare Australia processes and will compromise the healthcare of pregnant women.[109]

4.81 Whilst respecting the Senate's right to disallow regulations, the Australian Medical Association held that it was 'more appropriate for the Minister of Health and Ageing to consider the clinical and policy aspects of Medicare funding with the advice of the medical profession'.[110]

Senator Polley

Chair

108 Rural Doctors Association of Australia, *Submission 426*, p.1.

109 YMCA Australia, *Submission 180*, p.1.

110 Australian Medical Association, *Submission 191*, p.2.