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SENATE

STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Reference: Item 16525 in part 3 of schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007

WEDNESDAY, 29 OCTOBER 2008

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SENATE STANDING COMMITTEE ON

FINANCE AND PUBLIC ADMINISTRATION

Wednesday, 29 October 2008

Members: Senator Polley *(Chair)*, Senator Fifield *(Deputy Chair)*, Senators Cameron, Jacinta Collins, Fierravanti-Wells, Hanson-Young, Moore and Ryan

Participating members: Senators Abetz, Adams, Arbib, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Boyce, Brandis, Bob Brown, Carol Brown, Bushby, Cash, Colbeck, Coonan, Cormann, Crossin, Eggleston, Ellison, Farrell, Feeney, Fielding, Fisher, Forshaw, Furner, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Pratt, Ronaldson, Scullion, Siewert, Stephens, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Barnett, Carol Brown, Cameron, Collins, Eggleston, Fielding, Fierravanti-Wells, Fifield, Hanson-Young, Moore, Polley and Ryan

Terms of reference for the inquiry:

To inquire into and report on:

The subject of the motion for disallowance of item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007, with particular reference to:

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

(b) the number of services receiving payments under this item and the cost of these payments;

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

(d) the effects of disallowing this item.

WITNESSES

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WEISBERG, Dr Edith, Director of Research, Family Planning New South Wales 32

Committee met at 8.31 am

LAVERTY, Mr Martin, Chief Executive Officer, Catholic Health Australia

CHAIR (Senator Polley)—Good morning, everyone. Welcome to our hearing. The committee is commencing its inquiry into item 16525 in part 3 of schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007. Item 16525 relates to payments for the management of second trimester labour, with or without induction, for intrauterine foetal death, gross foetal abnormalities or life-threatening maternal disease, not being a service to which item 35643 applies. I draw attention to the terms of reference, which call for the committee to report on the terms of the item, the number of services receiving payment under this item, the cost of these payments, the basis for the payment of benefits and the effects of disallowing this item. The committee has a very full program for this inquiry. I ask committee members to bear in mind the time constraints imposed by today's program and, given the number of senators present, to keep questions succinct and to the point.

I welcome Mr Martin Laverty from Catholic Health Australia. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has before it your submission. I now invite you to make a short opening presentation. At the conclusion of your remarks, I will invite members of the committee to put questions to you.

Mr Laverty—Thank you for the opportunity to appear before this inquiry and particularly for accommodating my own travel schedule today by meeting so early. I am grateful. I think it is important to commend the Australian Senate and this inquiry for the energy that it is putting into an issue that, in a financial sense, is relatively modest in comparison to the size of the health expenditure through Medicare in Australia. Today we are meeting to discuss a matter of financial consequence of around $160,000 a year—an item number that each year is utilised by around 800 people or so. I think it is important to acknowledge that the Senate, by giving the time to consider this matter, is showing a respect to the sensitivity of the issues that are involved. It is a respect that, unfortunately, is not on display in all states in Australia. I make specific reference to recent decisions in Victoria dealing with similar matters, where the parliament of Victoria undertook a substantial change in relation to policy on the termination of pregnancies without a thorough consultation with all interested parties and indeed without giving proper consideration to its own Charter of Human Rights and Responsibilities.

I appear this morning on behalf of Catholic Health Australia, which has appeared before this committee before, so senators will be aware that it is the peak body representing 75 hospitals around Australia and 550 age care services providers. Across our hospitals we have some 9½ thousand hospital beds. We operate 21 public hospitals and 54 private hospitals where, in part, as a foundation of the Australian health care system, we represent about 15 per cent of all health services in Australia. It is with that background that we make the observations to this committee today and that we have provided in our formal submission.

The impact of the proposed disallowance that this inquiry is considering would not be a substantial impact on our hospitals. The reason for that is that we do not currently provide services to enable the termination of pregnancy. We do not provide referral to services that would provide termination of pregnancy. The reason for that is well known. The church's position—of which Catholic Health Australia and our members are an important component—in

relation to abortion is well known. I do not propose this morning to revisit the well established position of the church in relation to the termination of pregnancy other than to say that, within our Catholic hospitals and within our Catholic health services, we do not currently provide termination services and we do not provide referral to them.

To the extent that the item number being considered today does fund the termination of pregnancies, we support the proposal to disallow the item number. The Catholic Church's position, being well known in relation to abortion, it will come as no surprise that we do not believe, as a church and as Catholic Health Australia, that Medicare funding should be available for the provision of abortion services.

But there is an important distinction that this inquiry needs to consider. I note from reviewing other submissions that it is the case put forward by the Australian Christian Lobby and also by us that this item number that the inquiry is considering is not just used for the termination of pregnancies; it is also used in other circumstances where there is in fact not a live foetus involved in the procedure. Intrauterine foetal death is an eligible procedure that can be funded under the item number at the moment. What we are suggesting to the inquiry is that there is not at present sufficient knowledge to understand how many procedures relate specifically to the termination of pregnancy as funded under this item number, and then how many procedures are actually not dealing with a pregnancy at all, but are dealing with other circumstances that we, as lay people, might refer to, perhaps incorrectly, as miscarriage. In other circumstances in which a woman believes quite rightly that she is in fact undergoing pregnancy but, for certain circumstances, pregnancy has not occurred, this procedure is then utilised to provide remedy to that situation.

The issue that this inquiry has to consider is a difficult one because you do not actually have, at present, data to be able to, with confidence, know how many terminations of pregnancies each year does this item number actually fund or how many circumstances in which a woman needs the appropriate funding through Medicare that does not relate to the termination of pregnancy. We suggest that, in considering the disallowance of this funding to fund termination of pregnancy, that is an appropriate course, but this inquiry must not recommend that funding for other circumstances be taken away. The reason for that is that a woman who has experienced the foetal death of the child that she thought she was carrying deserves both financial support through Medicare, and also the care and compassion that our health system is able to provide to them. The dollar amount of this item number—if I am correct it is around some $270 to help contribute to the larger cost of the procedure—is significant in some circumstances where a woman, a family or a husband and wife might be going through very difficult circumstances, having discovered that the baby they were expecting is in fact not alive or there are other circumstances where pregnancy has not in fact occurred at all.

Our recommendation to this inquiry is: knowing that you do not have the data at the moment, you are in a difficult position on what to recommend. The church's position is quite clear: we do not support the provision of abortion through Medicare funding. However, there are other circumstances where this item number at present is utilised in the best interests of a woman's health, and this committee should not be making recommendations that would disadvantage a woman in those particular circumstances. Our evidence to this inquiry is relatively brief, and that is the content of our submission. I am very happy to take any questions that senators may have that effect.

CHAIR—Thank you very much.

Senator FIFIELD—I could not help but overhear this at the margins before—do I understand that you have only recently assumed this role?

Mr Laverty—I joined Catholic Health Australia in June.

Senator FIFIELD—What were you doing before that, just out of curiosity?

Mr Laverty—I am trained as a constitutional lawyer, so I should indicate that the evidence I give is not that of the clinician or a doctor.

Senator FIFIELD—Thank you for that. You faithfully reflected the Catholic position on abortion in your evidence. You have stated here and in your submission that your organisation would support a disallowance motion provided that an alternative item is established for non-termination procedures. I think I have got that correct. Through your submission you make a number of practical observations, such as if a separate item was established for termination—separate to an item for non-termination procedures—that that record could follow a woman who has had a termination and that there could be implications for the individual down the track, apart from the additional distress of actually having to formally nominate on a form to government that you have had a termination. You also acknowledge the unintended impact on the public health system—extra demand and the adverse effect on acute-care services. It is also noted that, if the disallowance motion went through, the situation would be one that probably would not reduce the demand for abortion in Australia. As I read your submission and listen to your evidence, while acknowledging you have faithfully reflected the position of the church, I cannot help but have the feeling—and correct me if I am wrong—that Catholic Health Australia would not actually mind if the status quo remained in this area. Is that an unfair characterisation?

Mr Laverty—What Catholic Health Australia likes to do is make its recommendations and decisions based on evidence. At the moment, because of the way that the procedures are reported, we do not with confidence have a full understanding of how many procedures in the last reporting period were actually to fund a termination of a viable pregnancy and how many procedures have related to other health implications to ensure a woman's ongoing health where something has gone tragically wrong with the development of the pregnancy. What we are suggesting is that, in the absence of that, the inquiry is in fact in a difficult situation. Our position is quite clear: we do not support the provision of Medicare funding for provision of termination of pregnancy. To the extent that disallowance would help achieve that, we support it. That would need to be on an understanding that we were not disadvantaging those women who utilise this procedure for other circumstances to ensure their own health and wellbeing. This inquiry would be misdirected if it was to support the disallowance without giving consideration to those other circumstances, where many additional impacts on the woman, the father and the family need to be taken into consideration. A woman wanting a pregnancy who has just been advised that for different circumstances her baby is no longer alive or in fact there was no pregnancy at all—those are the two classes of people that have access to this procedure at the moment. Catholic Health Australia would not like to see those individuals impacted by this item number being disallowed.

Senator FIFIELD—Thank you. As I said, I do not want to give your evidence a character that you do not intend. Would it be more accurate to say that your overriding concern in relation to this item number and its possible disallowance is the unintended consequences on those who require this item number for services other than termination—that you would hate to see those women put in a situation of financial disadvantage?

Mr Laverty—That is also the evidence of the Australian Christian Lobby, and I would not seek to represent that on their behalf. Their submission, together with the submissions of other more clinically experienced representative bodies, makes the same argument—that this item number at the moment does serve two purposes, and we must not disadvantage those who are using it in circumstances of personal difficulty. This inquiry should give consideration to those components, but the church's position on public funding of termination of pregnancies is quite clear.

Senator FIFIELD—Finally, before I yield to another colleague: Catholic Health would not support a separate and distinct item for terminations—

Mr Laverty—That is correct.

Senator FIFIELD—because you are opposed to public funding of terminations. But if the parliament saw the only way to address this issue as having two separate items to distinguish those procedures, would you in that circumstance, even though you do not support the public funding of terminations, support the recording of those details in relation to an individual?

Mr Laverty—We would be very comfortable with an item number that allowed situations where a woman having experienced a foetal death or a woman having experienced a molar or false pregnancy who is using an item number to remedy that situation is able to access Medicare funding. We would not give our support to an item number that funds the termination of pregnancy.

Senator FIFIELD—If there were such an item number, however, do you think that that item number should record, being government records, the names of the individuals who accessed that?

Mr Laverty—Our evidence in written form has been that there are problems in recording the names, the identification of individuals who have undergone these procedures. But we have also said that at the moment there is insufficient data for this inquiry to, with confidence, make the decisions it needs to make. I recognise the contradiction of that position, but we certainly do not want to create an environment in which the rights to privacy and the benefits a woman enjoys by not having to self-declare are quite important. They are significant human rights that do need to be considered. I am making an argument that in Victoria the parliament of Victoria has impinged upon the human rights of doctors and nurses by requiring them to identify their objection to the provision of abortion. If I am going to be consistent, I also need to ensure that we are protecting the rights to privacy of other individuals in other circumstances.

Senator FIFIELD—Thank you, Mr Laverty.

Senator MOORE—I think that through that whole process my question was answered. It is very clear from your evidence both today and in the submission that your opposition is the basic church opposition to abortion, and anything that is linked to that is part of your basic philosophy. It is true that none of your businesses have any provision or reference, so these regulations do not impact on your business.

Mr Laverty—The impact is modest to the point of being minor. I have suggested that this item number is utilised by women in circumstances where there has been an incidence of foetal death or in fact there has been a false pregnancy, and it is certainly the case that within our hospitals those procedures, quite rightly, are performed. We do not provide termination. Our hospitals will not, and they will not provide referral to them, so to that extent the disallowance would have a minimal impact within our not-for-profit organisations.

Senator MOORE—We differ there, Mr Laverty—having worked with the Mater for a long time. In terms of the process, though, through Catholic Health you would be using the regulation but only for the circumstances that you have described, and that is clearly understood by the practitioners and the community?

Mr Laverty—Absolutely.

Senator FIERRAVANTI-WELLS—Mr Laverty, I understand clearly that there are the viable pregnancies as opposed to the other health implications. As to a separation of the two items, I accept the evidence that you gave to Senator Fifield. Clearly one of the problems here is that they are both under the same item number, so, if there are 100,000 per annum, we do not know how many are viable pregnancies and how many are other health implications. A separation into two items will at least give us the necessary numbers or the necessary data to know that in effect there are potentially, say, 50,000 viable pregnancies and 50,000 other health implications. Insofar as the separation of the two items would give us that data, you would support that component? No?

Mr Laverty—Senator, we cannot. In the first instance, this particular item number is dealing with less than 800 or so procedures a year, so we recognise that there are very small numbers involved. We would not be lending our support to an item number that was specific for the termination of pregnancy. We would be lending our support to an item number that was specific to responding to circumstances of foetal death or false pregnancy or miscarriage, as those of us who are laymen would refer to it. Not knowing the current call on those 800, not knowing how many of those relate to a miscarriage situation, we do not know to what extent the item number is being utilised for that. So, if your question is, 'Would we support an item number that related to circumstances of foetal death or miscarriage?' the answer is that we would. Would we support a specific number in relation to the termination of a viable pregnancy? We would not.

Senator FIERRAVANTI-WELLS—No. I simply put it on the basis that a separation would at least give us the data, and insofar as that helped the other health implications then that would at least recognise that issue.

Senator RYAN—Mr Laverty, as you would know, the Senate only has the capacity in this case to disallow or to do nothing and allow it to stand, so an amendment is outside our capacity. It is within the capacity of the committee to make such a recommendation. I was wondering

whether you had made or were intending to make representations to government, to the minister who has the capacity to amend the regulations in the manner you have described.

Mr Laverty—We have not done that, and I would give consideration to it. If it appeared likely that this disallowance motion was to proceed, you can take from the evidence that we have given that we would do our bit to ensure that we were not creating a situation where women were put in a situation of disadvantage. We have supported access to Medicare funding in circumstances of foetal death or a layman's version of miscarriage. We would be quite comfortable in making that representation formally to the government if it became apparent that this item was likely to be disallowed.

Senator RYAN—Do CHA have a view—and I am just reading from your submission here—that you will support the disallowance only if provision is made for differentiation? That is a summary of words taken. Do CHA have a view on what should happen first—that disallowance should be followed by an amended regulation or that amended regulation should occur before the second step is taken with respect to funding optional terminations, I suppose?

Mr Laverty—We have not given consideration to the timing of how that might occur, but I think you can infer from our written recommendation to this inquiry that, if disallowance is to occur, it should be done so with provision to not create disadvantage for those women that are utilising it for those purposes. We would certainly be looking to make that case to the government if it becomes apparent that disallowance is a feasible path for both this inquiry and the Senate.

Senator RYAN—Thank you.

Senator FIELDING—Thanks for your submission and the information you have provided this morning. There are two ways of putting this about this disallowance motion. Unless there were another item or some way of funding what is currently performed under item 16525 for procedures other than induced abortion you would not support it. In other words, it is like a double negative. Unless there were something else in place to cover those positions of induced abortion, you would not support it. Is that right?

Mr Laverty—That is not the evidence that we have given and it is certainly not what I have suggested this morning. The church's position on public funding of termination is quite clear. To the extent that a disallowance of the item number is going to achieve our long held philosophical position, we would be supportive of the disallowance provision. We have said in our evidence that there is a perhaps unintended consequence of that—an unquantified number of women are utilising this item number for other purposes in order to ensure their health, and we should not be creating disadvantage. So in the event that disallowance is achieved, which we would lend our support to to the extent that it removes public funding through Medicare for the termination of pregnancy, a next step needs to be taken to ensure that we have not disadvantaged those women who are using it for these quite legitimate purposes.

Senator FIELDING—Thank you for that. I appreciate the clarification. On page 2 of your submission you express concern about women's privacy if there was a specific abortion item and that this would remain on their record. You have spoken about that already this morning. Are you aware of any breaches of people's privacy for items on their Medicare record? Wouldn't turning

up to a freestanding abortion clinic to seek an abortion be more likely to risk a woman's privacy than an item in a carefully controlled system subject to the Privacy Act?

Mr Laverty—No.

Senator FIELDING—You do not want to expand on that?

Mr Laverty—No.

Senator FIELDING—Okay. Thank you.

Senator CAMERON—In your evidence you said that you wanted to adopt an evidence based approach. I suppose this is a debate within the church that goes back to Galileo and even further. How do you deal with an evidence based approach that challenges the faith?

Mr Laverty—The circumstances in which our health services, our hospitals and our aged-care organisations operate are born out of thousands of years of religious tradition. Our organisations within our own circles are described as the ministries of care, just as Catholic schools are ministries of education, just as formal church is the ministry of the word. Our hospitals and our aged-care facilities are an expression of the ministry of care on behalf of the church. Within Australia, they exist to fulfil that ministry. As a contribution to the broader community, they then provide public health service, private health service and aged-care service based on commonly adopted clinical standards in Australia. But at their foundation they are faith based. If we are to remove that element from those hospitals and from those aged-care facilities, the church has no place there anymore. They would cease to be ministries of care.

I recognise that we walk an interesting path, that we are organisations founded in faith and founded in commitment to certain religious principles and we seek—in fact, we are obliged by canon law to commit to—fulfilment of those faith based principles. Within that we also seek to operate clinical services based on evidence within the framework of faith. All of our actions are within a framework of faith. For those of us of Catholic background, of Catholic experience, we recognise that is not easily understood in all circumstances but we ask and have enjoyed for many years a respect for that position, and it is a position that we seek to continue by appearing in forums such as this to make our case that the public funding through Medicare of abortions is something that in principle we cannot support.

Senator CAROL BROWN—I want to make it quite clear. Your evidence is that, with life-threatening maternal disease, you do not support access to the item—even where a doctor has said that to continue is life threatening to the mother?

Mr Laverty—The application of Catholic ethical standards within health care is such that the clinician has an obligation to the health and wellbeing of the mother. They also have an obligation to the health and wellbeing of the unborn child. The clinician must do everything within their power to ensure the health and wellbeing of both. There are circumstances where a mother's life is in jeopardy and the clinician must do all he or she can to save that mother's life. They must not intentionally set out to terminate the life of an unborn child. But an overriding consideration is that where the life of a mother or of a woman is in doubt the clinician must do everything they can to ensure that woman's health and wellbeing.

Senator CAROL BROWN—But, if that leads to a termination, you do not believe that they should access this Medicare number?

Mr Laverty—If the primary intent of the clinical intervention is termination, we do not believe that termination is the appropriate course or that there should be access to this item number. You will recognise the distinction that I am making. In circumstances a clinician is required to put the life and wellbeing of a mother front and centre and in a Catholic environment our clinicians are asked not to set out with the intent to provide the termination of a pregnancy.

Senator CAROL BROWN—Thank you.

Senator JACINTA COLLINS—We have heard previously that the management of a labour after 20 weeks, if it relates to a non-induced labour, is most likely to be claimed under a different Medicare item anyway. Correct me if I am wrong. If the mother's health is at risk and her care is being managed by inducing a labour, whether the child as a result of that is born alive or dead, which Medicare item would be relevant anyway?

Mr Laverty—Perhaps what is more relevant is that in a circumstance that we are talking about which is likely to be a significant emergency, a procedure that is not planned, the item number that this committee inquiry is considering does not relate to the provision of services in public hospitals. The item number being considered here today is an item number that is principally a service provided in a private setting of some sort. In a public hospital, intervention services are likely to be funded through state government block funding to that hospital, provided ultimately by the Commonwealth, so that in such a circumstance as the Senator is raising, it seems unlikely, indeed theoretical, that this item number would be called on to fund such a circumstance, principally because in the private setting where these procedures are undertaken they are usually planned and are not necessarily emergency procedures that would usually occur in a public hospital. Usually they would occur in an emergency ward in an emergency situation.

Senator CAROL BROWN—In relation to the level of funding and the demand for terminations, could you talk about the services that you believe need to be put in place and whether that includes age-appropriate reproductive and sex education?

Mr Laverty—We have not provided evidence to that extent in this inquiry. That is a significant discussion that perhaps does not fall within the terms of reference of what is being considered today, nor have we gone further to comment on other measures that could be implemented across other areas within the provision of public funding to health services. What we have suggested through this inquiry is that, given the relatively small number of procedures that are carried out under this item number, there is a case for more data and better understanding of the circumstances in which termination pregnancies are funded under this current item number and provided. That might actually help inform some of these discussions to a great extent.

Senator CAROL BROWN—In your submission you say that more funding should be made available to women. You state that the level of demand for terminations services is more likely to fall if sufficient levels of funding are made available to women and families in need of care.

Mr Laverty—One of the services that we provide proudly within our Catholic hospitals and within our health outreach services is a counselling service for women in understanding their role as a mother, their role as the glue of the family, if you like. We have suggested not just within our Catholic organisations but within any organisation the need for a greater option for counselling on those pathways that women have when they find themselves considering the issue of whether or not to terminate a child is going to be in the best interests of that woman,. Knowledge and the sympathetic exposure to options is something that surely the Australian government should be extending to all women.

Senator CAROL BROWN—Thank you.

Senator MOORE—Do you want to open that up again?

Mr Laverty—I prefer not, Senator.

CHAIR—There are no further questions. Thank you very much, Mr Laverty. You have survived your first appearance before the committee and we thank you for your submission.

Mr Laverty—Thank you.

[9.09 am]

HARVEY, Dr Bronwen, Medical Adviser, Population Health Division, Department of Health and Ageing

KINGDON, Mr Tony, First Assistant Secretary, Department of Health and Ageing

RICHARDS, Dr Brian, Medical Adviser, Department of Health and Ageing

RYAN, Mr Michael, Acting Assistant Secretary, Department of Health and Ageing

BENJAMIN, Ms Jenny, Acting General Manager, Medicare and associated government programs, Medicare Australia

BRIDGE, Mr Colin, General Manager, Program Review Division, Medicare Australia

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. As departmental officers, you will not be asked to give opinions on matters of policy, though this does not preclude questions asking for explanation of policy and factual questions about when and how policies were adopted. The committee has copies of the department's submissions. I invite you to make a short opening statement.

Mr Kingdon—Thank you for inviting the department to contribute to this committee's deliberations. The department welcomes the opportunity to discuss the material presented in our submission. I am sure that you have many questions that you want to ask, so I will be reasonably brief. Medicare was designed to ensure that all Australians have access to free or subsidised treatment by eligible health practitioners. This subsidised treatment is paid in the form of Medicare benefits. Services listed in the Medicare Benefits Schedule must be rendered according to the provisions of the relevant Commonwealth, state and territory laws.

The legislation relating to the termination of a pregnancy is the remit of states and territories, and each jurisdiction has different legislation governing the circumstances where pregnancy can be terminated. The medical service covered by this item—the management of a second trimester labour with or without induction—has been subsidised by Medicare since the inception of the scheme. In the 2007-08 financial year there was a total of 794 services claimed under item 16525, with total benefits of $164,424. The average number of services claimed under Medicare for this service over the last 20 financial years has been 773 services per annum.

It is important to note that the item is much broader than medical terminations and that it provides Medicare coverage for cases of foetal death, miscarriage and trophoblastic disease. The department is not aware of any evidence that women seek, or that doctors provide, the service listed in this item either unlawfully, capriciously or without serious consideration of the risks and benefits of the procedure. In the end, the decision as to whether or not to carry out this procedure is agreed by the woman and her practitioner based on an individual assessment of that woman's clinical situation.

CHAIR—In the last decade what expenditure has been identified as relating to 16525 for actual terminations? Can you identify the amount of money that the Australian government has paid out through Medicare?

Mr Ryan—'No' is the short answer. We would be aware of the total benefits that are paid under that item but not broken down to individual reasons behind it.

CHAIR—In your submission, while you mention that women would be priced out of terminations by this disallowance, with negative health consequences, isn't it also the case that women can also experience negative health consequences as a result of a termination?

Mr Kingdon—I will ask Dr Richards to respond.

CHAIR—It is an interesting comment in your submission.

Dr Richards—The literature is divided around whether or not there are negative health consequences of termination of pregnancy. Certainly in earlier days when different techniques were used, women may have developed incompetence of the cervix following a medically induced termination, but those complications are much less frequent these days. Again, there is still ongoing debate in the medical literature, with conflicting evidence in relation to psychological effects of termination. Some evidence suggests that women who choose a termination may have pre-existing psychological conditions which then continue afterwards. There is no clear conclusion drawn in the evidence in relation to whether or not termination of pregnancy itself has significant adverse consequences.

CHAIR—In the submission it was emphasised in relation to the price that women could be priced out of the option of having a termination, which could cause health issues. Yet there is no conclusion, as your evidence has just said, that there are not other health and psychological implications. Can I seek clarification of the definition of a gross foetal abnormality?

Dr Richards—Can you repeat that, please?

CHAIR—Can you give me a definition of what constitutes a gross foetal abnormality in a medical definition?

Dr Richards—Generally the term 'gross' in medical parlance indicates something that is macroscopically visible—that is, it does not require the aid of a microscope to identify. It is an abnormality that is obvious to the naked eye. While a pregnancy that is continuing, these days it is generally something that can be identified on ultrasound.

Senator FIFIELD—I will direct my questions through Mr Kingdon, who can farm them out as required. When was item 16525 first included on the MBS? I appreciate it has probably had a number of iterations and name changes.

Mr Ryan—1 November 1995 is when item 16525 was first introduced into the Medicare benefits schedule. However, the service of the management of a second trimester labour has been on Medicare since the inception of Medicare.

Senator FIFIELD—Since the inception of Medicare. Was there any similar government funded procedure prior to that? Let me rephrase that: what was the situation before Medicare in relation to Commonwealth funded terminations? Prior to 1984.

Dr Richards—I have to take that one on notice.

Senator FIFIELD—If you could, because it would be useful for the committee to know how long there has been Commonwealth funded support for terminations. Since the inception of Medicare, while the item number itself has changed, has the description changed as to what is eligible for funding?

Mr Ryan—The current descriptor has been in place since 1 November 1995 when the item was introduced. Prior to that, going back to 1984, it just said for the management of second trimester labour with or without induction, so it did not have intrauterine foetal death, gross foetal abnormality.

Senator FIFIELD—Was there any practical difference to the range of procedures covered by that change in description at that time?

Mr Ryan—Not that I am aware of.

Senator FIFIELD—So a similar range of procedures are covered.

Mr Ryan—Yes.

Senator JACINTA COLLINS—Sorry, Senator Fifield. Can you give us the policy rationale for that change?

Senator FIFIELD—Back in 1995 we, along with the medical profession—that is, the Australian Medical Association and the obstetric doctors—undertook a review of all the obstetric services in the Medicare Benefits Scheme, and we reworked the whole obstetric schedule. November 1995 is when the current schedule of services was put in place. So it was through extensive negotiation with the Australian Medical Association and the obstetric doctors.

Senator JACINTA COLLINS—But the new definition limits the scope as compared to what previously applied.

Mr Ryan—It provided greater clarification in what services were actually covered under the particular item but the number of services has remained fairly steady, so it would seem to imply that it provides a similar scope than prior to 1995.

Senator JACINTA COLLINS—But, from the consultations, you cannot tell us what the intent was for limiting the definition?

Mr Ryan—It was part of a complete overhaul of the obstetric status.

Senator JACINTA COLLINS—I understand that but that does not give us the policy intent.

Mr Ryan—The intent was basically to provide greater clarification of all the obstetric items within the obstetric part of the—

Senator JACINTA COLLINS—Could you take on notice the precise reason this definition was limited as a result of those consultations.

Mr Ryan—Yes.

Senator FIFIELD—Could you add to that: if there were any concerns expressed during the consultation as to the range, the nature and the circumstances of the procedures, which item was covered.

Mr Ryan—Yes.

Senator FIFIELD—I will ask what is probably an obvious question: why doesn't 16525 record the individual types of procedures which it is used to claim benefits for? Is that something that is common for item numbers—that you do not have to further identify the nature of the procedure?

Mr Ryan—There are currently about 5½ thousand Medicare item numbers. If we were to break down those item numbers to each of their individual components, you would be talking about tens of thousands, possibly hundreds of thousands, of items. So, for this particular item, as is the convention with most Medicare items, the basic service is the management of the second trimester labour with or without induction, and in this case it has those further limitations that are within the item.

Senator FIFIELD—Are there any Medicare item numbers where you do require that there be further identification of the nature of the procedure?

Dr Richards—There are some items in the schedule where the doctor is required to provide additional evidence that the service they are proposing to provide meets the requirements of the item.

CHAIR—Can you elaborate and give us an example of that?

Dr Richards—They include some of the cosmetic items on the schedule—breast augmentations, breast reductions—to try to control the appropriate use of those as a government subsidised service. Practitioners are currently required to demonstrate the clinical indication.

Senator FIFIELD—What would be required administratively and practically to have a greater identification of the types of procedures under this item number? What procedure would need to be gone through to give effect to that?

Dr Richards—I would ask that question of Medicare Australia.

Ms Benjamin—Can you repeat the question.

Senator FIFIELD—At the moment you just tick a box and you claim for item 16525. If government decided that it would be useful to know the different sorts of procedures that are claimed under that item, what would need to be done to give effect to that?

Ms Benjamin—I might need to take that on notice.

Senator FIFIELD—So government decides they want to know how many terminations there are because of gross foetal abnormality and how many situations there are where the foetus has already died and there is the need to remove it. If government wanted to know, if government wanted to be able to further break down the range of procedures, how would government give effect to that? What would have to happen in the bureaucracy?

Ms Benjamin—There would be a variety of different ways to implement that, and that would have to be investigated as to the most efficient way. One way might be to create different items. But, as I stated before, if you did that for all items we would end up with far too many.

Senator FIFIELD—I appreciate that. I would just be interested to know whether it is something that could just be done administratively, or whether there would have to be a new regulation passed—I do not have any idea as to what the practical mechanism would be of doing that.

Mr Ryan—There would have to be regulatory change.

Senator FIFIELD—There would have to be a regulatory change?

Mr Ryan—But there are various mechanisms that could be available, such as working with each state's and territory's births and deaths registry, or, potentially, splitting the item—though, once again, if you were to split all items there would be far too many items. Another mechanism could be that when the procedure is performed that particular report has to be provided to Medicare Australia. So there are various administrative mechanisms, but they would require a regulatory change and it depends on what mechanism is the preferred one as to what the regulatory change would be and how much of a regulatory change that would be.

Senator FIFIELD—Let us just go back to the case of the item number that deals with breast augmentation. The procedures which happen under that item number you say you know in greater detail. Is that a function of how the regulation itself was constructed?

Dr Richards—Yes, it is.

CHAIR—Can I just clarify a point on that—that is that, in relation to that procedure, there are more requirements and regulations relating to that than to the item we are looking at, which is 16525 and the termination of a life.

Dr Richards—In administrative terms, there are some additional requirements.

Senator RYAN—What are those requirements that a clinician must go through? Is it like a medicine, where you ring up and seek authority to use it beforehand?

Dr Richards—It is similar to that. The practitioner is required to submit, to a panel of medical advisers at Medicare Australia, colour photographs indicating the clinical necessity for the service in relation to the item descriptor.

Senator RYAN—What is the sort of time turnaround of seeking the permission or authority and it being granted?

Dr Richards—Some months, usually. The committee meets several times a year to assess these applications.

Senator RYAN—Just to clarify what you said earlier: is that driven primarily by an access and cost-containment, appropriate use—

Dr Richards—Yes.

Senator RYAN—Thank you.

Senator FIFIELD—I have a final question, Chair, before I yield. If item 16525 was disallowed, one would assume that the government would seek to introduce a new item to at least cover those non-termination procedures which are covered by 16525. What would be the process and the time frame involved in introducing a new item number?

Mr Kingdon—Normally, it would take six months. I will leave Michael Ryan to elaborate.

Mr Ryan—If the government made the policy decision to introduce a new item, then we would have to, obviously, go through the regulatory pathways.

Senator FIFIELD—Let us just assume Senator Barnett moves his disallowance motion. It is successful. The minister says, ‘Okay, we need a new item number, quick, to cover non-termination procedures.’

Mr Ryan—The recommended time frame to draft new regulations by the Office of Legislative Drafting and Publishing is eight to 12 weeks. That is the recommended time frame to draft new regulations. Following that time frame, those regulations have to be presented to executive council, and the recommended time frame for that is around four to six weeks. It would also obviously have to fit into the executive council meeting time frames, and they meet, as you would know, on a fortnightly basis. So it would really depend on all of those mechanisms.

As well, we would have to liaise with Medicare Australia as to how soon they could implement a new item on their system. The time frame for that also depends on what restrictions are on that item. The more restrictions on the item, the more potential work for Medicare Australia to implement.

Senator FIFIELD—What is the absolute minimum time frame for the new regulation?

Mr Ryan—For a standard new regulation, I would it is around the three- to four-month period.

Senator FIFIELD—If this item number was disallowed, there would be a three- to four-month period where women in the tragic and awful situation of having to have their dead foetuses removed would have no Medicare item number under which to claim the procedure—is that right?

Mr Ryan—Yes. While there is no regulation, Medicare benefits cannot legally be paid.

Senator FIFIELD—Thank you.

Senator FIELDING—The payment under item 16525 is $267. Is that correct?

Mr Ryan—That is the 1 November 2007 schedule fee. We index the fees in line with a general fee update every year on 1 November. I can give you the 1 November 2008 schedule fee.

Senator FIELDING—It is around that number, is it not?

Mr Ryan—Yes. It has only gone up by 2.3 per cent. I think it is $273.15.

Senator FIELDING—Thank you. What is the average copayment for services under item 16525 that women would have to pay on top of the $273?

Mr Ryan—I would have to take that on notice and get back to you on that particular one. I believe it is a relatively low copayment, but I do not have the figure with me. Would you like it for the 2007-08 calendar year?

Senator FIELDING—Yes. One of the submissions to the inquiry said the typical payment for an abortion pre 20 weeks is about $1,250 and the typical payment for an abortion after 20 weeks is about $4,000. Does that sound about right? I am not after exact numbers; I just want to know if I am in the right ballpark with those numbers. I assume you would know some of the figures.

Mr Ryan—Those are the figures I have seen as well, but it is not necessarily the fee that is charged to the patient to Medicare. Because this procedure is performed as an episode of hospital treatment there are also private health insurance costs on top of that such as the hospital stay, for which payments we do not see through the Medicare MBS system.

Senator FIELDING—Have there been any studies on the effect of cash costs on people accessing medical services in that they only get so much back from Medicare for their out-of-pocket expenses?

Mr Kingdon—Not to my knowledge.

Senator FIELDING—Medicare contributes $273 of the cost of an abortion, but there are other schemes that reduce the costs of an abortion such as the Medicare safety net, which would refund 85 per cent of the out-of-pocket costs if a woman had already reached the threshold. Is that correct?

Mr Ryan—This procedure is predominantly performed within the hospital setting, so the extended Medicare safety net that you refer to does not apply to that particular setting. It only

applies to the out-of-hospital setting. As the procedure is predominantly performed within the hospital system there is no extended to Medicare safety net for those particular procedures performed in hospital.

Senator FIELDING—They are no other out-of-pocket expenses associated with it through other schemes?

Mr Ryan—There would be a minimal amount in relation to the private health insurance scheme with the 30 per cent rebate. On top of that there is the potential, if the level of out-of-pocket expenses for the patient reaches a certain threshold and they have a tax return, for the medical tax offset.

Senator FIELDING—Is there any way of you looking at all those issues and then coming back to the committee as to what the cost out of pocket would be for the government?

Mr Ryan—No.

Senator FIELDING—Okay. I see for an abortion to be funded through Medicare it needs to be done according to the law. That is on page 2 of your submission. Is that correct?

Mr Ryan—Yes.

Senator FIELDING—Given state and territory laws differ, what procedure is in place to assess the lawfulness of each abortion to see if it should be funded?

Mr Bridge—At the initial stage of making a payment, Medicare is concerned in relation to three elements. One is the eligibility of the patient and the eligibility of the provider and that the service is actually being provided. At the first stage, we are looking at those prima facie points to confirm the details, and then a payment would be made. At a later point, we would be looking for any concerns in relation to the particular payment that we have made. However, our role is around the correctness of the payment rather than any clinical matters in relation to the payment.

Senator FIELDING—I come back to the question: how well are you assured that they are following the law, given that each state and territory has different laws? Do you check?

Mr Bridge—Our role is not in relation to the laws of the states and territories. We rely upon the doctor’s clinical judgement. When they make a bill for that particular item they are making an assertion that they have met the state laws, but that is a matter for the states to pursue.

Senator FIELDING—Thank you. This is a slightly different question to the one asked before: is it a simple administrative matter to redefine item 16525 to add in or take away particular procedures, and what would be the process for making the change?

Mr Ryan—That is a policy decision for the government to make.

Senator FIELDING—I am after the procedure.

Mr Ryan—It is the same process.

Senator FIELDING—So it is not just the policy.

Mr Ryan—Once the policy decision is made, it would require the same regulatory process. It would be an amendment to that particular set of regulations to amend that particular item, so it would require the same time frame exactly. Doing that would require the Office of Legislative Drafting and Publishing.

Senator FIELDING—Does that have the six-month time frame you mentioned before?

Mr Ryan—It would be three to four months.

Senator FIELDING—This is my last question. Item 16525 covers abortion up to 26 weeks. Does the department have any concern that this could be used to fund an abortion of a 25-week-old unborn child which might be 100 per cent viable and able to live outside its mother?

Mr Kingdon—I do not think it is a matter for the department to have a concern. This is a medical doctor's judgement and we rely upon that doctor's judgement. Our concern relates to the fact of whether we reimburse somebody for an appropriate procedure.

Dr Richards—To add to that answer, the role of the Commonwealth, as you understand, Senator Fielding, is in provision of medical benefits. The Commonwealth does not have a constitutional power to legislate in the area of health service provision as such. The states and territories define the circumstances under which it is lawful to terminate a pregnancy. In most states and territories, as I understand it, termination of an otherwise viable foetus at 25 weeks would be unlawful. As Mr Bridge said, in rendering an itemised account to the patient with a Medicare item number, the doctor not only is asserting that he or she has rendered the service in accordance with state, territory and relevant Commonwealth law but also is asserting under the requirements of the Health Insurance Act that the service rendered is a clinically relevant service. That is defined in the act as being a service that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered. Going back to the previous question around a missing digit, I would expect it would be unlikely that a termination of a pregnancy for missing a digit would be generally accepted in the medical profession as being reasonably necessary for the patient to whom it is rendered. Therefore, it would not constitute a valid Medicare claim.

Going a little further to Mr Ryan's earlier discussion around the time frames, the minimum regulatory time frame, as Mr Ryan stated, is three to four months in which to go through the regulatory change. The six-month time frame that was quoted initially allows for what is usual, which is a period of consultation with the medical profession, usually managed through the AMA and the relevant craft groups. The Medicare Benefits Schedule is essentially a list of services that the medical profession advises government are clinically relevant services, and the item descriptors are generally developed in consultation between the department and the medical profession so that it reflects the service that is rendered by medical practitioners.

Senator FIELDING—In relation to this change, in Victoria there was a recent change allowing abortion up to the time of birth. How does that change the Medicare funding where it says 'up to 26 weeks'? Does it take three months?

Mr Kingdon—No, it does not change it, because there is no Medicare benefit for the third trimester.

Dr Richards—It is still a requirement for it to be a clinically relevant service.

CHAIR—Before we move on, I want to clarify the point about changing the regulation. The point was made that there could be a three-month delay in payment. Are there any provisions for retrospective payment? Under these circumstances the government could make it possible so that families that suffer a miscarriage are not going to be disadvantaged. Are there provisions to be able to make retrospective claims?

Mr Ryan—Retrospective implementation of regulation is allowed under the Acts Interpretation Act as long as it does not impinge on private bodies. That means that the only liability is on the Commonwealth. Given that this procedure is predominantly done in hospital, there are private health insurers who are required, where the procedure is performed within that setting, to outlay the private health benefits to their constituents. We would have to be very careful that we do not impinge a retrospective liability on those private health insurers.

CHAIR—But the government does have the capacity to ensure that families, under the other medical procedures that are carried out, can actually do that without being disadvantaged. Sorry, Senator Fielding, had you finished?

Senator FIELDING—Yes, thank you, Chair.

Senator RYAN—We have received conflicting submissions on what I would describe as the actual medical procedure—the method of management of second trimester labour, so to speak. Does the item number limit or specify further what procedures can be used to fulfil the medical activity being undertaken, or is that at the discretion of the clinician?

Dr Richards—It is at the discretion of the clinician, but, for a Medicare benefit to be payable, it is still required to be a clinically relevant service. The method that is used must be generally accepted in the medical profession as being the appropriate answer.

Senator RYAN—Would it be possible, if there were a policy decision to do so, to actually have the regulation either specify a procedure or prohibit a particular procedure for this purpose? I am conscious of Mr Ryan's concern that we end up with phone books of Medicare item numbers. So would it be possible, in the item number, to either specify or prohibit a particular procedure?

Mr Ryan—If the government made the policy decision to do so, it is possible, and that could be done either through a rule of interpretation to the particular item or an amendment to the particular item.

Senator RYAN—Do other MBF item numbers have a procedure based description? Is that common in the schedule or is it very much about the purpose of the procedure?

Mr Ryan—There would be examples of that but it would be more in line with the particular service that is being covered. In providing coverage for that particular service, the only way to do it is through that particular procedure.

Senator RYAN—In the table you have on the second page of your submission, with the number of claims dating back to 1994, there seems to have been a slight trend down. When taken into account with the growth in the population, I think it is a reasonably significant downward trend. Do you have any evidence as to why the claims are falling? Is it that more procedures are being performed in public hospitals? I appreciate you may not have the data. Are there fewer deaths in utero?

Mr Ryan—We do not know.

Senator RYAN—No knowledge?

Mr Ryan—That information is not available.

Senator JACINTA COLLINS—I would like to look at some other ways to get behind the data you provided in the submission regarding the number of claims and what else we might be aware of. Am I correct in recalling that I have seen a breakdown of the claim numbers by state? Has the department or Medicare provide that previously elsewhere?

Ms Benjamin—Yes, we did. We provided that information to Senator Barnett by state, and it is on the Medicare Australia website.

Senator JACINTA COLLINS—Fine. Just in case you are aware of the state-by-state situation now—or you can take this on notice if you need to—if we look at the data coming out of Victoria which tells us that there has been an almost threefold increase in late-term terminations in Victoria between 2000 and 2006, is that reflected in the claims under this item?

Ms Benjamin—Just by looking at those numbers, it does not appear to have a significant increase. They are fairly consistent. In Victoria in 2001 the number was 41 and then there was 29, 29, 43 and 53. But it was also 43 back in 1994. So the numbers appear to have, I guess, annual ups and downs but in general are fairly consistent.

Senator JACINTA COLLINS—During that time period there was also a significant growth in Victoria of late-tem terminations performed on women coming from other states. That would not be reflected in any way in that data, would it? In terms of it being a state claim, does that relate to the claim of where the mother has come from or does it relate to the claim of the clinic or the doctor who performed the service?

Ms Benjamin—I would actually have to take that on notice. I am fairly sure they are against the patient, but I would want to double check that.

Senator JACINTA COLLINS—If they are against the patient then they would not necessarily be relevant to this shift that the Victorian government has been reporting in their statistics?

Ms Benjamin—No.

Senator JACINTA COLLINS—If you would not mind, could you take that on notice? Also, in terms of a different legislative regime, South Australia, for instance, historically have limited termination services to the public sector. Is that reflected in their statistics? Is there a lower level of claim per population in South Australia than in other states?

Ms Benjamin—I just need to correct my previous answer and the numbers I was reading off with the dollar amounts. I apologise. My comments actually apply—

Senator JACINTA COLLINS—Well, they would reflect the dollar amounts, too.

Ms Benjamin—The numbers were fairly consistent for Victoria. For South Australia, again, the figure is reasonably consistent.

Senator JACINTA COLLINS—I am not asking about the consistency; I am asking about how they compare per head of population with respect to the other states. Is there a lower incidence of these claims in South Australia because the provision of termination services in South Australia has historically been limited to their public sector?

Ms Benjamin—No, I do not think the figures show that.

Senator JACINTA COLLINS—You do not think that is reflected in these statistics?

Ms Benjamin—No.

Mr Kingdon—Proportionally, population-wise, Western Australia would be greater.

Dr Richards—In South Australia, the limitations, as I understand it, apply after 20 weeks, so from 13 to 20 weeks terminations are—

Senator JACINTA COLLINS—In the private sector there.

Dr Richards—able to be performed as in other states.

Senator JACINTA COLLINS—That has not been the description that I have seen elsewhere. We might need to clarify that.

Dr Richards—We can clarify that.

Senator JACINTA COLLINS—It has been put to us that the major provider of psychosocial indicator terminations in Victoria does not claim this item. Are you able to confirm that? Presumably you know who you pay the item to.

Ms Benjamin—Yes, we do. I am sorry, I do not have any of those details with me.

Mr Bridge—Normally we would not be able to provide specific details in relation to any one particular practitioner or patient.

Senator JACINTA COLLINS—Are you able to provide us with the details of the clinics through which services are provided in a way which does not identify particular clinics but can give us a sense of the data beyond simply what is being reported?

Mr Bridge—We would have to look at how the data patterns look to see if we could do that.

Senator JACINTA COLLINS—Let us say in Victoria, for instance—and this is just a guess—there are four termination specific private providers. The question is: are they all claiming this item? It is a serious question for this inquiry because what has been put to us is that there is one provider who has not been claiming it because the question is whether the services provided would actually meet the clinically relevant test.

Mr Bridge—We would have to take on notice whether we could look at providing information to give you some indication of the range of providers that might be using the service.

Senator JACINTA COLLINS—I would be interested to know the range of public versus private hospitals, as in what proportion of the claims relate to private patients in public hospitals. I would also be interested in information on the private clinics by state in a way which is not going to compromise the privacy issues or those aspects.

Mr Bridge—Again, we will have a look at that. The data we have relates to a provider rather than a practice or a clinic, so we will have to look at whether we can actually construct that information for you.

Senator JACINTA COLLINS—Okay, but there may at least be a way that you can break it down by providers as well. For instance, I would be interested to see the number of providers in Victoria claiming under this item as compared to another state. We might then ultimately have to surmise whether they are operating out of a clinic or in some other way as well.

Mr Bridge—That is probably one of the easier ones to do. We will take that on notice. We can certainly look at the number of providers in any one state for you.

Senator JACINTA COLLINS—That brings me to the question about the clinically relevant service test. Is that tested in any way? Do we assure ourselves that this standard is being met in any way?

Mr Bridge—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.

Senator JACINTA COLLINS—Has that ever occurred in relation to this item number?

Mr Bridge—From our 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.

Senator JACINTA COLLINS—Has it occurred in relation to any of the other termination service related item numbers?

Mr Bridge—Not that we can tell from our records at the moment.

Senator JACINTA COLLINS—Going back to the definitional issues, are you able to give us what is regarded as the definition of ‘stillbirth’? During the estimates process we had this discussion. I have seen a few different definitions. Some of them separate stillbirth from an induced abortion. I am interested in what sort of definition of ‘stillbirth’ we are operating on at the Commonwealth level.

Dr Richards—As far as I am aware, it is not a definitional matter for the Commonwealth. There is no Medicare item that pays in any relation to stillbirth.

Senator JACINTA COLLINS—I found a definition in a New South Wales act but that was all I could find.

Dr Richards—As I say, states and territories have the residual power in relation to health service regulation, so each state and territory would have a definition, I would imagine.

Senator JACINTA COLLINS—Fine. One issue that I am interested in exploring and unfortunately the evidence that has come to us at this stage does not cover, apart from a brief mention in the department’s submission about health insurance, is what is the situation in relation to private health insurance and the provision of termination services. It is mentioned that if this item number were withdrawn that might impact on decisions by health insurance funds as to whether they continue to provide rebates for termination services. Is there anyone who can actually give me a description of what the current state of play is? If you pay $4,000 for a late-term psychosocial termination and are a private health insurance participant, what proportion of that is rebated?

Dr Richards—Each health insurer may have a different schedule for rebate of that, so it is not possible to say because there were so many private health insurers in Australia.

Senator JACINTA COLLINS—Let us say Medibank Private.

Dr Richards—In terms of the definition of the question, are you referring to mid-term rather than late-term termination?

Senator JACINTA COLLINS—Let us say late term for this one. That is where you are normally looking at the about $4,000 price.

Dr Richards—There is no Medicare benefit for a third trimester termination. Do you mean mid term?

Senator JACINTA COLLINS—Sorry, mid term, then. I would call after 24 weeks late term.

Dr Richards—We do not have that information in relation to private health insurers' schedules. It is a matter for each insurer.

Senator JACINTA COLLINS—What about Medibank Private?

Dr Richards—That is an independent company.

Senator JACINTA COLLINS—We will need to ask them separately. I think that is all the questions I have.

Senator FIERRAVANTI-WELLS—I have one question. Going back to the passage and procedures, the Fuelwatch bill was hurried through in 36 hours with people working, so if there is a will it can be done. If there is a recommendation for a change to the regulations, I understand that it is really quite a simple procedure, because all you are really doing is amending one item on the schedule. Mr Ryan, I hear what you say about the procedures, but if there is a will to do this it really is quite a simple process. If there is the political will to hurry the thing up, it can be done in a lot less time than what you have suggested. Have there been other instances where that can be done?

Mr Ryan—It can be done quicker where there is a will to do it quicker. However, as Dr Richards highlighted, with changes to Medicare items we like to go through a consultation process with the profession to assist in the defining of the particular service being covered. Particularly with this one we would want to work closely with the profession to clearly define the service to meet the requirements of the policy as set up by the government.

Senator FIERRAVANTI-WELLS—Since the definition has not changed and I have got a question in front of me going back to estimates in 2000 when then Senator Harradine asked questions about definitions of gross foetal abnormality. There was no definition then, so there clearly is not a definition now. In the process you have not obviously consulted on that. So in the end are we talking about something that is really a separation of items which you have previously not defined so you would suddenly want to go out there and find a definition, where you have not found one for many years.

Mr Ryan—As I said, it is a standard process to go through this consultation with the profession. As part of the Acts Interpretation Act we have to outline what consultation is undertaken. However, if there is a will it can be done quicker is the short answer to your question.

Senator FIFIELD—On that point, as a matter of logic, if you were creating a separate item number you would have to come up with a new definition—wouldn't you?

Mr Ryan—Yes.

Senator FIERRAVANTI-WELLS—You would finally have to come up with a definition.

Mr Ryan—Yes, and that may require defining it in regulations as well.

Senator JACINTA COLLINS—Where do you find information on next year's table?

Mr Ryan—The Health Insurance (General Medical Services Table) Regulations 2008 has just been registered on the Federal Register of Legislative Instruments. It was tabled in the House of Representatives on 23 October, so I believe it is probably due to be tabled in the Senate shortly.

Senator JACINTA COLLINS—So we only just dealt with the previous ones a few months back. When were they last tabled?

Mr Ryan—They were last tabled back in February, I believe.

Senator JACINTA COLLINS—They are usually tabled every 12 months but for some reason we are having them compacted.

Mr Ryan—They come into effect on 1 November each year. It is a legislative requirement that the General Medical Services Table be remade annually—it needs to be remade every 12 months and 15 sitting days. It was last tabled in February. I believe it was registered on the Federal Register of Legislative Instruments in October 2007, but with the election the first opportunity to table it would have been in February.

Senator JACINTA COLLINS—I understand; thank you.

Senator HANSON-YOUNG—Mr Ryan, what is the department's view on the claims from various people who have given submissions and will be presenting throughout the next two days that practitioners are being liberal in interpreting the descriptions under this particular item?

Mr Kingdon—The department can only hold to the judgement of the practitioner. If someone were to draw to our attention what they felt were inappropriate practices then this would be referred to Medicare, who, in turn, if they felt there were a matter to be answered, would probably refer it to the PSR because that is the only body that can peer review.

Senator HANSON-YOUNG—And that has not been the case?

Mr Kingdon—There has been no instance drawn to our attention.

Senator HANSON-YOUNG—So throughout the country, regardless of the different states' jurisdictions and the different legalities of what is mid-term and late-term abortion in the different states, no-one has brought to the attention of the department practitioners being, in their view, quite relaxed with their definitions.

Mr Kingdon—No specific instances. People can make assertions about practitioners in general but that does not help us to pinpoint the—

Senator HANSON-YOUNG—So no evidence has been presented to the department.

Mr Kingdon—No.

Senator HANSON-YOUNG—My next two questions are in relation to what impact a disallowance of this item would have particularly on women in rural and remote areas and also on women who come from socioeconomically disadvantaged backgrounds. At the end of the

day, if the only services that they are able to access are through the public sector, those are the people who are going to be most affected, I would imagine. Do we have any numbers?

Mr Kingdon—We have no numbers, and that is making assumptions about the socioeconomic status of essentially people who hold private health insurance. These items really only relate to out-of-public hospital services—they can occur in a public hospital but with the patient as a private patient—so we have not looked at that demographic.

Senator HANSON-YOUNG—So you do not think disallowing this particular item you would have any effect on people in rural and remote areas above and beyond that on people in metropolitan Sydney, for example?

Mr Kingdon—No, I did not say that.

Senator HANSON-YOUNG—This is what I am clarifying.

Mr Kingdon—You can only extrapolate in terms of the accessibility of services. If you are living in a rural or remote area, you usually have much more difficulty in accessing a service and getting an appointment. I would have thought that anything that interfered with the process of someone having their situation managed as soon as possible, any impact there, would probably be more difficult for a person in a rural or remote area, simply because it would be harder for them to find an alternative arrangement. And any delay, particularly if you are talking about second trimester pregnancy, is obviously going to be far more critical.

Senator HANSON-YOUNG—Absolutely. If you are in outback South Australia and you have to organise somebody to come and look after your farm and your other kids or something, so you can make your way into Adelaide, that is going to add a few extra weeks to something that perhaps could have been managed earlier if you were already living in Adelaide.

Mr Kingdon—One can make that assumption, but we obviously have not modelled or looked at that specifically.

Senator HANSON-YOUNG—Thank you.

Senator CAROL BROWN—I just want to ask a question about the private health insurance issue. Am I reading correctly from your submission that currently private health insurers are obligated to refund items claimed under 16525? Is that right?

Mr Ryan—Only where they offer that service within the private hospital.

Senator CAROL BROWN—You have said in here that they would not be obligated to pay benefits. Do you mean they are not currently obligated?

Mr Ryan—If they do not offer the service within their hospital.

Senator CAROL BROWN—I just wanted to clear that up. We have talked about the process in terms of reissuing different item numbers. I just want to ask two things. I take it that there was

consultation carried out with the medical profession and that an agreement was reached about the current descriptors that are under this item.

Mr Ryan—Yes. Back from 1994-95.

Senator CAROL BROWN—That is a long time ago. Do you know how long that consultation took?

Mr Ryan—I believe it commenced in mid-1994 with the submission that we received from the medical profession. As I said, it was to review the whole of the obstetrics services within the Medicare Benefits Schedule. There was a series of meetings that went through late 1994 and early and mid-1995 and resulted in the final change in November 1995. So I would say it was probably about 18 months worth of consultation.

Senator CAROL BROWN—We have had suggestions that the descriptors should be changed. If that decision was taken, would you be following the same consultation process?

Mr Ryan—It is our preferred consultation process to work with the profession to come up with the most clinically relevant item descriptor, so that there is an understanding from the government side of things as well as the profession—so that it is agreed.

Senator CAROL BROWN—So that is the preferred consultation process that the profession likes to see?

Mr Ryan—Yes.

Senator CAROL BROWN—And I would like to take up an issue that Senator Ryan asked questions on: describing actual procedures in an item. Would that require the same sort of consultation procedure?

Mr Ryan—The item descriptor is, in a sense, part of a regulation, so any change to that item descriptor would require regulatory change.

Senator CAROL BROWN—But, if it were a more comprehensive descriptor—I think he was talking about describing procedures—basically it is the same consultation process that you have currently undertaken?

Mr Ryan—Yes.

Senator CAMERON—Dr Richards, we have a submission before the committee which claims that second trimester abortions in abortion clinics around Australia are performed for psychosocial indications, where there is both a healthy baby and a healthy mother, rarely ever for grave medical indications. Does the department agree with that?

Dr Richards—We have no information in relation to the indications for which this item is claimed.

Senator CAMERON—The other assertion is that this item is accessed by deranged adults. Do you have any evidence that this is generally being accessed by deranged adults?

Dr Richards—We have no such evidence.

Senator BARNETT—You have touched on this but I understand not specifically in terms of the term 'gross foetal abnormality'. In this item does it include intellectual disability such has Down syndrome?

Dr Richards—The medical terms used in just about every item in the medical benefits schedule are not specifically defined in the regulations. They are understood by the medical profession and interpreted by the medical profession in alignment with the clinical relevance. It would need to be an interpretation that would be generally accepted in the profession.

Senator BARNETT—And is it?

Dr Richards—My personal view is that the term 'gross', as I said before, generally implies that it is macroscopic—that is, visible—and arguably Down syndrome would be a visible abnormality. With most children who have Down syndrome you can see physical stigmata, suggesting the diagnosis.

Senator BARNETT—That confirms my understanding. Does it include correctable conditions such as cleft lip and cleft palate?

Dr Richards—The term 'gross abnormality' could encompass such conditions but whether or not that would warrant a termination is a subject for—

Senator BARNETT—Does it include short stature, as in dwarfism?

Dr Richards—If it is a visible abnormality, one would imagine that that would fall within that definition.

Senator BARNETT—Does the term 'life-threatening maternal disease' include maternal psychosocial indications?

Dr Richards—That is a matter for the practitioner to determine?

Senator BARNETT—What is your advice?

Dr Richards—If the practitioner determined that the psychosocial condition of the mother was a threat to that mother's health, I would imagine that that would probably be generally accepted in the profession.

Senator BARNETT—Has there ever been an audit or investigation of claims made under this item?

Dr Richards—I refer that to Medicare Australia.

Mr Bridge—We have had no specific investigations of this item over the last 10-year period.

Senator BARNETT—Was a claim ever made under this item by Dr Suman Sood for the procedure for which she was subsequently convicted of performing an unlawful abortion?

Mr Bridge—That information would potentially be a question of privacy, which we would have to be careful of, but, as far as I am aware, the case in relation to Dr Sood did not involve that particular item, from our perspective.

Senator BARNETT—If we needed to go on in camera we obviously could, but you are not aware that—

Mr Bridge—Not aware of it.

Senator BARNETT—Not aware or you do not know?

Mr Bridge—It was not the issue at point in the Dr Sood case.

Senator BARNETT—What about claims by Dr Sood with regard to the other procedures on which the subject of the malpractice inquiry was taking place? If you are not able to answer that, that is fine, but if you are aware, that would be helpful.

Mr Bridge—I do not have the specific—

Senator BARNETT—Does the item cover the partial birth abortion method? It may be better for Dr Richards to answer that. I am not sure who would like to answer that question.

Dr Richards—The assertion by the practitioner claiming the item would need to be testable that it was a clinically relevant service, that it would be generally accepted. You would need to get advice from the profession as to whether such a method would be generally accepted.

Senator BARNETT—It is generally known—and you have seen the evidence both publicly and privately in terms of the partial birth abortion method—that it is undertaken by at least some practitioners, and there will be further evidence to this inquiry about it over today and tomorrow, so can you advise that that is covered by this item number if it is claimed as such?

Dr Richards—I think that is a question that is best asked of the profession—the AMA or the obstetricians—as to whether or not that would be a clinically relevant service.

Senator BARNETT—Thank you. I have two final, brief questions. Is pain relief administered to babies aborted in the second trimester or to late-term abortions, that you are aware?

Dr Richards—Again, that is a question best directed to the specialists.

Senator BARNETT—You do not know or you cannot comment?

Dr Richards—I do not know.

Senator BARNETT—Finally, what is your definition of 'psychosocial'?

Dr Richards—I do not have a definition in front of me.

Senator BARNETT—Can you give your best estimate?

Dr Richards—I find it difficult to speak on behalf of the department in defining that word immediately but I could take it on notice if you wish.

Senator BARNETT—The Medicare item number does cover psychosocial abortions.

Dr Richards—That is right, and so, if a practitioner claims that item, they are asserting that it is a clinically relevant service which meets that criteria.

Senator BARNETT—So there would be an understanding by the department that that would be an appropriate one.

Dr Richards—There would be an understanding within the profession and, if there were complaints made to Medicare Australia that such an indication was not clinically relevant in a particular instance, that could be subject to professional services review.

Senator BARNETT—I would be surprised if the department were not aware of the definition. If you would like to take it on notice, I am happy for you to do so.

Dr Richards—I would like to take that on notice.

Senator JACINTA COLLINS—I want to revisit a couple of those issues. In claiming this item, are they actually reporting psychosocial indications?

Dr Richards—No.

Senator JACINTA COLLINS—So that is not available.

Dr Richards—The specific indications that are encompassed by that item, which include foetal death, trophoblastic disease and a range of other conditions, are not specified in the claim.

Senator JACINTA COLLINS—Going back to my question about where this item number is being paid, are you able to look at whether you can give me the data relating to payments to practitioners in freestanding private clinics in Victoria, and also, which other related Medicare item numbers they might be claiming?

Mr Bridge—As a general rule, we only have the data in relation to the particular provider; not the clinic or the practice that they might be involved with.

Senator JACINTA COLLINS—Yes, but it would not take a great deal of work to identify some providers with some clinics.

Mr Bridge—I would have to look at the data but, as a general rule, we just do not have that information. Because the system is based on the provider, the patient and the service, we do not actually have readily available the connection between a particular provider and any particular practice.

Senator JACINTA COLLINS—I understand that, but I am suggesting that there would be less than a handful of freestanding private clinics in Victoria, and it would not be very difficult to identify which practitioners are practising in them and to give us data which does not compromise anyone's privacy, but enables us to look at how the various Medicare items in this area are being applied. I do not think that it is an onerous requirement to seek that information.

Mr Bridge—We can take that on notice.

Senator BARNETT—Can I just seek one piece of confirmation that has been tabled today in the submission. For whoever would like to confirm this, the statistics show, in the figures to August 2008, that there have been a total of 10,722 second trimester and late-term abortions—10,722 under this item number at a cost of $1.893716 million. Is that correct?

Mr Ryan—That figure is correct for the claiming of this item. It is not possible to ascertain a breakdown of whether or not it was for a termination.

Senator BARNETT—But under this item?

Mr Ryan—Under this item, yes.

Senator BARNETT—Those figures are correct.

Mr Ryan—Yes.

CHAIR—Could we have as much information as has been taken on notice turned around today where possible, particularly in light of definitions. I would have thought that those would have been easily accessible from the department's point of view. I thank you all for appearing before us.

[10.21 am]

BRASSIL, Ms Ann Elizabeth, Chief Executive Officer, Family Planning New South Wales

WEISBERG, Dr Edith, Director of Research, Family Planning New South Wales

NIXON, Ms Letitia Anne, Manager, Sexual Health information networking and education (SHine SA)

CHAIR—I welcome representatives from Family Planning New South Wales and SHine South Australia. Information on parliamentary privilege, the protection of witnesses and evidence has been provided to you. The committee has before it your submissions. I now invite each of you to make a short opening presentation, and on conclusion of your remarks I will invite members of the committee to put forward their questions.

Ms Brassil—Dr Weisberg will give the opening statement on behalf of Family Planning New South Wales.

Dr Weisberg—Family Planning New South Wales is interested in the reproductive and sexual health of the community. We are not abortion providers but we are very concerned that this item should not be removed from Medicare. The indications for this item are purely medical indications and we have no evidence that it is being used for anything other than medical indications. We are concerned that this is a very traumatic issue for women who are faced with either an intrauterine death or foetal abnormality or serious illness on the part of the mother, that delays in being able to obtain a termination or evacuation of that pregnancy in these traumatic situations will add to the stress and that there is no way these terminations can be done earlier because the diagnostic tests are not available until halfway through the second trimester.

We are concerned that families need time to make decisions to terminate a pregnancy for an abnormality because of the effect it has on the extended family, not just on the unborn child, due to the trauma and stress of having a handicapped child in that family. We are concerned that public hospitals which may be able to provide the service to disadvantaged women may be overloaded, that there will be a time factor and a further delay before women can have a solution to their problem and that this item number therefore is important so that they can seek private facilities if the waiting time at hospitals is too great.

Ms Nixon—Speaking from a South Australian perspective—and we are one of the states that gathers data—there is not an adequate data reporting system in Australia. That is clearly one of the issues you are struggling with around this item. Obviously this item is used overwhelmingly—and that data is further clear from South Australia—around managing second trimester labour for a range of foetal and maternal indications that have nothing to do with planned terminations of pregnancy.

The other piece of the puzzle, I think, is that, Australia, like other industrial and developed countries, has a universal antenatal genetic screening program in place. It has become a normal part of antenatal care. I have been a midwife for 24 years and it is very hard to receive antenatal

care now in a developed country that does not involve genetic screening. That whole process is based on the ability to terminate, usually in the second trimester, certainly often after 20 weeks, with a safe, available procedure. Morphology scans in an overloaded maternity system—we are in the midst of a baby boom; there is a maternity services review underway at the moment—means that access to some of those screens and the way that the actual chromosome testing is done, specifically for some lethal conditions, is not available before 22 or 23 weeks.

This is really a clear issue of equity. This particular Medicare item of course is for private patients in public hospitals or private patients in private hospitals. Those kinds of procedures in South Australia certainly only occur in the public system not in the private system. This item is not used much, but where it is used and needed it would be very iniquitous to remove it in terms of access for women, particularly with a government that puts so much money into supporting people to have private health coverage. Thank you.

Ms Brassil—I would like to add to the discussion that we believe all people with private health insurance are not necessarily wealthy. Some individuals who are in private health insurance are quite disadvantaged financially but choose to use private health insurance. We think that it is not necessarily the case that people who have private health insurance are able to better afford these procedures. We would also like to say that we think that women from rural regions are also more disadvantaged by this item being removed because they have such difficulty accessing public health services. Indeed, in some states and territories, access to abortion in public sector facilities is actually quite limited in places.

CHAIR—Thank you all for your opening comments. We will go to questions.

Senator HANSON-YOUNG—On the introductory page of your submission, you say that disallowing this item would actually be contrary to the Millennium Development Goals, to which Australia is a signatory. Could you explain that?

Ms Brassil—The government signed up to the Millennium Development Goals, one of which is to reduce maternal mortality and morbidity. We believe that introduction of this item would just add to the stress, particularly for women in our society and potentially create problems for maternal mortality and morbidity.

Senator HANSON-YOUNG—In relation to women in rural and remote communities, even if there is a local hospital chances are they would not perform these types of procedures anyway. A woman and her family would have to work out how she would get to a city. In terms of providing support and advice to clients and practitioners, would that put extra stress on people to perhaps put off undergoing any of these procedures, perhaps before that late term item would kick in? You would not know whether somebody needed to be managed through this process because the genetic testing would not happen until 20 weeks. What if it happened earlier—say the woman was sick and the pregnancy was looking dangerous? If it is going to take six to eight weeks to work things out—get on the list at a metropolitan hospital and, say, make sure the farm is looked after—how does a woman manage that situation?

Ms Nixon—I know that you are from South Australia. You are probably aware that rural maternity services have been closed down consistently over the last 15 years. That means services are pretty unavailable in regional and certainly remote South Australia. What we are

talking about is a very upsetting procedure for anybody. Whether it is a planned pregnancy, an unplanned pregnancy, a wanted screened pregnancy or ending a pregnancy after 14 weeks and in the second trimester, it is an enormous emotional burden for anyone—for a person on their own, for a woman in a family context or with children. Transport issues are enormous in South Australia, as are childcare issues. These are the very basic things that anybody would have to cope with on top of the grief and loss involved with ending or losing a pregnancy.

So I think it does really speak for itself in terms of what we are talking about here. This is not a technical issue; it is a very deeply interwoven social issue. And we are operating in a social context that has changed around social acceptance of genetic screening. I think that is a really important piece of the background information. It is different than it was 20 years ago.

Senator HANSON-YOUNG—Just so that we can be clear and concise: in terms of the women and the families that any of you would be in contact with, what would be the reasons that somebody would need to access this item?

Dr Weisberg—Basically, it would be because there is something wrong with the pregnancy. Either they have had a death in utero or they have had genetic screening or they have had an ultrasound at 18 weeks which has shown a major abnormality of the foetus, or there is a probability of the mother having a life-threatening condition which the pregnancy would aggravate. Those would be the major reasons. They would be medical contraindications or medical indications to have the pregnancy terminated.

For a woman who is carrying a child to 16 or 20 weeks to then have to have a further delay while she accesses public hospitals, knowing that there is something wrong with the pregnancy, just adds to the stress. It is a difficult enough decision and an emotion decision and a very sad decision for women to have to make. It is not one that women make easily. I think that any delay that would be occasioned by removing this item number would add to the stress—not just of the woman herself but also of the whole family who are involved in the decision making and considering how this abnormal child would affect the whole family.

Senator HANSON-YOUNG—If you do not feel like answering this question, please, by all means, deflect it. Do you feel that the debate that we are having here in relation to whether we fund a particular item number is something that we should be discussing or is this simply the federal jurisdiction trying to impact on what is currently managed by the states in terms of whether or not abortion should be legalised?

Dr Weisberg—If you are asking me my opinion about abortion—

CHAIR—Can I just remind everyone—so that we keep on track in relation to all witnesses and the questioning—that we are not here to debate abortion.

Senator HANSON-YOUNG—That was not my question.

Dr Weisberg—Your question is whether it should be the state legislation or the federal. I honestly believe it is better to have a federal legislation, because that applies to the whole of Australia, and not have different legislation in each state, which just confuses the issues.

Senator HANSON-YOUNG—You have spoken about why women and their families perhaps need to access this item number. If it was disallowed, what is the process from here? If you were not able to access this, what types of avenues would a woman have and what types of costs would be incurred?

Ms Brassil—If this is disallowed, for a start, there is a pejorative in that in that it really says to women, 'We're not going to support you through this very difficult time.' It feels like a value judgement in relation to second trimester abortions. I can only say that I think people should think about themselves being in the situation where you might be carrying a foetus that has died or carrying a very severely abnormal foetus and have to make those terrible decisions.

It adds another level of grief associated with what is already a very difficult decision and it therefore also adds a deal of complexity around that that may not have occurred, through a very, very difficult time for the woman and her family—her immediate family, her husband, often her children as well and then her extended family and, in a rural area, members of the community. It is difficult to understand, to some degree, why we are having this discussion when it is very clear in terms of the item that it is for very specific areas. The woman and her family are forced into these very, very difficult decisions which then create a whole series of psychological complexity, financial complexity and organisational complexity for their lives. Given the small number of charges against this item, it seems difficult to understand why we are having this discussion.

Ms Nixon—I think that, in addition, you would be simply shifting what might be currently performed in private hospitals, in terms of maternity services in private hospitals, directly into the public system which, as we know, is already overburdened. That is a very clear shift. And there would be a waiting time involved, which would make it an even later procedure with more distress for everyone.

Dr Weisberg—It certainly will not make any difference to the number of late terminations that are done for these indications, because they are very real indications.

CHAIR—No-one makes this decision flippantly, then. Do you have any further questions?

Senator HANSON-YOUNG—No.

CHAIR—Senator Fielding.

Senator FIELDING—Family Planning have said, on page 1 of their submission, that this disallowance would increase levels of poverty in Australia. It is an interesting angle to come from. If this disallowance did go through, wouldn't the poorest in the community still get access through the public health system anyway?

Ms Brassil—I think there is limited access through the public health system at the best of times. So I am not sure that it is as easy as to say that it shifts from the private sector to the public sector. If one looks at the availability of these services—if you want to ring around to the hospitals, for instance, in New South Wales and find out who provides these services—that is not very forthcoming, so it is very difficult. Sorry; did that answer your question?

Senator FIELDING—If the disallowance went through, they could still get access through the public health system. You are debating whether they would be able to get that quickly or slowly. But they could get access to the public health system.

Ms Brassil—I am debating whether that would occur in a way that makes it possible for them to pursue that option. The second thing is that, if they do not pursue that option and they go through to the full-term pregnancy with one of these very, very severely delayed children—and, again, I think that it is worthwhile experiencing the lives of some families who are dealing with very severely delayed children, and with more than one of them, because in fact a lot of women do not have amniocentesis until they already have one severely delayed child; it is not an easy decision for women to make to have that particular test—there is an enormous burden of cost to those families in rearing those children and to the community in rearing those children, not to mention the incidental costs of the procedural things around trying to get the abortion in these circumstances.

Senator FIELDING—SHine also says that item 16525 is 'not used by medical practitioners for the provision of surgical termination of pregnancy'. Are you distinguishing between induced abortions and surgical abortions, and can you explain those comments?

Ms Nixon—I am writing from a state perspective, so any of the second trimester terminations are done in a public hospital and the procedure is very straightforward. This item is about management of second trimester labour in those contexts. 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.

Senator FIELDING—So you have drawn that distinction for what reasons?

Ms Nixon—That is the nature of how the services are provided in our state.

Senator FIELDING—Okay. Thank you.

Senator JACINTA COLLINS—Ms Nixon, I was interested in your comments now and in the submission on concerns about the shift from the private to the public system, given the history of the South Australian system. So correct me if I am wrong but my impression of how the law developed in South Australia is that back in, I think, 1969 the public policy decision was made to contain the delivery of termination services to the public system. Is that correct?

Ms Nixon—The statistics are available since 1970. I arrived more recently—I am Canadian; I have been here 10 years. I think Edith—

Senator JACINTA COLLINS—But I think the legislation itself was passed in 1969—

Dr Weisberg—Yes, it was.

Senator JACINTA COLLINS—and my understanding of the background to that is that the public policy decision was made to allow for terminations under certain circumstances but to limit them to the public system.

Dr Weisberg—Yes, that is correct.

Senator JACINTA COLLINS—Is there a distinction at 20 weeks which the earlier—

Ms Nixon—The issue is that—and, again, this is around data and reporting—20 weeks or 400 grams is considered a stillbirth by the reporting system in South Australia. There are differences internationally. You were asking earlier for a national definition. There is not one yet in Australia but, for the purposes of reporting, that is what is used in South Australia. So data is collected against that.

Senator JACINTA COLLINS—If I am a woman in South Australia seeking a termination at 12 weeks or at 20 weeks, I am still essentially within the public system. Is that correct?

Ms Nixon—You could be a private patient in a private maternity hospital that provides terminations for up to about 14 weeks. After 14 weeks you are definitely in the public system.

Senator JACINTA COLLINS—So there are some prescribed hospitals in South Australia that are private hospitals.

Ms Nixon—We have a handful of private maternity hospitals in South Australia and they are all in Adelaide.

Senator JACINTA COLLINS—And some of them do perform terminations.

Ms Nixon—First trimester.

Senator JACINTA COLLINS—In the first 14 weeks. So that would make up for the three per cent you are talking about here.

Ms Nixon—A small percentage.

Senator JACINTA COLLINS—Given that the South Australian system has for quite a number of years been principally delivering termination services in the public sector, have you had problems with delays?

Ms Nixon—The maternity sector is underresourced in terms of specialists, midwives and access. You would be aware of that. So there are waiting times which are not good in this kind of situation, for sure.

Senator JACINTA COLLINS—Is there any significant indication of difficulties created for women over and above what might occur in any other state by virtue of the fact that the delivery in South Australia is principally within the public system?

Ms Nixon—Are there difficulties for women? I think that whenever you have decided on a termination and you cannot have one in a timely manner, if you need to wait one or two or three or four weeks for that, that is a difficulty. That is an issue.

Senator JACINTA COLLINS—What I am asking you is: is there any way to demonstrate that in South Australia, beyond anecdotal impressions, there are concerns with the delivery of these services, in comparison to another state where delivery is both public and private?

Ms Nixon—It is hard for me to comment in terms of comparison.

Senator JACINTA COLLINS—So you are not really aware of that?

Ms Nixon—No.

Senator JACINTA COLLINS—When I read your submission—and far be it from me to be offended on behalf of Senator Barnett—I saw the material you adopted from Children by Choice. I went back to the Children by Choice website after the officer from to the department suggested that my understanding of the situation in South Australia might not be accurate. They do actually clearly indicate that abortion is not provided in any freestanding private clinics in South Australia.

My principal concern, being from Victoria, is about what is occurring in freestanding private clinics in Victoria. I might ask Dr Weisberg to respond. For instance, there was a concerning report of a grieving woman in the recent Victorian abortion debate published in the *Herald Sun* newspaper. The woman was concerned about a very severe foetal abnormality in that the baby would probably not have survived birth. She wanted to end the pregnancy sooner but was concerned about accessing the public system because she would need to go through an ethics board process. So she instead went to one of the private clinics in Victoria. She complained, in the article, about very poor practice and procedure in the private clinic.

Have you got any reflection on the conundrum between having ethical standards and practice standards on the one hand—potentially generating delay but establishing best practice in the public sector—as compared to quite a large number of anecdotal reports of concerns coming out of some of the freestanding private clinics delivering services in this area?

Dr Weisberg—My understanding is that in the public hospitals there are committees that are involved in looking at individual cases and seeing whether they are in fact ethical or moral, to terminate the pregnancy. As far as I know, this does not happen in the private clinics. In New South Wales most of the private clinics only terminate until about 14 weeks. I am not aware of which ones carry out late terminations. But I think that most of the terminations under this item number would take place in either the public or the private hospitals, not in the freestanding clinics. I think that the major issue in Australia is that there are no good data on the termination of pregnancies and there are no consistent data throughout the country. It is high time that we set up a system whereby we had accurate information and then we could look at whether this in fact is a discussion that should be taking place.

Senator JACINTA COLLINS—Thank you.

Senator CAROL BROWN—I want to draw your attention to the SHine submission where you talk about the regulations that govern second trimester terminations. Can you expand on that area for the committee, please?

Ms Nixon—These would be practice guidelines within hospitals, primarily. You would be aware that medical practice is a community-based issue and is also based on best-practice evidence from international standards. That is how these things are determined, that is how procedures are determined. It is a movable feast: over a period of 10 or 15 years those things will change. There is also the issue of the point of viability, and so much of this discussion hinges on that debate. The second semester goes from 14 to 27 weeks. Concerns about viability of foetuses begin about the 23 or 24 week gestation mark. After 24 weeks you might have about 50 per cent viability with severe handicap with the best neonatal intensive care. Once you are looking at ending a pregnancy even for maternal medical indications or for foetal condition indications, at about that point there are ethical discussions between hospital ethicists and the practitioners and the woman's wishes and the family concerns at that point. So it is not an unregulated situation; it is actually quite codified in terms of daily practice in hospitals.

Senator CAROL BROWN—Can you step the committee through that process in terms of how it is regulated in terms of hospital review?

Ms Nixon—A review board would meet around a specific case. It would be called by in this case the consultant obstetrician with probably an RMO involved in the case. It would be presented to the ethics board in the hospital to discuss, the pros and cons would be debated and the record would be described about what the discussions had been and whether the procedure would proceed on that basis.

Senator CAROL BROWN—How long would that process take?

Ms Nixon—That can be done in a day.

Senator CAROL BROWN—I have one other question. When we are talking about delays in diagnosing any gross abnormality, the nature of the tests that are given to women now obviously causes delay because the results take time to come back. In the case of amniocentesis, if you are placed in the high-risk category and decide to undergo the test, my understanding is that it takes about two weeks to get those results back. And you can only have that test after, I think, 15 weeks. That places obviously a lot of stress, and it is a very emotional time for the woman. Is there a way that those results can be obtained more speedily?

Ms Nixon—There is something called the FISH test which gives you a result in 48 hours, but it is actually only for the three most common trisomies, 13 and 18, which are not compatible with life, and trisomy 21, which is Down syndrome. You can have a result in 48 hours for those, but you do need the two-week culture results for complex mosaicism No. 6 and No. 8. There are a range of different chromosomal abnormalities which again are not compatible with life which can take two weeks to come back. This issue of delays in access to what is called morphology scanning, which is a good look head to toe of the foetus at about 19 to 20 weeks, might bring the inter-amnio at that point. Your sample could not have enough fetal cells and you might have to re-sample and you would not have that information for a couple of weeks. So it is a really difficult window. There was research done on early amnio from 13 to 15 weeks in North America but it is not widely practised here. Of course CVS exists, which is much earlier, but it is quite practitioner dependent in terms of outcomes.

Senator CAROL BROWN—Essentially if you are placed in a high-risk category for whatever reason, age being one—I had my last child at 41, so I undertook all these tests myself and there were a number of weeks, five to six weeks, that pushed me up past the 20-week period. It is obviously very stressful and it is not something that a woman undertakes lightly.

Dr Weisberg—Can I just make a point about amniocentesis? There is a slight risk to the foetus with the actual procedure and, therefore, women are unlikely to have the procedure unless they have already decided that if there is an abnormality of that child that they would have the pregnancy terminated.

Senator CAROL BROWN—Great amount of stress when you have to weigh those issues.

Senator CAMERON—I am not sure if I heard you correctly, but I am sure you said that the number of abortions carried out on psychosocial grounds was about seven per cent.

Ms Nixon—It is 0.7 after 20 weeks in South Australia. That is 2006 data. It is a very small component.

Senator CAMERON—We have a submission before us that says that the majority of second trimester abortions in abortion clinics around Australia, where we have both a healthy baby and a healthy mother, are performed for psychosocial indications. Do you have any comment on that assertion?

Ms Nixon—I think that this discussion is about a particular Medicare item, a second trimester labour management or termination. I would imagine that statement would be referring to the gross number of terminations at any gestation, including first trimester abortions. As you would probably be aware, the abortion rate in Australia has been falling for years and that those are very personal decisions made between a woman, her partner, her family and her healthcare provider.

Senator CAMERON—Your figures are South Australian figures?

Ms Nixon—Yes. South Australia collects this data and reports on it annually, with all of the indications very specific. We are a small state, but sometimes, because we have good data, it gets extrapolated for the whole country. There are very big regional variations and we really need a much better data recording system to be able to comment on your question.

CHAIR—Ms Nixon, you are a practitioner; is that correct? Are you a midwife?

Ms Nixon—I have been a midwife for 24 years.

CHAIR—Can you give me your definition of ‘gross abnormalities’?

Ms Nixon—’Gross’ is a term that simply meant large.

CHAIR—The department said a cleft palate can be construed as medical evidence to terminate. Would you agree with that?

Ms Nixon—I had a chat with the head of obstetrics at the Women's and Children's Hospital, which for us is the tertiary centre in South Australia—it also services the Northern Territory, WA and Victoria when there is an overload, so it is a big centre—and those issues do arise and those issues go to ethics committees. Visualising a cleft palate situation on a morphology scan is quite difficult, so they are not so likely to be picked up. It is pretty rare.

CHAIR—And dwarfism?

Ms Nixon—Dwarfism is not a condition that you can pick up antenatally. What you can pick up are chromosomal abnormalities like Turner syndrome. Associated with Turner syndrome are small stature and a range of intellectual issues.

CHAIR—In relation to Family Planning New South Wales, when a mother confronts the issue of having a baby that is suffering from abnormalities, what sort of counselling is provided by your service for them to make an informed decision?

Dr Weisberg—We would help the woman decide, looking at all the options and what it means to the family and to herself to have a handicapped child, but ultimately we certainly would only help the family to come to a decision. However, usually we do not see women who are already at that stage; they would be looked after by the obstetrician rather than by Family Planning New South Wales.

CHAIR—This is a question for the panel: is there any evidence to suggest that if this element was taken out of this item number, which only relates to termination, it would prevent women from being able to obtain a termination?

Dr Weisberg—It depends on where they are living and what the facilities are like.

CHAIR—It is the same for any medical condition in rural Australia, unfortunately.

Dr Weisberg—Yes, but this is a particularly traumatic situation for the woman. I think you have to look at what having a grossly handicapped child means to a family. I spent a year doing research at a hospital for handicapped children in Sydney and I had to look through all the case history notes of those children. Almost invariably, the marriages of the parents had broken up with the stress of looking after a handicapped child. You also have to look at what would mean to the community to have an increase in the number of handicapped children who needed assistance, because that would be a far greater cost than this Medicare item.

CHAIR—It is pretty hard to define perfection, though, isn't it?

Ms Nixon—But we are in a culture that does that. This is happening in a social context.

CHAIR—As women we fight that every day as well, don't we?

Ms Nixon—I think funding for parents caring for children with disabilities is something that also needs to be part of this discussion.

Dr Weisberg—Yes, because in fact the services are not there. I happen to have within my extended family a child with severe autism. If the grandparents could not afford to pay for the extra care for this child, I do not know where that family would be.

Senator BARNETT—I got a bit of a shock, Dr Weisberg, when you talked about the number of children in the community with disabilities—I think you referred to them as 'handicapped'—and the impact on the community. Are you talking about the economic cost or the social cost?

Dr Weisberg—I am talking about all the costs, both to the community and to the family, what it does to a family and the support that they need, which is not available within the community.

Senator BARNETT—Do you think the community would be better off if we had fewer children with disabilities?

Dr Weisberg—I would not make a judgement like that. I think that the judgement has to be made by the individual family as to how their coping skills are and what they can cope with. I know a family, for instance, who have two autistic children and I know how difficult life is for them. I am not suggesting that those children should not have been born—that is a decision for the parents, not for me.

Senator BARNETT—So if the parents are aware of any disability whatsoever in utero then it is up to them to decide whether that child lives and is born or otherwise—that is your advice to our committee?

Dr Weisberg—I think that the decision would be for the parents to make in consultation with professionals who would tell them exactly—

Senator BARNETT—Sure. Ultimately it is up to the parents to decide.

Dr Weisberg—They are the ones who are going to have to cope with it.

Senator BARNETT—And that is because in your view there are economic, social and other costs involved.

Dr Weisberg—There is a tremendous social and economic cost to the family of having a handicapped child, as I saw from my days at Marsden Hospital.

Senator BARNETT—Are you aware of the United Nations Universal Declaration of Human Rights?

Dr Weisberg—Yes.

Senator BARNETT—Are you aware that it includes a reference to the legal protection of children before as well as after birth?

Dr Weisberg—I am quite aware that there should be legal protection for children before birth and after birth, but I think that this is a particular situation. What you are talking about is what

sort of life you are subjecting the child to and the family to, and the effects are widespread. That child has no ability to decide whether it wants to live or it wants to not live—

Senator BARNETT—Absolutely correct. They have no ability to decide.

Dr Weisberg—and therefore I do not see that we should be making those decisions; I think the parents have to make those decisions.

Senator BARNETT—Right. So the child has no rights and no opportunity to make—

Dr Weisberg—Well, it cannot do anything until it is an adult or old enough to be able to.

Senator BARNETT—Well, isn't that our job? We are legislators; we are there to prepare the policy and to protect the rights of those unborn children. Isn't that our job?

Dr Weisberg—But I do not see how you can decide for an unborn child who has a disability whether the child wants to live or not, so I think it has to be left to the parents.

CHAIR—Can I remind both the panel and the committee members that we are not here to debate the rights or wrongs of abortion; we are actually here in relation to the reference that is before us.

Senator BARNETT—Thank you, Chair. I was responding to the evidence presented by Dr Weisberg.

CHAIR—I have been fairly lenient. I am just reminding everyone.

Senator BARNETT—Dr Weisberg, do you understand item 16525 to cover all second trimester abortions performed in accordance with state law?

Dr Weisberg—No. I would see it as applying only to medical indications for a second trimester abortion.

Senator BARNETT—Do you think it should?

Dr Weisberg—No, I do not think it should. I think it should stay as it is at the moment.

Senator BARNETT—The situation in Victoria has changed, obviously, in recent weeks. You would be aware of that.

Dr Weisberg—Yes, I am aware.

Senator BARNETT—You made the comment earlier that you prefer federal, rather than state, legislation to cover these instances, but the state of Victoria has now said that it is up to the parents to have an abortion up to 24 weeks. Would you support that law?

Dr Weisberg—I still think that that sort of decision is up to the parents, not up to the law.

Senator BARNETT—It is up to the parents, not up to the law.

Dr Weisberg—We would be debating abortion again if I answer that, so I think I would prefer not to answer that.

Senator BARNETT—The point you are making is that it is up to the parents. My only other question relates to your definition of gross foetal abnormality. You used the words 'major abnormality' and I think there is a reference to 'severe abnormality', but it pretty much covers all forms of disability, as far as you are concerned, whether it be Down syndrome, dwarfism, cleft lip or cleft palate.

Dr Weisberg—I have never said that it applies to cleft palate. I would not regard that as a major abnormality because it can be corrected. We are talking about major abnormalities which are not able to be corrected surgically.

Senator BARNETT—Can you describe them for us?

Dr Weisberg—Chromosomal abnormalities which cause severe disability in children. I cannot list them off.

Senator BARNETT—Can you describe some of them for us?

Dr Weisberg—For instance, parents would be counselled about the wide range of abnormalities that occur with Down syndrome. You can have a very high-grade person with Down syndrome who is perfectly able to function in the community and someone who is totally unable to and who also has physical abnormalities. In that case, the parents have to make a decision about whether they are prepared to take the risk of having a high-grade Down syndrome child or one who has more disability. I still think that the ability to cope and to deal with an abnormal child has to be the decision of the parents and the family, not of me as an individual.

Senator BARNETT—Yes, you have made that point quite strongly over the last few minutes. Have you ever met Gianna Jessen?

Dr Weisberg—No, I do not know who she is.

Senator BARNETT—She is an abortion survivor. She is from the US and was in this country a couple of months ago.

Dr Weisberg—No, I am not aware of her.

Senator BARNETT—She asked the question: 'What about me and what about my rights?' I will leave it there.

CHAIR—I thank you all for coming forward today and for your submissions and contributions.

Proceedings suspended from 11.03 am to 11.22 am

DUNJEY, Dr Lachlan, Convenor, Medicine with Morality

van GEND, Dr David, State Secretary, Queensland Branch, World Federation of Doctors Who Respect Human Life

CHAIR—Welcome. Information on parliamentary privilege and protection of witnesses and evidence has been provided to you. The committee has before it the submissions, and I now invite each of you to make a short opening presentation. At the conclusion of your remarks, I will seek questions from my colleagues. I acknowledge that we have received the document that you have presented to us, but we need time to look at that before we table it.

Dr van Gend—Thank you very much for this opportunity to contribute to your deliberations. Item 16525 was no doubt drafted in good faith but, because of loose definitions, it is open to subjective interpretation by doctors, and terrible abuse. By disallowing the item in its current form and redrafting it to close the current loopholes, this abuse can be largely prevented and the valid medical intention of the item can be restored.

As documented in my submission, this abuse involves the unspeakably cruel and unjustifiable abortion of babies even older than those being cared for in our hospital nurseries—often entirely healthy babies of entirely healthy mothers. It is not just the usual pro-life suspects who recoil at this abuse. Even an abortion practitioner, the late Dr Peter Bayliss, is on the public record describing this practice of late second trimester abortion as murder. I table the transcript from the ABC's *The 7.30 Report*. Dr Bayliss gets to the heart of the matter when he says:

… you look at an ultrasound and you know it's an inescapable fact that if you did a miniature caesar on that woman at 26 weeks and passed the baby across to the neonatologist you've got a living human being.

Senators are free to look at the ultrasounds at the Harley Street IVF clinic website, createhealth.org, and confront the same inescapable fact that we are dealing with a living human being, and reach the same inescapable conclusion, as Dr Bayliss, that an elective abortion on such a baby is essentially murder.

The question before this committee is whether to limit the abuse of item 16525 by disallowing it and redrafting it in a safe form or to leave the item intact and effectively be giving financial support and succour to unjustifiable acts of unspeakable cruelty. My contribution to your deliberations is threefold: (1) to ensure you are fully aware of what is involved in second trimester abortion in Australia; (2) to give examples of how the current loosely worded item 16525 makes abuses possible, and what is required to redraft the item in a safer form; and (3) to relieve senators of the intellectual paralysis that comes from believing the myth of the 'backyard holocaust', reassuring them that removing this relatively trivial amount of funding from unjustifiable abortions under item 16525 while providing funding for valid indications is irrelevant to the safety of women, just as restricting public funding or restricting legal access to abortion over the last century has never had any detectable correlation with the safety of women. Thank you very much.

Dr Dunjey—Once again, thank you for the opportunity. The vision of Medicine with Morality is to preserve, in an age of rapid scientific and technological change, traditional medical ethics consistent with absolute values and to preserve the liberty of medical professionals holding these values to practise medicine according to their conscience. It was formed in early 2006 to unite doctors across Australia in response to an increasing drift of medical ethics away from moral absolutes. Medicine with Morality is not a religious organisation. Any person of any background can join as long as they agree with the statement of belief upholding the intrinsic value of human life. Apart from personal communication, I have very little idea of whether any individual doctor is a Christian, a Muslim or an atheist—I guess there are not too many of the latter, although if they have a high moral view of the value of life then they are welcome of course to join.

Why does Medicine with Morality have a view on the matter of medical benefits? Being concerned with the ethics and outcomes of medical procedures, those that exist now and those that may be contemplated for the future, the doctors of Medicine with Morality are also concerned whether such procedures should attract medical financial benefits, thereby seeming to have some inferred national approval by virtue of those benefits being granted. Specifically, the concern with item 16525 is that this item is being used for elective abortion in circumstances where the definition of 'life threatening maternal disease' has come to mean 'psychosocial distress' and 'gross foetal abnormality' has come to mean 'any abnormality or considered defect'. I was interested to hear the doctor from Medicare and the department talk about the old medical definition of 'gross'. If we are looking at gross abnormalities at autopsy, for instance, we are looking at the abnormalities from outside that are visible to the human eye not the severe defects that might be inside when we come to proceed with the autopsy. However, Dr Weisberg interpreted it—as, in fact, I think we all interpret it—as being 'severe' or 'major'. There is no satisfactory definition of 'gross'.

Our objections to such a use of item 16525 encompass not only the fact that life of an unborn child is being taken but also the nature of the abortion processes coupled with the lack of any consideration of foetal pain, the issue eugenic selection in our society and the implications of this with respect to our attitudes to the disabled in our society and our concern for the mother, who in her distress has chosen a solution she may later regret. We are concerned that termination of pregnancy has come to mean terminating the life of a child, when in reality the condition of pregnancy is terminated simply by induction of labour with delivery. Killing the child is not an essential part of this process and although we acknowledge this is done by some practitioners, seemingly within the confines of legal precedent, it is not something which should have any hint of national approval by the granting of medical benefits, nor, I would add, the granting of the baby bonus for a stillborn baby.

We are concerned that abortion for minor, readily correctable abnormalities such as a cleft lip should have implied national approval by the granting of medical benefits. We are concerned that potentially viable babies of, say, 22 weeks can either have their lives terminated prior to delivery, with no consideration of foetal pain, or be delivered alive and then put aside to die, and that such should also have implied or inferred national approval.

Our concerns also extend to the mother who, in her distress, has come to see that terminating the life of her baby at this later stage of pregnancy is her only option. Such has become an accepted way of thinking, although rejected as a solution by most in our society. Killing the baby should never be seen as a solution for misery, and certainly should not have inferred national

approval. In any case, we would argue that any temporary alleviation of distress would be counteracted by a later, greater distress when the full realisation of what has taken place hits home. Doctors have always known this to be true because we see these women in our practices. But such women are often reluctant to talk about this as it would increase their distress. However, this is increasingly being recognised in the medical literature.

It will be argued by other doctors that abolition of this bill will only disadvantage the poor. But the precedent is already there, with such procedures as elective cosmetic surgery, though this may also be said to disadvantage the poor, and any moral significance that cosmetic surgery might have certainly pales into insignificance compared with the moral issues and outcomes of mid-trimester abortion.

One of the submissions indicates that any support for disallowance of this extreme item would be extreme and radical. The doctors of Medicine with Morality are anything but extreme and radical. I am glad you have got the full list of the doctors there on the submission. We submit that the arguments we have presented are for the good of Australian society and the future of medicine in this country. Thank you.

CHAIR—Thank you very much. I will ask a question in relation to a reference you have made in your submission. I note that you were down the back earlier—although I did not know who were at the time—so you have heard the evidence this morning. There has obviously been an emphasis placed, and rightly so, on the mother and her health and wellbeing, and on her having to make a decision. There has also been evidence that families have to be taken into consideration as to, if there is a severely disabled child, what impact that is going to have on the family. I have not yet heard anyone speak about the impact on the baby that would be terminated. In your submission you refer to pain. Could you step the committee through that, and have you got evidence to suggest that babies of 20 weeks gestation are able to feel pain?

Dr Dunjey—There are conflicting views about that, although there are more and more people who are recognising that, with babies of 20 weeks or even younger, any sort of reflex withdrawal from a needle, for instance, is not just due to reflex but is in fact due to the perception of pain—that in fact the pathways to the brain are already there and that those pathways will register pain. Dr Anand suggests that the pain felt by the foetus at that kind of maturity is in fact extreme and severe pain, and perhaps more than we can feel. So, although there is conflicting evidence, how can we possibly say that those children do not feel pain? This is also recognised by the fact that, okay, no anaesthetic is given to the baby at 24 weeks who is being terminated—by extreme and brutal methods which I am sure I do not need to enlarge on—but anaesthetic is given to the 24-week baby outside the mother's womb when it is being operated on. Although once upon a time no anaesthetic was given because it was considered that pain is not perceived, that at least is now recognised and is a part of those procedures. So why are we so inconsistent in saying that a baby that is still inside the safe-haven womb does not feel pain? We cannot establish that, and certainly, because we cannot establish it, it should be considered.

CHAIR—In relation to the definition of gross abnormalities, do you have a definition which you believe the medical fraternity abide by when they are making a decision to terminate a pregnancy during this time under this Medicare item number?

Dr Dunjey—I would like to see this restricted to lethal foetal abnormality, rather than gross. Once upon a time we considered gross to be lethal and inconsistent with life. I would certainly like to see it limited to lethal. I was interested to hear of the dilemma of the Medicare and Department of Health and Ageing representatives who talked about the lack of statistics on this and the lack of ability to get any statistics.

I submit that we could find that out very easily—although this would cause an outcry—simply by separating item 16525 into spontaneous intrauterine death, as a start, which would then separate the intrauterine death from being a deliberately induced abortion, as one item, and another item for lethal foetal abnormality, which would overcome this problem, and another item for the mother at risk of death.

We could—but it would not be accepted, I am sure—add two extra items. One would be for lethal foetal abnormality, with killing of the baby first, but then we would require a diagnosis for statistical purposes. That would be easy enough to put on the Medicare claim form. And then there would be another for the mother at risk of death, with killing of the baby first, which would also require a diagnosis. This would very, very quickly give us the indications and the statistics and would certainly raise the whole public awareness of what is happening under the radar in Australia.

Senator FIELDING—Dr van Gend, you may want to expand on this—you touched on it briefly before. Do you see this disallowance as a move to provide a financial disincentive to seeking second trimester abortion, or is it about stopping federal government funding for a controversial procedure that many people in the community object to?

Dr van Gend—I think it should be restored to its original good faith intention and cover valid medical indications. It is simply a matter of changing the descriptors so they are not wide open to abuse. It is not that difficult. There are three descriptors, the first being intrauterine foetal death, which would seem straightforward. But of course when you cause intrauterine foetal death by injection of potassium chloride into the heart, or by the partial birth abortion method, the baby is dead before delivery, so it is intrauterine foetal death. That would be an anomaly and the first descriptor could simply specify intrauterine foetal death other than where caused by procured abortion. The second descriptor, again, has a valid intention of essentially supporting couples through a tragic lethal abnormality, or in the old understanding, gross being really incompatible with life.

We heard very clearly this morning from the health department spokesman, Dr Richards, that ‘gross’ means anything detectable, including cleft lip and including, no doubt, a missing finger—that is what gross means—and that that would be covered by the current indication. That is not the spirit of this item and it would be necessary to be quite firm in the redrafting and limit it to lethal. If you have any word other than ‘lethal’ abnormality the floodgates are open to the subjective interpretation of the doctor. Again and again we hear it is up to the clinical decision of the doctor.

Let me give you one example. It is a case by one of the leading proponents of second trimester abortion, Dr David Grundmann, Medical Director of Planned Parenthood, with whom I have a lot of exchanges. This exchange took place when we were both invited to address the AMA in Queensland in 1995 in the aftermath of revelations concerning his partial birth abortion

technique. I do not speak for the AMA—please be clear—but I was a witness to inform their deliberations. What Dr Grundmann said was that he had notes of a 23-week abortion for cleft lip and palate. A surgeon present said, ‘How can you justify that when we can repair that condition?’ His response was, ‘It depends on whether the woman wants to put her foetus through all that surgery’.

His clinical judgement was that this was gross and justified partial birth abortion at 23 weeks. When I asked him how minor an abnormality he would use—because in his lecture he says he will do late-term abortion for ‘doubtful or minor abnormalities’—he would not specify. I do hope the Senate has the opportunity to ask him at some stage. That is an example of the clinical judgement of the doctor saying that cleft lip is gross abnormality. I would suggest to the Senate that it is not keeping good faith with the public to fund any gross, as in visible, abnormality that the doctor involved, who has a commercial interest, deems gross.

Finally, the third descriptor is that of ‘life-threatening maternal disease’. That also would seem straightforward but unfortunately, as you heard from the health department spokesman, Dr Richards, psychosocial stress, if deemed by the doctor to be a threat to the woman’s health, would constitute a valid indication under this item.

Therefore, again, to keep the integrity of the item and direct the money to where it is intended, you would need to have something firmer. May I suggest for your consideration that you simply move to the item above, 16522, and rephrase the phrase they use in that item, which is ‘conditions that pose a significant risk of maternal death’. That is far harder to construe in terms of stress, however grave the stress, but stress we all have to face. ‘Significant risk of maternal death’ would, I think, give integrity back to the descriptors. Then you would reissue the item with all its valid indications intact and that would keep faith with the public.

Senator FIELDING—Thank you for that. You reckon that 16522 is another way of addressing the issue?

Dr van Gend—It may be that 16522 already covers cases of women facing life-threatening conditions. I think it should, because it is paid far more generously. For that your rebate is $1,066. For a doctor to manage a life-threatening maternal disease and get $226 is incongruous. It may be that the descriptor of ‘life-threatening maternal disease’ for management of second trimester labour is already better covered by 16522, which is management of complicated labour.

Senator FIELDING—To tie it all together: if this disallowance went through, 16522 could cover quite a few of those circumstances and in addition, if people were seeking an abortion, they could go through the public health system and therefore avoid the federal government being seen to be funding a controversial procedure through 16525?

Dr van Gend—The 16522 item number would only really apply to risk of maternal death. It does not fit intrauterine foetal death—not comfortably anyway—and it does not attend to lethal foetal abnormality. You could just as well cut and paste ‘significant risk of maternal death’ into 16525 and achieve the same integrity, I think. The point you make about public hospitals is very important because that addresses the obvious concern of those very grave abnormalities which are not lethal. That is a matter for terrible clinical agonising, not to mention parental agonising. The only valid place for such a complex and unclear clinical situation to be considered is in a

major institution, a public or private hospital with ethics committees, with specialists. I put it to the committee: that sort of decision is not to be made by a commercial abortion doctor on his own.

Senator FIELDING—Your argument there would be that the public hospital system has more public accountability for those sorts of life and death type judgements, which are therefore better suited to the public hospital hierarchy?

Dr van Gend—If it is granted that non-lethal abnormalities do require great deliberation, public hospitals are the place or major private hospitals, where there are checks and balances, there are committees, there are impartial people without vested interests and, importantly, there are support networks for those families—counselling, integration with the community. It is the place where grave abnormalities should be attended to—not predicting any outcome, but that is where they should be deliberated. Therefore, by changing this item to only 'lethal', you are not causing any particular trouble to someone who is dealing with a grave predicament; you are simply directing them to where they are most appropriately attended to—not a private clinic.

Senator FIELDING—Thanks for those insights. The other issue is about second trimester abortions and whether it is best that they take place in private clinics or in public hospitals for women's safety. Can you expand on that a little bit, please?

Dr van Gend—This would be an additional consideration for the Senate but an immensely constructive one. The head of the AMA in Queensland, Dr David Molloy, when he was head—I have the date referenced in my submission—he stated that abortion over 20 weeks is so dangerous for women that it should never take place anywhere other than in a major hospital with full facilities. That was purely on grounds of women's safety. This was after revelations by Dr David Baartz, who I understand will address you tomorrow, of the very grave life-threatening injuries coming to his gynaecological department at the Royal Women's Hospital in Brisbane from the surrounding abortion clinics, where abortions in the second trimester, particularly the later ones, led to grave consequences. Dr Molloy was only restating the position of the Royal Australian College of Obstetricians and Gynaecologists, where they said in one of their written statements:

> There is absolutely no justification for termination of pregnancy after 20 weeks by anyone other than a recognised specialist.

As I understand, Dr Grundmann, who is the prominent spokesman on these matters, is not an obstetric and gynaecological specialist.

Therefore purely on prudential grounds of women's care, anything over 20 weeks should only happen in major facilities. We have often said that if, for instance, at a COAG level, health departments agreed that private abortion clinics would have a condition of licensing that they did not perform abortion over 20 weeks, that would be a great benefit for the safety of women. And, from the perspective of those like me who are concerned for unjustifiable late-term abortion, it would be a tremendous benefit there because it would cut out a great number of unjustifiable late-term abortions.

Just to give you one figure: from Victoria, where we have the best data, the perinatal statistics from 2001-05 show that there were 581 abortions over 20 weeks of a healthy baby of a healthy mother. That is psychosocial indication. Of those 581, all but four were rejected by public hospitals and occurred in the private clinics. Therefore, post-20 weeks for psychosocial reasons is a commercial clinic venture. They are not dealt with at the public hospital because they would not be considered valid grounds. How the current law in Victoria changes that, I do not know. But that was between 2001 and 2005. Cutting the private clinics out of post-20 week abortion on the grounds of women's safety alone, would have the extra benefit of removing the large number of grave abuses that occur at present.

Senator FIELDING—Dr Dunjey, does ending pregnancy have to mean ending an unborn child's life or are there alternatives?

Dr Dunjey—Yes, definitely. It is unfortunate that termination of pregnancy has become synonymous with abortion when in fact a pregnancy can be terminated by induction of labour with delivery of a live baby. So pregnancy is a condition of the mother. The baby of course is involved, but we can terminate that pregnancy by induction of labour in instances where there is gross foetal abnormality, in instances where there is risk to the life of the mother, and we can have a live baby at the end of that, and maybe one which is viable. In instances of gross foetal abnormality incompatible with life but where the baby may be born alive, the mother then has a chance to cuddle that baby, to name that baby, until the baby dies. I have been witness to this kind of event, rather than killing the baby in utero and having a dead baby.

It seems that there is some supposed advantage in delivering a dead baby, which I find very hard to understand, but it was actually part of an eventually abandoned report of the NHMRC in 1994 and they said this procedure, being in fact the partial birth abortion procedure, has the advantage of delivering a dead baby. I wonder what is going on in people's mind when they think that this is an advantage. If a mother can cuddle her anencephalic baby which does not show and you have got the baby wrapped properly and then for that baby to die in the mother's arms after some hours is a wonderful privilege, and I have been witness to that privilege. The grieving process is just so much further enhanced by being able to cuddle and name that baby rather than having the baby killed in utero and then having a dead baby. I just do not understand that. It is a shame when we have to consider that termination of pregnancy automatically means termination of the baby's life. That is a tragedy.

Dr van Gend—Can I add one thing that is relevant to that. The AMA in Queensland brought out a position statement on late second trimester after this comprehensive inquiry they had in 1995 and they addressed that point. They said that, because of the duty of care to the foetus in the late second trimester, which is 20 weeks on, in the case of a viable foetus, the AMA says, the practitioner performing a late second trimester termination of pregnancy must be able to demonstrate that the foetus could not reasonably have been delivered alive but necessitated a destructive procedure such as cranial decompression. At that inquiry I put to Dr Grundmann one of his cases that he publicly stated on the *7.30 Report*, a Lebanese woman over 20 weeks—it transpired it was about 24, as best we could determine—who came to him and said that she would be killed if she went back to Lebanon in a pregnant state because it was to her boyfriend. Let me quote him exactly:

This clearly is a case of life and death for her. I felt I had no option but to help this woman regain her life and indeed to save her life.

At the meeting I said to him, 'Could you not have talked to this woman and waited only a week or two, gone two blocks up the road to the Royal Women's Hospital,' where I had been working, 'talk to the medical superintendent, Dr Ifor Thomas, and say, we have a problem, can we deliver this baby and help this woman?' To me that would have been a case of terminating the pregnancy but bringing the baby alive, who would then have been happily adopted out or some other arrangement. His response was: 'I am there to perform an abortion, not put some woman's foetus in an incubator.' That again is his judgement that this was a case of life and death, therefore it was his duty to perform an abortion but not let the baby be born alive. That is a case which would fall under the current descriptors. The clinical judgement of the doctor says it is life-threatening and so it would be paid. I think that loophole should be closed.

Senator FIFIELD—Dr Dunjey, in the opening paragraph of your submission you state that the principal use of item 16525 is for abortion. I know that it is difficult to obtain data as to the range of procedures funded under this item, but I wonder on what basis you make that statement? Do you have any data or anecdotal evidence for the basis for that statement?

Dr Dunjey—The data has been furnished by others. I knew that was happening. I know David has data on that and several of the other submissions have and I felt it was better for me to avoid the actual numbers on that and, as I said, it is a matter to be verified by the committee. I think the data is something like 95 per cent are related to abortion rather than gross foetal abnormality or life-threatening disease. David, do you have some of those figures in front of you?

Dr van Gend—I am not sure I understand the way we are using the word 'abortion'. These are all abortions in that they end a pregnancy. Can you make a distinction that I can help you with?

Senator FIFIELD—For a member of the public who might read the submission online, they might think that that was referring to terminations of pregnancies that were at the request of the women, that were not for reasons of clinical judgement that the foetus was unviable. I think most people would read that statement and see that as an abortion voluntarily entered into by a mother for whatever reasons she may have. I think that is how most people would view the word 'abortion'.

Dr Dunjey—Yes, that was my intention. That is correct. Do I have figures on that? No, and the health department could not provide figures on that either. From the figures in Victoria, I think it is clear that the vast majority of abortions were for psychosocial distress and therefore, yes, elected by the mother and agreed to by the doctor. Some were due to foetal abnormalities of various descriptions and descriptions which, in my view, certainly do not fit within the range of lethal abnormality. The vast majority of these were for elective reasons and should not be given ipso facto national approval by granting medical benefits for these procedures.

Dr van Gend—I think there might have been some confusion from an earlier speaker who gave a figure of psychosocial abortions over 20 weeks in South Australia as 0.7 per cent, but she did not say per cent of what. What she meant was per cent of all abortions in the state, not mid term, not post 20 weeks and there was no relative percentage of psychosocial versus congenital.

Also, in South Australia, there are particular laws in the public hospital guidelines that limit psychosocial. The figures that Lachlan referred to, I took and had in my submission purely from the perinatal statistics of Victoria. Early in the year when I researched this, the most recent was 2005. So 2001-05 were the figures I quoted before about psychosocial abortions—581 over that time post 20 weeks.

Senator CAMERON—What was that time frame?

Dr van Gend—The 2005 online perinatal statistics data for Victoria, which I have referenced in here, give a cumulative graph of 2001 to 2005. Over that time, there were 581 psychosocial justifications for post 20 weeks, of which only four were attended to in public hospitals.

The other figure that I mentioned was that the preponderance of post-20 weeks is not, as is commonly assumed, for grave abnormalities. The preponderance is for psychosocial reasons, and again the figures, particularly if you look at viability—that is, 23 weeks on—if you go 23 to 27 weeks, the records for 2005 showed 108 babies terminated for psychosocial reasons, which was five times as many as those terminated for congenital abnormality. Therefore, the preponderance under Victorian data is for psychosocial reasons.

Dr Dunjey—As a matter of argument, if it might be considered that I am incorrect in using the word 'principal'. Even if the number of elective abortions for the psychosocial reasons or mild congenital abnormalities was not principal, our argument would be the same—that is, these should not have implied national approval through the granting of Medicare benefits.

Senator RYAN—I noticed earlier you referred to the use of anaesthetic for procedures on 25-week babies in your discussion. Do you know whether anaesthetic is used for—and excuse me if I get the medical terminology wrong—prenatal operations? Is it used in that situation as well?

Dr van Gend—As I understand it, it is, yes. The *Lancet* journal in 1994—and many journals since—observed the full range of pain responses when unborn babies were given needling for blood collection. They would recoil, their adrenalin would surge, their heart rate would rise and so on. In my submission I mention an expert testimony to the Senate in the United States by a professor of paediatrics and anaesthetics Jean Wright, who said that because in that age group they have their pain fibres, but they lack the inhibitory system that naturally dampens pain, they therefore get no limitation on experience of pain. Her quote was:

> … the pain experienced during 'partial birth abortions' by the human fetus would have a much greater intensity than any similar procedures performed in older age groups.

Senator RYAN—My question was not so much about that part of your testimony, it was more about whether it is common procedure during those prenatal operations that you see on the TV news every now and then for anaesthetic to be used in this post-20-week period.

Dr van Gend—I think it is, but please confirm with the obstetric specialist tomorrow.

Senator RYAN—I shall. I notice you suggested the use of the words used in 16522—and correct me if I am wrong—of significant risk of death to the—I do not remember the exact phrase.

Dr van Gend—The phrase from the item above is:

Conditions that pose a significant risk of maternal death …

Senator RYAN—'Significant' legally is a very high hurdle. Do you have a particular view on why 'significant'—I am assuming that if there is something that was not a significant risk at 22 weeks that could still, because that hurdle is so high, result in the death of the mother later on then it might be a 'reasonable' risk or it might be an 'unforeseen' risk. Is there any particular reason you have chosen to set the hurdle that high? Would 'reasonable' open too many loopholes?

Dr van Gend—No. The word 'significant' is not important; it is the word 'death' versus the word 'life'. 'Life-threatening' incorporates psychosocial risk to the life and well being. As Mr Richards said this morning, if the doctor's opinion is that psychosocial stress is a significant risk to the health of the woman—that is what he said—then that would fit under the current descriptor. If you change that very subtly from 'life-threatening' to 'risk of maternal death', you have not changed the valid indications at all. It still means the same diseases—pre-eclampsia, major renal or heart disease and a few others listed in the Medicare schedule—but you have made it very hard for abuse to occur because of economic stress as an indication for late abortion. As Dr Grundmann says, 'major socioeconomic changes, such as desertion of a partner' would no longer apply because you cannot construe that as a risk to death.

Senator RYAN—So the word 'significant' is not the issue for you?

Dr van Gend—No, I can take or leave that. It is 'risk of death' rather than 'life-threatening'.

Senator RYAN—The first time that you mentioned the Victorian data, before it came up again then in response to Senator Fifield, I think you said that only five were not rejected by the public system. I stand to be corrected on that if the record shows otherwise. I accept your comment that five were done in the public system and 576 were done outside, but were you trying to say that, of that 581, many had been rejected by the public hospital system?

Dr van Gend—Sorry; they were not done in the public hospital system. Sorry; that would be overstating it. I would clarify that. No, four of the 581 were done in the public system.

Senator RYAN—In the public hospital system? I thought so.

Dr van Gend—All of the others were done elsewhere. I am not sure how many were first seen in the public system.

Senator RYAN—I thought that was what your submission said; I just wanted to clarify it. Much of your submission and testimony today has focused on the post-20-week scenario and procedures. Do you have anything to add to that, specifically about the 14 to 19 week part that is covered by this Medicare item number?

Dr van Gend—The reason that so much of my submission was on post 20 weeks is that that is what I have had to deal with, through dealings with Dr Grundmann, through the AMA inquiry, and through the corresponding debate in the United States, where the partial birth abortion

technique has now been banned by the Congress and the United States Supreme Court. That is where most of the data and material is. This item deals with the second trimester. So, as you say, it is 13 through 26 weeks. I think the conditions still apply, whether you are at 16 or 23 weeks. Intrauterine foetal death still applies. Life-threatening maternal disease can still apply. It is a little unlikely to get life-threatening pre-eclampsia before 20 weeks, but it is conceivable. And the third valid indicator, of lethal foetal abnormality, would equally apply before or after. So I think those three valid indicators can apply throughout the second trimester and there is no need to change that time span at all.

Senator RYAN—So, just to clarify something you said then: the risk of life-threatening maternal disease—which is, I think, the phrase currently used—a significant risk to the mother's life, only becomes apparent more commonly later in the second trimester, does it?

Dr van Gend—Generally, it would. That varies from case to case. Individual women may have severe renal disease before their pregnancy begins. But, in the medical criteria listed in the Medicare schedule book, for the examples they give—of pre-eclampsia at a severe level, renal or hepatic failure, coagulopathy—it is a fair comment that these things tend to become more severe, post 20 weeks. Again, please clarify that with the obstetricians, but that is a fair generalisation.

CHAIR—Can I just indicate that, thus far, a limited number of committee members have been able to make a contribution and we have quite a few remaining, so could you just summarise it so that we can move through and give everyone an opportunity to ask questions.

Senator RYAN—I have one last question. Just to highlight the issue: we can only disallow. The committee can recommend things, but it is one of the frustrations of being a legislator I suppose that it is completely in the hands of the minister to take action on the recommendations you suggest. Just briefly—given that my colleagues want to say something—do you have a particular view on that dilemma with which the Senate is faced: we cannot undertake the recommendations you have suggested by changing the item number; we can only disallow this.

Dr van Gend—If the Senate expressed the opinion that there should be changes and made recommendations, I would imagine there would be a cooperative spirit between the health minister and the Senate, because, if the health minister declined to do that, I would imagine that the Senate would simply disallow the motion when it returned if it were unsatisfactory. That is just looking on as a spectator. I am afraid that the machinations of redrafting this is beyond my experience or competence.

Senator CAMERON—Dr Dunjey, I just want to try to contextualise your submission. You indicated that your submission was on the basis of a drift away from moral absolutes. Are these religious or secular absolutes that you are talking about?

Dr Dunjey—Secular—well, scientific absolutes. The actual belief statement of Medicine with Morality hinges on the definition of life and when life begins and has nothing to do with religious principles or when we become human, because that is capable of various definitions. What we say is that human life begins at conception, when the embryo has 46 chromosomes and adult characteristics are already determined. So, no, it is not religious.

Senator CAMERON—In terms of moral absolutism, that means that the context of the act has no place in any of your considerations—the context of how the act is undertaken or why the act was undertaken. Is that correct?

Dr Dunjey—Various submissions and various doctors have argued from time to time when it comes down to questions of moral and ethical outcomes that evidence based medicine alone should decide what happens. We would argue that evidence based medicine in an ethical vacuum is not good medicine. To take an obvious recent case, if physician assisted suicide had been made legal in Victoria—and there was lobbying for an item number on physician assisted suicide—Medicine with Morality doctors would say: 'Hang on. There is an ethical component to be decided here. Should we be giving national approval for the granting of Medicare benefits for such an item?' We would say, 'No.' We would submit that any Medicare items, and therefore the context of the act, must be phrased in terms of the public good, for the future of society and in particular for the future of medicine.

Senator CAMERON—So it is not really absolutism. You are agreeing that there is a need for some context of the act to be taken into account.

Dr Dunjey—Yes, for the public good.

Senator CAMERON—Dr van Gend, in your submission you talk about the need to stay away from loose definitions. Then in the last page of your submission you ask:

> Why should the public be forced to contribute money through Medicare for deranged adults to go to doctors to have such babies killed … ?

What is the evidence that there are these deranged adults going to have babies killed?

Dr van Gend—I am trying to give such adults the benefit of the doubt. I am trying to attribute to them diminished responsibility—that is, they are not of their right mind. If you were in cool consideration to take a six-month visibly jumping baby, entirely healthy, and yourself in perfect health to a doctor to have partial birth abortion performed on it, I would say that would be a far greater culpability than merely not being in your right mind. As I said in my submission, if someone does that act they need restraint and counselling. They do not need Medicare subsidies. I do not consider that that is a normal act of a settled, calm mind. That is what I meant by that phrase.

Senator CAMERON—What percentage do you think there is of these deranged adults accessing this Medicare benefit?

Dr van Gend—I have no reason to put a percentage on it. I am saying that to be in that state, where we know people go for psychosocial reasons—that is, they are distressed, possibly to the state of not being in their correct mind, which is what deranged means—they need support and counselling. They do not need to have their way smoothed to the private clinic and subsidised by Medicare. That is the point—it is the wrong approach for adults in that situation.

Senator CAMERON—In your submission you talk about healthy babies and healthy mothers being involved in this. Then you link these people to having this psychosocial disorder. Are you saying that you can have a severe psychosocial disorder but still be healthy?

Dr van Gend—Yes. In definitions we cannot call it a disease unless it fits the DSM-IV psychiatry criteria.

Senator CAMERON—But it is an illness, isn't it?

Dr van Gend—It is an illness as in a normal non-medicalised disorder, yes.

Senator CAMERON—But there is plenty of medical evidence about how disruptive this can be to an individual. There are specialists in psychosocial disorders—disorders which can go to schizophrenia.

Dr van Gend—Once you are schizophrenia you are a psychiatric defined disorder, whereas psychosocial by definition cannot be fitted into a medicalised model of psychiatric illness.

Senator CAMERON—But there are other views on that. That is your view.

Dr van Gend—No, I do not think so. I think 'psychosocial' is by definition something that is not definable as schizophrenia, major depression, bipolar disorder or post-traumatic stress disorder—those would be medical conditions. Psychosocial would be more like major life stress, which we all go through, but I do not think it would be considered a disease.

Senator CAMERON—So we all go through anxiety disorders—

Dr van Gend—They may meet the threshold of a diagnosable anxiety state, yes. But the proper treatment for an anxiety disorder is to treat the anxiety, not to abort the baby.

Senator CAMERON—What if having that baby means that there are significant pressures on that individual which drive them to massive illness?

Dr van Gend—Correct. That would be similar to the recently revisited de Crespigny case, where the allegedly dwarf baby was aborted because of the psychological distress of the mother. The obvious question—which I hope you will put to the professor tomorrow—is: if you need to end the pregnancy, why in the world do you have to kill the baby in the process? Why not let it be born and, if the mother is not in a fit mental state to care for that baby, let that baby be protected as a ward of the state or adopted.

Senator CAMERON—But couldn't that be in some cases a contributing factor to making the disorder even worse—if you take the baby away from the mother?

Dr van Gend—It could. And it could also be a contributing factor to procure an abortion on a mentally disturbed patient. And it could also be a contributing factor to leave the baby with the mother. There is no easy way out, but there certainly is no simple answer in abortion.

Senator CAMERON—I am really interested in this figure you have given us in Victoria of 581 for psychosocial disorder abortions. I have got the figures here from the Department of Health and Ageing, and they say that in 2008, up until now, there were only 540 cases accessing this particular area of abortion. The evidence that is before the committee from South Australia is that it is 0.7 of post-20-week abortions. How do we get these massively different views from Victoria and South Australia?

Dr van Gend—They are all correct. Remember the Victorian data has nothing to do with the Medicare item. The Victorian data is from death certificates from all sources of stillbirth and perinatal death, and that has nothing to do with the number of psychosocial abortions that happened to be claimed on Medicare. They are quite different bodies of data. It may be that only a small number of that 581 triggered item 16525, in which case the Medicare figures would be very small. The perinatal data captures every baby in its net. Therefore, the perinatal data figure will be higher than the Medicare claim figure. I think that South Australian figure referred to 0.7 per cent of all abortions.

Senator CAMERON—No—

Dr van Gend—Was it abortions post 20 weeks?

Senator CAMERON—Yes.

Dr van Gend—That is fine. Remember that it is a different system in South Australia. Everything is done through public hospitals, where hopefully psychosocials are screened out rather than permitted. That is why the number is so small. In Victoria the psychosocials can go to the commercial clinics, where they are certainly not screened out.

Senator CAMERON—Do you come at this debate from a moral absolute as well?

Dr van Gend—I do not because I am not sure of the philosophical meaning of that. I come to this from a morally human point of view—that is, I consider the deepest human moral relationship to be that between mother and child and the greatest duty of care in society to be between adults and defenceless young. That generates enormous moral energy because that is the source of the greatest potential abuse and also our greatest duty of care. That is what motivates me.

Senator MOORE—Doctor, I will not waste too much of your time, because we have had these discussions on many occasions. I just want to follow up from Senator Cameron. There have been lots of figures thrown around. I know that you have read all the submissions, but the submission from the National Association of Specialist Obstetricians and Gynaecologists refers to Victorian figures. I just want to see whether they are the same figures that you are using. They say that they are using the figures from the Victorian Council on Obstetric and Paediatric Mortality and Morbidity. Is that the same database that you have used in your statements?

Dr van Gend—That is the one I have looked up. When I looked earlier this year it was 2005. Subsequently 2006 has come in.

Senator MOORE—Two thousand and six is the one they quote in their submission. That is the latest.

Dr van Gend—Sorry, I have not seen that one.

Senator MOORE—In their submission, which I know you have looked at—but you might want to have another look—

Dr van Gend—I have not, but I will.

Senator MOORE—they quote 2006 as the latest publicly available figures, using the statements you have made. They have a premise there about how those figures came to pass and why the data around definition could be different, in that people from interstate and overseas are part of the database. I know this argument is going to go on, but I would like us to be trying to compare the same lots of data all the way through.

Dr van Gend—I quite agree, and it probably is exaggerated because Dr Grundmann is based in Victoria.

Senator MOORE—I think that is true.

Dr van Gend—It would be nice if we had equally good data around the country.

Senator MOORE—Just following on from Senator Cameron, the issue that seems to be at point is motivation and the definition of 'psychosocial'. Just so we have it on the record, in the data that we have using the term 'psychosocial', there is no examination or further discussion of that in any way. It is just a term that is put on the note—'psychosocial reasons'. So your premise, which is determining what you believe is psychosocial, can only be done from what you believe is psychosocial reasoning. The actual interaction between the patient and their doctor, what was discussed, the degree of concern and what was determined, cannot be determined just by that term 'psychosocial'.

Dr van Gend—It is a category of exclusion. It means the indication is not physical disease in the mother, it is not lethal abnormality in the foetus and it is not a psychiatric diagnosable condition in the mother. Generally that would, I think, leave the body of 'psychosocial'. But I agree it is not a firm term.

Senator MOORE—Your submission, amongst others, has dismissed that as purely a personal choice.

Dr van Gend—No, it was not dismissed. It does not indicate how grave the distress is, but what it does specify is that you have a healthy baby and a healthy mother and yet termination is undertaken. There are other ways to deal with psychosocial stress than by killing a baby.

Senator MOORE—That is your position and I recognise it.

Dr van Gend—Yes. It is also Dr Bayliss's position, incidentally, if you read the material from *The 7.30 Report*.

Senator MOORE—I have read it, yes. In terms of the ongoing process, the point that is made throughout many of the submissions is that the discussion and the decision are between the parent and the doctor. Your premise is that the individual doctors do not have the ability to effectively make that diagnosis. Is that your position?

Dr van Gend—Not at all, because these abortions will proceed based on the decision of the parent and the doctor. The only question for the Senate is whether we the public fund it on unjustifiable conditions or whether we the public fund it on narrow, valid conditions.

Senator MOORE—As a public health process.

Dr van Gend—As a Medicare subsidy from the taxpayer. We are not determining whether an abortion will happen or not by withdrawing this relatively paltry sum.

Senator MOORE—That is absolutely true—there is not full funding; it is a partial funding of the process.

Dr van Gend—Exactly. It is only about five per cent to 20 per cent of the actual cost of the abortion.

Senator MOORE—What I am trying to get from you is this. Your argument is that individual doctors—and you have quoted one in particular all the way through—are making decisions that you do not believe they should make or are capable of making, in fact, I think you have said.

Dr van Gend—The doctor in question has been very upfront about his decisions. He says he will do late-term abortions where women have missed six periods and did not realise they were pregnant, where you have desertion of a partner, where you have minor or doubtful abnormalities and so on. Those I consider outrageous and unjustified and yet they continue to be open to funding by this item. I would say, if you change the item to—

Senator MOORE—You have gone on record very clearly about those processes. Do you know whether the cases that you have identified were subject to Medicare funding?

Dr van Gend—They are open to claiming the item.

Senator MOORE—But do you know whether they were claimed?

Dr van Gend—How would I know? Even the Department of Health and Ageing does not know.

Senator MOORE—The way you have actually presented it, you are saying they have been funded—

Dr van Gend—It does not matter whether the doctor did claim for a given abortion. The offence is that he can claim. He can claim a Medicare subsidy for that abortion, as we have heard from the health department. He will qualify under the current descriptors even if the case is psychosocial, even if it is a cleft lip—he qualifies under these current, faulty descriptors. I am happy for us to fund valid descriptors: intrauterine foetal death, risk of woman's death—let us

fund those. But let us close the loopholes so this item has integrity instead of being wide open to abuse. It is abuse of such a grave and inhuman nature that we should take this terribly seriously.

Senator MOORE—You do not think it is the responsibility of the individual practitioner to actually make a claim under the current position? That is not their responsibility?

Dr van Gend—It is, but the current descriptors are so wide open to abuse that he can claim for unjustifiable cases. I think we should tighten that and direct the money where it is deserved.

CHAIR—Senator Barnett is the proponent of this motion and he has questions.

Senator BARNETT—I am happy to defer to Senator Eggleston at this stage.

CHAIR—We have Senator Collins, Senator Carol Brown and Senator Eggleston still waiting. The reality is we have an appointment at 12.30 pm, so we can continue for a little while.

Senator BARNETT—I will defer my right to Senator Eggleston if that is okay, subject to the approval of the chair and the meeting.

Senator EGGLESTON—I do not want to pre-empt full members of this committee. I am just a participating member. I am very interested in the United Nations charter with respect to children with disabilities. I wonder if you could tell us what that charter says.

Dr van Gend—I am afraid not. I am aware of it but I do not have it with me and I would not be able to give you accurate content. I am sorry. Subsequent witnesses may be able to.

Senator EGGLESTON—Yes, I believe they will later this afternoon. My question following that was going to be: what are the implications of Australia having adopted the United Nations Convention on the Rights of Persons with Disabilities in relation to the Commonwealth department of health interpretation of gross foetal abnormality under 16525?

Dr van Gend—I think we need to bolster our public thinking on the treatment of disabled babies with some sober international statements like that. I felt quite chilled to hear earlier witnesses essentially argue that the economic burden of disabled children is grounds for abortion. Even in Senator Claire Moore’s submission to her very own committee there is that argument that economic reasons for aborting disabled children should, if I understand you correctly, be a reason for second trimester abortion. That is the old eugenic argument out of which the whole Planned Parenthood movement had its roots, with Margaret Sanger. We are right back to the eugenic justification of getting rid of disabled babies. I think that is a dramatic statement to hear in a place like this.

Senator EGGLESTON—That is a very interesting point. We have recently seen abortion law passed in Victoria. We have seen the famous case concerning the Royal Women’s Hospital. Would you say there is some sort of sociological change occurring in Australian society with respect to eugenics and the increased number of mid-term abortions?

Dr van Gend—It would take a very profound analysis to show what has changed in recent decades to make what was once unthinkable now quite commonly approved. Those changes

occur very subtly, by a process of desensitisation, and a very large part of the desensitisation that leads us to consider aborting disabled babies purely because of economic burden on society is that we have, effectively, negated the humanity of any unborn child by approving the unlimited abortion licence. If it is open to adults to end the life of their unborn child, throughout pregnancy, for no reason—as is now the case in Victoria, up to 24 weeks, at least, and beyond that purely on the colluding nod of two abortion clinic doctors—then what does that say about the status of any baby in the womb, let alone a disabled one who is going to cost society money? That is part of the desensitising process that has brought us to a fairly brutal state.

Dr Dunjey—And, can I add, it has crept in with the aiding and abetting of the medical profession. A lot of women undergoing antenatal testing do not really understand the full significance of that antenatal testing, and then they are suddenly confronted with a diagnosis of, for instance, a Down syndrome baby, and then the expectation, it seems, from the doctors, in talking with patients who are confronted with this is, 'Well, yes, of course; why shouldn't you have it aborted?'—to the extent that, in England, women who refuse such abortions at that point have been termed 'genetic outlaws'. So this change has crept in very subtly, and with, unfortunately, the cooperation of the medical profession. Women have not had time to think about these things at this point. One of the things that I do in confronting—in a patient with an early pregnancy, is to talk about what the testing will be and what the implications of that testing are. I mean, this is properly informed consent.

Dr van Gend—I will give just one personal anecdote of the way that the medical profession imposes an expectation on parents to get rid of disabled babies in some circumstances. My sister, with her first child, was told by an obstetrician that the ultrasound showed Down syndrome, and that 'it will be no better than a pet'. This obstetrician knew nothing of my sister, of her understanding of life and of her response to this news. He simply said, 'It will be no better than a pet,' and therefore termination is the recommended option. Of course she did not have the termination, and of course it did not have Down syndrome—which is another reason why non-lethal abnormalities should be excluded from this item, simply because the search-and-destroy mechanisms are not foolproof for non-lethal abnormalities. That is an example of the culture change in medicine.

CHAIR—I am now going to go to—

Senator MOORE—I am sorry, Chair, but I think that both doctors have made general statements. If there are individual cases of practitioners who have behaved in that way then that should be brought to people's attention, but to make statements generally, that one situation reflects the whole medical practice, is, I think, not particularly strong for the medical practice. Also, on Dr Dunjey's statement about people having informed consent: I think that that is a wide concern, Doctor, for all interactions between patients and doctors. Certainly, to make a statement about people not understanding antenatal processes—that is really serious and, should that occur, it is everybody's responsibility to ensure that that is improved. But I am very concerned, Chair, that we are making statements across the whole profession.

CHAIR—I do remind people that we are not here to debate the merits or otherwise of abortion. In fairness, on the balance of time, Senator Collins, you have five minutes, I am afraid.

Senator JACINTA COLLINS—I hope I should fit easily within that. Firstly—and I ask this just as a Victorian Senator—could you inform us on your understanding of why Dr Grundmann is now operating in Victoria?

Dr van Gend—We would like to think that life became uncomfortable for him in Brisbane so he moved. There were a number of major public outcries at his practice. When it was first tabled in parliament on 26 October 1994, the AMA president, Dr Rob Hodge, decreed that Dr Grundmann was on his own in this practice. There were calls for legal action. There was a submission of some 20,000 petitions calling for—

CHAIR—I am sorry to interrupt, but we have to be very careful that we stay within the terms of reference.

Dr van Gend—Sorry.

CHAIR—We also have to be very careful of how we refer to individuals who do not have the right of reply.

Dr van Gend—I am happy to just remove all that if you would like and get back to a different question.

CHAIR—We cannot remove it; it is now public—

Dr van Gend—Fine.

CHAIR—because this is being broadcast. So could we just be mindful of people. We have strict terms of reference—

Dr van Gend—Yes.

CHAIR—so can we keep our questions and answers relating to that.

Dr van Gend—Okay, all I can presume is that things were not favourable in Brisbane. Perhaps that was his reason for preferring Melbourne. However, that is all speculation, because he has not told me.

Senator JACINTA COLLINS—When he was operating in Brisbane was he also providing services to women from around Australia and overseas?

Dr van Gend—I understand so, yes.

Senator JACINTA COLLINS—The relevance here, Chair, is that it provides a framework by which to look at the statistics as well as operations in terms of understanding statistics on a state-by-state basis. Going to the concerns about foetal abnormality, I am interested in what evidence, if any, can be provided regarding terminations for reasons such as cleft palates, missing digits et cetera—those sorts of foetal abnormalities that you hear anecdotally referred to. I would like you to reflect on that in terms of the context provided by the department today that were concerns

raised about whether a service met the clinically relevant test then such matters would be referred to a peer review process but that this has never occurred.

I can understand why that might be on one side, because often such challenges probably exist within the state legislative field and, particularly with respect to this item number, the quantum of the money involved or the connection is possibly seen as a bit less direct. But none of that helps us understand what clear evidence there is, if any, that these sorts of terminations are actually occurring.

Dr van Gend—We do have specific cases described by certain doctors, and I am witness to a couple of them from Dr Grundmann, such as the cleft lip, the transposition of the great vessels—he described it, I think, 26 weeks—which is a heart condition, which one of my patients had and he is a great young athlete. It is something correctable. There is the 24-week Lebanese woman whom he aborted out of fear that she would be killed back in Lebanon.

These are cases but, as the health department made clear this morning, they do not know the grounds for any of these abortions because no-one asks. The AMA submission to this inquiry said, ‘We have no evidence that these items are being misused.’ Of course we have no evidence, because nobody looks and nobody reports, because who wants to report. The patients involved will not want to do anything like that and the doctors involved will not. So who is left—the police? This is something that simply cannot be found out under the current system.

It may be that the professional authorities could bring in a system of improved notification of criteria for abortion. One of the health department people mentioned taking photos for cosmetic surgery of the breast and applying for the Medicare item based on the photos. One can imagine—

Senator CAMERON—It is a real indictment of the medical profession.

Dr van Gend—What is, Senator?

Senator CAMERON—These generalisations that you are coming up with are a real indictment of the medical profession—that they are just behaving in such a bad manner that we need to deal with it.

Dr van Gend—No, I am not saying that at all. I am saying that nobody knows the criteria for these abortions because nobody asks. Whose responsibility is it to ask? I do not think it is the AMA’s. I do not think it is even Medicare Australia. I think it is some professional standards body, which at present has not done the job of finding what criteria are used for these late-term abortions. It would be a great step forward if criteria had to be given for mid-trimester abortions.

CHAIR—Time has beat us on this, but I thank you both for appearing before us and for your submissions.

[12.39 pm]

McENIERY, Dr Thomas, Private capacity

CHAIR—Welcome. For the *Hansard* record, could you please state the capacity in which you appear today?

Dr McEniery—I am a general practitioner in Queensland and I am appearing as an individual.

CHAIR—Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has before it your submission. I now invite you to make a short opening presentation, and at the conclusion of your remarks I will invite members of the committee to put questions to you.

Dr McEniery—Yes.

CHAIR—Excellent. Would you like to make some opening comments?

Dr McEniery—I am going to restrict my comments strictly to the submission that I have made. The actual AMA Queensland policy was developed in 1996, 12 years ago, and I was the chairman of the committee. There was a lot of controversy, particularly in the press in Brisbane at that time, over various forms of termination of pregnancy, particularly late second trimester terminations. There were some pressure on the association. I was on the executive of it and was nominated to be chairman of a committee that would develop a policy that the association could go to the general public with or go to the press with or deal with this if there were press inquiries about it. It was not an easy task. It took us about eight months to develop this policy because there was lots of disagreement about it. If you read it, it is a bit disjointed. It is obviously the production of a committee; I would say that is evident to you. But that was the best we could come up with.

We discussed this at various meetings of the branch council of the association. We ran a forum. Your previous speaker, Dr van Gend, actually presented at our forum and the other doctor he mentioned, Dr David Grundmann, presented at the forum. It was a means of raising the issue, getting each side of it, promoting debate within the council. The branch council at that stage was a group of 26 doctors representative of the Queensland branch of the Australian Medical Association, which had at that stage about 5,000 members. So this was a committee which came up with this policy, which was eventually approved by the branch council as the policy. I am not sure if it is still the policy. That is why I am not seeking to present this on behalf of the Queensland AMA. I am no longer on the branch council and I am pretty sure they would not have gone through the same process again, but I am not sure if they would to this day endorse it as their current policy. That would be a matter for the current branch council.

CHAIR—Thank you very much.

Senator EGGLESTON—I am medically qualified as well. In Queensland I understand a death certificate has to be issued for any foetus born dead after 20 weeks. Is that the case?

Dr McEniery—Yes.

Senator EGGLESTON—When was that introduced?

Dr McEniery—That was part of the new death certificates that came out about 18 months ago. I think they had a new coroner up here and he reformed the whole thing. I am never good with dates and that sort of thing but that is my impression, that it was done in the last 18 months.

Senator EGGLESTON—In other words, any death in utero resulting in a delivery beyond 20 weeks becomes a coroner's matter. Is that correct?

Dr McEniery—I just got one of the death certificates out of my top drawer. I have never really thought about this. Look, there is a certificate for a stillborn child. You have to state the main disease or condition in the foetus or neonate. You just have to document any illnesses in the mother. From my reading of this document, I have never filled in that top part of it. All the other death certificates are done lower on the page; it is all done on the same form. But I do not think that it actually becomes a matter for any sort of coroner's—

Senator EGGLESTON—You said it was introduced, didn't you, by the coroner.

Dr McEniery—Yes. Well, he is responsible for the death certificates, yes.

Senator EGGLESTON—Yes, that is right. And that is different to the rest of Australia, I gather. Can you tell us something about the position in other states?

Dr McEniery—I have no experience of it, I am afraid. I only practise in Queensland. I have not looked closely at this death certificate or compared it to other states' procedures at all.

Senator EGGLESTON—Thank you very much. That is really the only matter I wanted to question you about.

Senator CAMERON—Dr McEniery, I note that the policy position you bring to the inquiry is 11 years old.

Dr McEniery—Yes.

Senator CAMERON—Are you aware of any changes to that policy position within Queensland?

Dr McEniery—I am not, and I am pretty confident that I would have heard about it if they had. The problem was that it was such a difficult procedure for the branch council—I am pretty sure they would not have revisited this issue and tried to do another policy committee and develop another policy, and I am sure I would have heard about it in the meantime if they had, because they would have referred to the previous policy.

Senator CAMERON—Are you still a member of the AMA?

Dr McEniery—Yes.

Senator CAMERON—Active?

Dr McEniery—Yes, I am a Fellow of the Australian Medical Association.

Senator CAMERON—Could you advise, then, as to this 11-year-old policy: is that being implemented in Queensland across the board by medical practitioners?

Dr McEniery—The AMA is not that sort of a body. We do not prescribe practice. This was solely developed in a situation where this was a controversial issue and it was seen that the association needed to have a policy on it. It is not as if we then say to all our members or, further, to all doctors in Queensland that this is the code of practice. All of those sorts of issues are really a responsibility of the Medical Board of Queensland. It is just that the AMA are a representative professional body, and we wanted to have a policy on this issue.

Senator CAMERON—Are you aware of whether the AMA nationally have a similar policy and what happened in this debate 11 years ago? Was that then debated at the national level?

Dr McEniery—It was probably the case that a copy of this policy was sent to the national body, but I am not aware of any outcome of that. Generally, they would just note a policy that is sent to them; it is not a case of our body referring and making input to their council to duplicate that policy. I do not think anything of that nature was undertaken.

Senator CAMERON—Do you have a view on the issue of psychosocial abortions?

Dr McEniery—Are you speaking about terminations in general or this specific issue of the late second—

Senator CAMERON—For this specific issue.

Dr McEniery—The terminations that we were considering were from 20 to 24 weeks. I do not think anyone was doing them after 24 weeks. I think that probably at that stage the doctors and the counsellors who made this decision recognised that the foetus was in such a stage of development and only a few weeks, a very short time, from being independently viable. I am not sure of exactly the stage at which they can salvage babies, but at that stage it was 24 weeks, and some babies at that gestation were living and surviving independently. So there was such a short time between this stage, where terminations were being considered and were being done, and an independently viable foetus, a baby, that the general feeling was that there had to be a very substantial reason for having a termination at that stage. There had to be a grave threat to the physical or mental health of the mother.

Senator CAMERON—So do you see no place for the issue of psychosocial illnesses being a factor?

Dr McEniery—There is such a broad range. That was always the problem with these definitions. It was a bit of a problem with our policy. We found that you had to make generalisations. You could not be absolutely specific. But the whole thrust of the policy was that most psychosocial terminations were probably done on fairly minor grounds—

Senator CAMERON—Do you have evidence of that?

Dr McEniery—but it had to be a very grave—sorry?

Senator CAMERON—Do you have specific evidence that any psychosocial abortions are on minor grounds, or is that just a—

Dr McEniery—The problem within our policy was that we started trying to identify specific conditions, then you got this whole spectrum of things and then you decided, 'Oh, where do you draw the line?' We sort of moved away from all of that and made very general comments. I think we put 'a serious threat to the'—

Senator CAMERON—I am sorry to interrupt you, but the question I have asked is on this issue of psychosocial abortions. You say that they are done on minor grounds. The question I am asking is: what evidence do you have of that for the committee? If you make that assertion, do you have evidence to support that assertion to the committee?

Dr McEniery—We did not have any real evidence that these late second trimester terminations were being done on minor social grounds. As I said, the only evidence we had was the presentations to us by experts on either side of the argument. It is not that we had evidence that they were being done on minor grounds; it is just that the policy that we came up with stated that that was not a ground on which they should be done.

Senator BARNETT—I will try and be brief. I want to follow up a question from Senator Eggleston regarding the death certificate required after 20 weeks.

Dr McEniery—Sure, I will just get it out again.

Senator BARNETT—Thank you. Can you just outline again to clarify for the committee the rationale as to why they chose 20 weeks as opposed to some other time? I understand that Queensland is the only state that has that requirement. Are you aware if that is correct or not?

Dr McEniery—I am sorry; I cannot really help you as to whether we are alone in doing that. I have not really been prepared on this issue, but I just have the document in front of me. I could just read you the—

Senator BARNETT—Why did they introduce it? Is it because there was an assumption that the baby was alive and therefore a death certificate was required if it was aborted or killed or whatever?

Dr McEniery—I am not exactly sure why it was introduced. I can only presume that, as I said before, if a stillbirth occurs or a termination is done about that time, it is so close to the sort of

gestation at which a baby is independently viable. That is all I could offer there as an explanation.

Senator BARNETT—Sure. We will have further evidence from other witnesses regarding certainly some Victorian evidence where the babies are born alive and then simply left to die, and I do not think they require a death certificate in Victoria. But I am just trying to find out the rationale as to why they introduced it in Queensland.

Dr McEniery—I haven't any other information on that.

Senator BARNETT—Did it follow through or did it follow up or did it relate to other issues or concerns that had been raised in Queensland?

Dr McEniery—I am not sure that this change in the death certificate was directly related to the controversy over late second trimester terminations that erupted in the state in about 1996. This was a product of a change in the office of the coroner.

Senator BARNETT—But it makes some sense if the baby is born alive and then is dead or dies that you would have a death certificate, so I am just trying to find out about the Queensland situation. But I appreciate that you need to do further research. If you want to take it on notice, that is fine; otherwise we will make some further inquiries. Thank you.

Dr McEniery—Thank you.

CHAIR—There are no further questions, Dr McEniery. I thank you very much for your submission and your time today. Committee members, we are due to have from Dr van Gend some further information that we have accepted. I now need the agreement of the committee to make it public. That is agreed to.

Proceedings suspended from 12.55 pm to 2.05 pm

POWELL, Ms Kelsey Lee, Director, Australian Reproductive Health Alliance

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has before it your submission, and I now invite you to make a short opening statement. At the conclusion of your remarks, I will seek questions from committee members.

Ms Powell—Thank you for the opportunity to present. The Australian Reproductive Health Alliance was established in 1995, following the International Conference on Population and Development held in Cairo in 1994. The Australian Reproductive Health Alliance, or ARHA, is involved in sexual and reproductive health programs throughout the Asia-Pacific region and provides a secretariat for the Parliamentary Group on Population and Development. The parliamentary group is a cross-party group of over 100 parliamentarians, drawn from federal, state and territory parliaments who support the empowerment of women and girls through their commitment to gender equity and the advancement of women, as set down in the ICPD program of action. In 2005 ARHA was granted United Nations ECOSOC status, enabling it to participate in its own right at certain UN meetings and conferences.

ARHA supports and advocates for enhanced reproductive and sexual health in Australia and internationally and, as part of this, the rights of women to have access to safe and affordable abortion, performed by qualified health professionals. The deletion of Medicare item 16525 would limit access and affordability for a small number of women who are facing difficult and distressing circumstances. While it is not possible to know the total number of terminations carried out in Australia, the actual number of claims made under this item is relatively small. The details of the numbers and costs are included in our submission. The failure to continue government financial support of this item will have a number of negative outcomes.

Medicare states that it is ‘Australia’s universal healthcare system’, aiming to ‘give all Australians, regardless of their personal circumstances, access to health care.’ The removal of this item from the Health Insurance Regulations ignores the stated intentions of Medicare, denying universal access to affordable and safe termination of a pregnancy. Removing the financial support currently made available to private medical providers will also place further pressure on the public hospital services available, with an increased number of these services provided in public hospitals and an increased waiting time for women wishing to access these services. Testing for foetal abnormalities is a routine aspect of antenatal care and is offered in some form to all women. Diagnosis of many abnormalities is not possible until late gestation, and removal of this item has the potential to put unnecessary financial hardship on women and their families at this difficult time.

The removal of item 16525 also has the potential to violate the rights of women of reproductive age in Australia. Why are one category of pregnant women denied the government health payment programs offered to other pregnant women? The removal of this item is discrimination against a category of women based on their reproductive status. Considering these outcomes, the Australian Reproductive Health Alliance recommends the move to disallow this item be denied. Thank you.

CHAIR—We have heard some conflicting evidence today and I want to seek your views. Are you saying that if this disallowance motion was to be successful then there would be women who would not have access to an abortion, that they would not be able to go to the public health system?

Ms Powell—It certainly would put extra strain on the public health system. From the point of view of Queensland, very limited services are offered in the public health system and a lot of women rely on private practitioners.

Senator FIFIELD—In summary, you say that disallowance would remove women's access to a legal medical procedure. As a statement of fact that is not really correct—is it? The procedure would still be legal, it is just that there would be no Medicare funding for that.

Ms Powell—Yes, that is right.

Senator FIFIELD—In your view does item 16525 play any part in a woman's decision to choose whether to use a private clinic rather than being a public patient in a public hospital?

Ms Powell—Sorry?

Senator FIFIELD—Does the existence of the item number play a role in a woman's decision whether to go to a private clinic or to access the procedure as a public patient in a public hospital?

Ms Powell—It gives women the option to do that because they do get some financial support. If they go to a public hospital, while it is not costing them anything there are limitations to access to public hospitals for these women. As I said, in Queensland it is very difficult for women to access the public hospital system for a termination.

Senator FIFIELD—Other than the fact that there is great demand in public hospitals and there may be a wait for a procedure, what other factors does a woman consider in determining whether to go to a private clinic or a public hospital?

Ms Powell—From what I know, the main thing would be that time period. It is difficult for women to get into the public system. Also, women would have the choice of their practitioner if they go to a private, freestanding clinic.

Senator FIFIELD—No other factors? Given the purpose of this inquiry is this particular item number, I am curious as to whether you have any observations as to the factors which may affect a woman's decision to avail themselves of this item number?

Ms Powell—As I said, I think it is general access but there is also that waiting time. By the time these things are diagnosed and then they have to wait, it is sometimes quicker to access a private practitioner, which makes it safer for the woman.

CHAIR—If it was a life-threatening situation, that would not be the case?

Ms Powell—No.

CHAIR—If it was an abnormality—

Ms Powell—A foetal abnormality might be more difficult, yes.

Senator RYAN—I am troubled by the tone of part of your submission. The relevant bits relate to the community impact of increased numbers of children with severe disabilities. It states:

> The cost and impact of an increased number of individuals with severe disabilities living in Australia cannot, however, be ignored ...
>
> … … …
>
> It is logical to assume that an increase in demand for disability services as a result of the abolishment of item 16525 will place greater demand on what is already an underfunded and overwhelmed sector.

It troubles me because it seems to me that the potential for fewer terminations—which I assume you are alluding to—of babies that would otherwise be born is being used as an argument to retain this particular item number. What I want to know is: are you actually using that as an argument to retain this particular item number?

Ms Powell—I think it was put there as something that we felt we needed to raise because the issue of this item number was mentioned as being a cost in the health budget and I guess we would say that that is a relatively small cost because there are a relatively small number of claims made under this item. I think it is something that we have to consider. While some people might believe there is no reason to terminate a pregnancy no matter how severe the abnormality, there is testing available for women. It is routine as part of antenatal care and, although abortion is not an automatic outcome and it is usually not an outcome of a diagnosis, it is a reality. No matter what decision the woman or the family make, we need to be able to support that decision, so we are putting out that if a child is born with a severe abnormality there is a cost to that family, and the community needs to recognise that and resources need to be available to support that cost.

Senator RYAN—It seems to me that, in the way it is described in this submission, it is not talked about it in terms of individuals but in terms of collectives and the collective costs. I hope you would understand why it may trouble many people to look at this in the context of cost effectiveness or some other measure, and I do not think the cost of providing services is a legitimate matter for me to consider in this. I am assuming then that you are not saying that this is relevant to the consideration of this item before the Senate.

Ms Powell—Not the cost, but if we do have children born with severe abnormalities I think we need to recognise that there need to be resources for the families of those children. One of the points made to review this item was the cost and I am saying that this item is a relatively small cost in terms of some of the other costs that we need to consider as well when people make these decisions.

Senator RYAN—I appreciate that. What would you say in response to the argument that has been put to at least me, which is that just because a medical procedure is legal does not make it necessary for the Commonwealth or the taxpayer to fund it. There are medical procedures that

are entirely legal which are not funded and legality is not a matter for this committee nor this parliament. What would be your response to that? To me the ‘it is legal therefore it should be funded’ argument does not hold.

Ms Powell—I think it is one aspect but I know there are legal procedures that are not funded under Medicare, so I take that point. But procedures under this item are clinically accepted procedures. They are accepted procedures and we are looking at the best interests of the mother and the family, so it is something that is relevant to be supported. It is not just the fact that it is a legal issue. It is a health issue as well, and the decision for the procedure is made with medical input by a qualified doctor who has access to a woman’s medical history in consultation with the woman and in some cases it is also made in consultation with ethics committees and regulations of hospitals and other legal regulations as well, so I think it is legal but it is also important for other reasons as well.

Senator RYAN—Do you or your organisation have a view on the issue that has been raised with us many times this morning so far about breaking down this item number into separate item numbers?

Ms Powell—No, ARHA has not considered that. We have not developed a policy on that.

Senator RYAN—I want to ask about the human rights argument. Human rights can be used on both sides of this debate, as they have been thus far today. I am not sure how not funding an item through the Medicare benefits schedule for a procedure that is still available through a public hospital system—funded by the Commonwealth and the states—would discriminate against women’s human rights. Could you explain that a bit further?

Ms Powell—I am not sure whether these procedures are that easily accessed through all public hospitals.

Senator RYAN—I did not say all, but we have heard testimony they are accessible through the public health system.

Ms Powell—If you look at women in rural and regional areas, I think you will find that a lot of these women cannot access the public system as easily for those. That is where it is important for women to be able to still access a private provider. In regional and rural Queensland, for example, it is not easy for women to access these services in the public system throughout that state.

Senator RYAN—I appreciate that. That is the general rural and regional challenge. Are you aware of these services being provided in regional areas? Everything I have heard and read in relation to this inquiry is they are basically provided only in capital cities anyway.

Ms Powell—That is right, but there are still some private providers—I am not sure exactly of the private providers who might provide it outside their areas, but I just know, as I said, from a Queensland point of view that it is not always easy for women to access these, even in the larger public hospitals.

Senator FIELDING—I want to pick up one of those earlier threads. On page 12 of your submission—I was a bit disturbed by some of these; this is a similar sort of thread—you say:

The financial cost of caring for a severely disabled individual is high not only for the family, but for the greater community. Removing item 16525 would save the Commonwealth, by some estimates, $181,560 per year based on 2007 utilisation of item 16525. Adequately supporting an individual with high support needs costs the community and families far more than this.

Are you saying that keeping this abortion item makes good financial sense because the government, in effect, makes a profit because there are fewer people with a disability around? Is that what you are basically arguing?

Ms Powell—No, I answered that question with Senator Ryan. I thought I had answered that it was there because the cost of this item had been raised as an issue, as far as the health budget, and so it was important for us to put forth the idea that there would also be other costs associated and that they need to be addressed as well. We are certainly not saying it is purely a financial decision, and it should not be.

Senator FIELDING—I certainly agree that caring for a child with a disability does put a lot of pressure and stress on a family—I know that from personal circumstances—but I think we should be looking at supporting those families more rather than looking at it as a cost. You certainly make the claim in your submission about the extra cost for the community and for the family.

Ms Powell—I agree, those people should be supported of course, but the reality is screening for foetal abnormalities is being done and people then do have the choice either to continue with the pregnancy or terminate the pregnancy for gross foetal abnormalities. I think we need to support both of those sets of parents.

Senator FIELDING—You are saying you have raised the issue of the cost for the community because someone else raised the issue of what it cost to provide the Medicare funding. I worry about that argument purely from the point of view—if you look at free marketeers or economic rationalists—of the cost of an individual and when they become a liability. All of a sudden the same arguments could be put forward. When someone’s cost is higher than what they put into the community, you could say they are not worth being around.

Ms Powell—We also make the point that we are not saying that a person with a disability is not a valued member of the community as well. We are just making the point about the cost of raising a child who has severe abnormalities.

Senator FIELDING—On page 10 of your submission there is an argument you put forward that disallowing this item would be ‘denying universal access to affordable and safe termination of a pregnancy’. But, given third trimester abortions are not funded, is Medicare universal? Are you asking for funding to be given to third trimester abortions too to make it universal?

Ms Powell—No.

Senator FIELDING—So it is not universal.

Ms Powell—We are quoting what Medicare states, and it states that. We are just saying, within the context of the Medicare system, if this item is removed it will be a problem. We are not saying that Medicare should fund additional things; we are saying that this item should not be disallowed.

Senator FIELDING—But when you say ‘denying universal access to affordable and safe termination of pregnancy’ you are saying Medicare should be universally accessed. It is not universally accessed at the moment.

Ms Powell—We do not say ‘third trimester abortions’ in this statement.

Senator BARNETT—You do not support that.

Ms Powell—I am not saying we do not support it; I am just saying that we are not saying that in this statement.

Senator BARNETT—You do support it?

Ms Powell—This is not relevant. This is about the Medicare items covering second trimester terminations, and that is what I am speaking to.

Senator HANSON-YOUNG—We heard earlier today that the view of some organisations is that disallowing this particular Medicare item will not necessarily impact on a woman’s choice of whether or not to have a termination, based on her advice and consultations with her practitioner, but may simply defer the process and push it back even further.

Ms Powell—That is a concern as well.

Senator HANSON-YOUNG—Why do you think that is the case?

Ms Powell—Again, it is about access and the time it can sometimes take, the waiting lists there can be in public hospital systems—procedures, whether they are terminations or not, can be done later, and that increases the risks. It is about the waiting and the delay.

Senator HANSON-YOUNG—Do you have any examples of time delays in terms of individual clients that you have worked with?

Ms Powell—ARHA does not provide client based services, so, no.

Senator HANSON-YOUNG—In terms of your organisation’s objections to this disallowance motion, what do you think could be done to alleviate the concerns that some people have? Despite the fact that the department has not actually received any complaints from anyone that this is being used flippantly by some practitioners, there does seem to be a suggestion that it is. What do you think the approach could be to alleviate those concerns or, if they are legitimate, deal with them?

Ms Powell—As I was saying before, much of the decision about this procedure is already under scrutiny in a range of ways—first through the professionalism and the skills of the doctor

concerned and through the policies and procedures of the hospitals and the places where the procedure is carried out, such as hospital ethics committees. So I think there is adequate scrutiny of this procedure. Then there are also the normal complaints processes that people can go through if they are concerned about any medical procedure. We do not see that the decision needs to be scrutinised through a disallowing of this item because there are other ways that this is very well monitored.

Senator HANSON-YOUNG—In terms of what your organisation does, do you think that there is public outcry that the public is funding 500-odd terminations a year? Do you think that there is a public concern about this? Do people think that it is being used flippantly and that practitioners are willy-nilly going around and making decisions without proper consultation, without thinking, rather than making decisions because a woman's life is in danger or a child is perhaps not going to survive anyway?

Ms Powell—We as an organisation are not aware of that. Any research that we are aware of with regard to termination tends to say that most people believe that it is a decision between the woman and her medical practitioner.

CHAIR—In your submission you refer to Senator Barnett's motion. You claim that this motion will 'increase the likelihood of mental health issues in women who are pregnant'. Are you saying that a woman who has decided to terminate because her child has a cleft palette will suffer mental health issues because she may have to wait and go to a public hospital? Would I be correct in saying that your organisation generally holds the view that women potentially do not suffer mental health issues having had a termination? Is it the case that you think that delaying a termination is going to cause mental health issues but that the actual termination is not?

Ms Powell—It depends on the circumstances. I think we agree that the decision that a woman or a family might make is not going to be an easy one. In most jurisdictions where this is done, counselling is given—and genetic counselling, if that is relevant, is done. The research that I am aware of regarding women post terminations tends to say that if women receive support at the time—and that might not be from a professional counsellor; that might be family support—depending on their circumstances, their psychological and mental health in the future is not unduly affected by the termination. So I think it depends on the circumstances of the termination and the quality of the counselling and care that they get at the time.

CHAIR—You made reference to the fact that an increase in the number of babies that could be born with disabilities would increase the cost to the community. Do you foresee that we need to put a cost on everyone in terms of what sort of health care they can expect?

Ms Powell—I do not think that as an organisation we have thought that or have an opinion on that at this stage.

Senator BARNETT—Ms Powell, just to clarify: you are a board member and you have authorised the submission which has been authored by Jane Singleton, your CEO?

Ms Powell—Yes.

Senator BARNETT—I just want to clarify a few things with you and then take up a point which Senator Mitch Fifield asked earlier. You have done a six-point summary. The second dot point says that this Medicare item number, if denied, ‘would remove women’s access to a legal medical procedure’. Could you confirm whether, in your view, that is correct or incorrect.

Ms Powell—We are saying that, because of the lack of financial support, some women might not be able to afford what is a legal medical procedure.

Senator BARNETT—Let me read it to you. It is the second point. You have done a summary. It is in your document, on page 3. It says:

... it would remove women’s access to a legal medical procedure ...

Will the denial of this Medicare item number remove women’s access to a legal medical procedure? Yes or no?

Ms Powell—I guess it would have been better to say ‘decrease women’s access’. It will make it more difficult for women.

Senator BARNETT—So that statement is wrong? It is a summary dot point and it seems to me that it is incorrect.

Ms Powell—Well, I apologise if you interpret it that way.

Senator BARNETT—Well, how do you interpret it?

Ms Powell—I guess I am interpreting it as it was meant: that we were saying that—I am sorry; what page was it?

Senator BARNETT—Page 3—the second point of your summary.

Ms Powell—My summary?

CHAIR—It is headed up ‘Summary’.

Ms Powell—Right. I am sorry; I was thinking of the summary I did today. I guess it was meaning ‘to lessen women’s access’ or ‘to remove access for some women’.

Senator BARNETT—That is different from ‘remove women’s access’.

Ms Powell—In some cases some women will have access removed, if they cannot access a public system.

Senator BARNETT—All right. I will go on to the next point. You were answering a question from Senator Collins regarding rural and regional parts of Australia; can you identify the clinics in rural and regional parts of Australia? Can you advise the committee of how many there are outside capital cities?

Ms Powell—No, I cannot.

Senator BARNETT—Have you got any idea at all? Are you aware of any?

Ms Powell—I know that there are some clinics that provide termination services outside the capital cities, but I do not have details of those.

Senator BARNETT—Is that something that you could take on notice and perhaps get back to the committee on?

Ms Powell—I certainly can, yes.

Senator BARNETT—That would be appreciated.

CHAIR—I think that was actually Senator Hanson-Young's rather than Senator Collins's question.

Senator BARNETT—I apologise if that was the case. I thought there was a reference to rural and regional; many apologies. Thank you for the clarification there, Chair. I just wanted to go back to pages 11 and 12 of your submission. I know a number of my colleague Senators have asked about this, including the chair. There is a rationale, a logic, to your argument, which goes: if you remove this Medicare item number there will be more people with disabilities in the community. And you argue in your submission, on pages 11 and 12, very succinctly and I think with some clarity, that that will increase the cost to families and, secondly, will increase the cost to the community. In fact, you have sourced a quote of $181,560 per year, based on 2007 utilisation of the item number. You have actually sourced the quote.

So, Ms Powell, the argument that you are putting to us is that if this Medicare item number is denied it will increase the number of people with disabilities in the community, increase the cost to families and increase the cost to the community, and, using your words, 'will place greater demand on what is already an underfunded and overwhelmed sector' and will 'result in further strain being placed on Australia's disability support sector'. They are very strong arguments in favour of opposing the motion that I have put to the Senate. I am not sure how anybody else could interpret your submission, which has been considered, I presume, by your board and authorised by your organisation. Do you have any response to that?

Ms Powell—I thought I had answered that: that we felt it was relevant to bring up the cost issue because of—

Senator BARNETT—You have an opportunity today, now, if you want to change your submission or retract your submission. But it is in your submission.

Senator CAMERON—A point of order.

CHAIR—Senator Cameron, your point of order is?

Senator CAMERON—This is the second time the witness has answered this question in some detail and I just do not think it is appropriate to keep pursuing the witness in this manner, given that she has unequivocally answered the question on two occasions.

CHAIR—Senator Barnett, do you want to rephrase your question?

Senator BARNETT—I will rephrase the question. Ms Powell, in light of the words that are succinctly expressed in your submission, do you wish to expand or clarify the words that are in your submission regarding putting stress and strain on the family budget and, secondly, the cost to the community and indeed the taxpayer and, quoting you, 'further strain being placed on Australia's disability support sector'?

Ms Powell—I feel I have responded to that.

Senator BARNETT—Okay. We will leave it there. Thank you.

CHAIR—There being no further questions, thank you, Ms Powell, for your submission and for appearing before the committee today.

Ms Powell—Thank you for the opportunity.

[2.40 pm]

SHELTON, Mr Lyle Gavin, Chief of Staff, Australian Christian Lobby

JOSEPH, Mrs Rita, Private capacity

CHAIR—I would like to welcome you both here today. Do you have any additional comments to make about the capacity in which you are appearing?

Mrs Joseph—I am here as a citizen. My background is in philosophy, especially the language of human rights. At the present moment, I have a book at the publishers Martinus Nijhoff in The Hague. The title of the book is *The human rights of the unborn child in international human rights instruments*—

CHAIR—Thank you, Mrs Joseph. We can leave it there. That gives your title and the reason you are here. We will give you an opportunity a little later for opening comments. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has before it your submissions. I now invite each of you to make a short opening presentation. At the conclusion of your remarks, I will call on committee members for any questions that they would like to put to you. Mrs Joseph, would you like to make an opening statement?

Mrs Joseph—Yes. In my submission to you I set out in detail some of the ways in which this piece of funding legislation fails to comply with Australia's new obligations under the United Nations Convention on the Rights of Persons with Disabilities. It fails to comply in the specific case of protecting children at risk of abortion because of their disabilities. Abortion policies that condone selective abortion of children because of their disabilities cannot be reconciled with the treaty's core commitment: acceptance of and respect for all human beings with disabilities. When the Commonwealth ratifies a convention, it undertakes a solemn obligation to ensure that domestic legislation is compatible with the human rights principles codified in law in each convention. That has always been the case for the Australian government. Right from our first negotiations over the universal declaration, Australia understood and accepted this obligation. I can produce the original cablegrams that were sent in May and December 1948 to the Australian government from New York and London, making it clear that the international human rights conventions would require our government to change domestic laws to conform to the new international human rights standards.

I hope the committee is going to recommend changing this funding law, because this committee has a very serious problem. You have a real problem here. It is just the tip of the iceberg. You are trying to administer Medicare payments where there is a gap in the law. To date, you have based these payments on two assumptions. The first is that lawful termination of a pregnancy is regulated by the states and territories. This is not so. The ACT and Victoria no longer regulate lawful termination of second trimester pregnancy in any meaningful way. In the Northern Territory and the other states, remaining regulations have either fallen into disuse or they have been reinterpreted so loosely as to be ineffective. Your second assumption is that, in the absence of a court decision to the contrary, an assumption of innocence is made that every

termination of the life of an unborn child is performed by a medical practitioner in accordance with relevant state or territory law. In fact, that is what your Medicare administrators said in their submission:

For a termination to be funded through Medicare it needs to be provided in accordance with State and Territory law. Section 2 of the GMST states that an item in Part 3 does not apply to a service provided in contravention of a law of the Commonwealth or of a State or Territory.

No mention is made here of international human rights law, which comes into play in precisely these circumstances, where the states and territories have failed to provide appropriate legal protection for the child at risk of abortion, and where now the Commonwealth must fill the gap which has opened up in state and territory law, especially where those laws protecting the unborn child at risk of abortion are inadequate either in their framing or in their interpretation. This funding is in contravention of Commonwealth law because it is in contravention of international human rights law. I can tell you that this funding of second trimester abortions without balances or checks, without proper transparency or scrutiny, without appropriate legislative protection for each child at risk of abortion, this funding is in contravention of the international human rights law.

I know you know that human rights are inherent and inalienable and all modern international human rights instruments guarantee the human rights of every member of the human family. For a child at risk of abortion, membership of the human family is never dependent on discretionary permission to be granted by individuals or by the state. Neither the child's mother nor the doctor nor the state can say to the child at risk of abortion, this child has no human rights. Indiscriminate funding of abortions on a 'don't ask' basis contravenes Australia's international human rights obligations to provide 'appropriate legal protection before as well as after birth', as recognised by the Universal Declaration of Human Rights. The Commonwealth has no legitimate capacity to ignore or abolish the fundamental obligations of common-law protection for unborn children. There are two factors: the first is that you have the obligation to scrutinise all decisions concerning children at risk of abortion; and the second is that you have the obligation to assess objectively the common-law defences of necessity and proportionality in relation to such decisions—to every decision.

Put simply, this funding law approved authorises, pays for and so makes the Commonwealth complicit in any arbitrary deprivation of the lives of unborn children selected on possibly discriminatory grounds such as disability. This is basically your problem, and is a very serious problem. Thank you.

CHAIR—Thank you, Mrs Joseph. Mr Shelton.

Mr Shelton—Thank you. The Australian Christian Lobby represents a broad constituency of Christians across the denominational spectrum. ACL was able to mobilise 80,000 to 100,000 Christians prior to last federal election to participate in a webcast in church auditoriums and halls throughout Australia where the then Prime Minister and the then opposition leader addressed the constituency live from the National Press Club. This is a modest indicator of the number of people who share our values on issues like this. Christians everywhere have a particular concern for those in society who are voiceless, and this translates into practical care for the poor, both locally and overseas, and for the disabled and the elderly. One of the most

active, if not the most active, group in the community pressuring the government to meet its obligations to the Millennium Development Goals is the Christian church, again active across a spectrum of denominations and organisations on this issue. This reflects our values for the disadvantaged and for the disempowered. There are none more disempowered and more voiceless in our society than unborn babies.

Those of us from generation X and since who have had children know the delights of viewing our children for the first time on ultrasound. We saw our children for the first time as early as nine weeks, their clearly defined limbs and beating hearts leaving us with no doubt about their humanity. Our generation knows that the 'blob of foetal tissue' rhetoric, used in the 1970s and 80s to dumb down public opinion and secure political support for legal abortion and public funding of it, is a lie. Children in the womb can now be viewed in 4D, full-colour reality, with their pulsating humanity clear for all to see.

The vast majority of Christians are appalled at the practice of abortion where there is no risk to the life of the mother and where a baby does not have a lethal abnormality. ACL supports the proposition that Medicare funding should be withdrawn from second trimester abortions, as long as the unintended consequence of this is not to deny public funding in those rare cases where there is an already-dead baby in utero, a lethal abnormality to the unborn child or unequivocal physical risk to the mother's life.

More and more Australians are waking up to the horrific practices used to kill second trimester babies. Many submissions, including ours, detail the brutal practices of partial birth abortionist Dr David Grundmann. This practice has been banned in the US—a ban which was upheld last year by the US Supreme Court—and yet we pay for it in this country with Medicare. Another common method used is the dilation and evacuation method, and this was clearly detailed in other submissions, including Dr David van Gend's submission which provided these rather gruesome medical diagrams. Pulling apart a baby in the womb with a pliers-like instrument should offend the sensibilities of even the most hard-hearted. As lay people, we do not understand why these practices are allowed—let alone funded by us through our compulsory Medicare levy. Our perplexity is magnified by media reports like the ones this week in Canberra, where two men were rightly charged for torturing their pet ferrets. In a society where it is illegal to dock the tail of a puppy, the taxpayer pays for the slow and painful destruction of human offspring using the most agricultural of methods. Our submission summarises the scientific consensus about foetal pain. Few argue that unborn babies do not feel pain at 20 weeks and beyond, and many would contend that pain is experienced earlier. Abortion methods used to kill second trimester babies make mulesing look humane. Our submission, like others to this inquiry, quotes Victorian statistics which showed that 47 out of 309 post-20-week abortions performed in 2005 resulted in the delivery of a live child who was then, tragically, left to die. Again, we do not understand how this can happen in a civil society. We strongly recommend that the Senate makes further investigations into this. I cannot imagine that the great 19th-century antislavery campaigner William Wilberforce was not motivated to his opinion on slavery with exactly the same abhorrence to it as we now feel to this. That situations where babies are born alive after botched abortions could also attract Medicare funding is unthinkable.

During September, ACL, along with other like-minded groups, sponsored the visit to Australia of the American late-term abortion survivor Gianna Jessen. I had the privilege of taking her to meet more than 20 senators and members over a three-day period here in Canberra. In each of

these meetings, she uttered the thought-provoking words: 'If abortion is solely about women's rights, then what were mine?' Gianna's is indeed a rare voice in this debate. We know that women are not going to die in the backyard if Medicare funding of second trimester abortion is withdrawn. All that is available to them is access to a $267 subsidy to kill a healthy baby, when the total cost of the procedure can be between $1,250 to $4,000 at a for-profit abortion clinic. ACL believes that women's real needs would be better served if public funding were used to help women with unsupported pregnancies and help them make an informed initial choice.

In reading through the submissions to this inquiry, I was surprised to see the Parliamentary Group on Population and Development's submission, lodged on behalf of 41 members and senators. This submission is a direct cut and paste of the submission lodged by the radical pro-abortion group the Australian Reproductive Health Alliance who gave evidence just prior to me. The two identical submissions express the view that public funding for second trimester abortion should remain because removal:

… increases the likelihood of a greater number of persons being born with severe disabilities and high support needs.

The submissions—both of them, in lock step—go on to state:

The financial cost of caring for a severely disabled individual is high not only for the family, but for the … community … It is logical to assume that an increase in demand for disability services as a result of the abolishment of item 16525 will place greater demand on what is already an underfunded and overwhelmed sector.

In short, these submissions are saying that disabled people should be aborted because it costs too much to look after them. This is a prime example of the completely flawed logic, let alone the moral argument, that surrounds abortion. That a parliamentary group with position and influence as elected members should seemingly uncritically accept verbatim the line of argument and moral premise of so extreme a position as that of the Australian Reproductive Health Alliance is to us profoundly disturbing. That eugenics towards the disabled is being advocated at all is frightening enough. That a group of 41 members and senators have seemingly endorsed this does not bode well for civil society. I would have hoped that these views would trouble most if not all of the 41 MPs, and we hope that the politicians involved have done so unwittingly and that clarifications will be made.

ACL believes that the overwhelming weight of evidence bodes well for the eventual demise of abortion in Australia. We are simply coming to a tipping point where the public now knows too much. Ultrasound technology, the cruelty of the methods, babies born alive after botched abortion, the trauma abortion causes to women and the lifting of the veil of secrecy surrounding other choices and support for women will inevitably lead to positive change. In the meantime, if we are to persist with the practice, it is not appropriate that conscientious objectors should be forced to have blood on their Medicare cards.

CHAIR—Thank you.

Senator FIELDING—The ACL submission, on page 3, notes that public opinion in Australia opposes Medicare funding of abortion in the second trimester. Can you tell us about that?

Mr Shelton—We are simply quoting the 2005 Market Facts survey, which I believe has been quoted in other submissions. They are well-known statistics. It clearly shows that there is great public concern not just from the Christian constituency but from the broader Australian community.

Senator FIELDING—I was disturbed to see in the ACL submission on page 5:

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.

Can you tell us about the report that is from and what else it had to say?

Mr Shelton—In our submission we have referenced that. They are VicHealth statistics, which, as we understand it, have been made available by the Victorian government. We are, as I said in my opening remarks, profoundly disturbed by that and shocked that this could happen in a country like Australia. We would highly recommend that the Senate, or certainly authorities, should look into this if indeed it is true, which obviously it is, because VicHealth is reporting it.

Senator FIELDING—Further on, there is also some evidence about gross foetal abnormality and the concerns the ACL has about how that is being applied in practice. Is that a concern that you have?

Mr Shelton—Absolutely. I had the benefit of watching some of the earlier testimony today from previous witnesses. We are very concerned that this seems to be a loophole in the guidelines. Obviously, we are seeing babies aborted for non-lethal conditions, and that of course is of grave concern. We believe that all life is worth living and that certainly a dollar figure should not be placed on the life of someone who might have an abnormality or disability just because it might cost the community to care for that person.

Senator FIELDING—Thanks for that. Mrs Joseph, you raise concerns about the human rights treaties, which you say are a big dilemma. I can buy into that argument. Where does this leave us? Is there public pressure about this? Is there some court that people can go to?

Mrs Joseph—Not at present, but there will be. I understand that we are signing the optional protocol. As well as that there is a real possibility that one day—I do not know when—there will be an international human rights tribunal that will call some of the present Senate, perhaps, before them and accuse them of participating in a crime against humanity as was defined in the Nuremberg trials. Those judgements and definitions from the Nuremberg trial through resolution 95 of the UN formed the basis of modern international human rights law, the universal declaration and all the conventions that have come from it. In particular, there is the crime of genocide and its definition, which one of the Australian Prime Ministers at the time helped to put together. It included this idea of taking a group of human beings and applying abortion to them—such as, for example, is happening here in Australia right now.

In Victoria the statistics are that 95 per cent of children who are detected before birth to have a particular foetal abnormality—that is how they describe it—like Down syndrome, are aborted. That 95 per cent represents a very big part of a group which is being eliminated through abortion. With funding, with laws like the one that you are looking at now, this becomes

possible. It facilitates a crime of genocide. It facilitates a crime against humanity. The fact that right now there is no legal protection in Victoria for this 95 per cent of children with a disability, such as Downs syndrome, detected who are aborted is part of what a criminal tribunal in the future will say is the fault of the present government.

I should explain this a little better. Right from the beginning this was the whole idea of international human rights law. I will quote to you from Professor Hersch Lauterpacht, a very influential international law professor. He made it very clear that the role of international law is to intervene where states either legalise or fail to punish inhuman acts that violate human rights:

> Mr. LAUTERPACHT … said that crimes in violation of international law could be distinguished from crimes in municipal law by means of the following test: all inhuman acts committed by the organs of the State, or other individuals employed by the State to commit those acts, were international offences if prescribed or authorized by the law of the State or if left unpunished by it. In those cases, the sanctity of human rights prevailed over the sovereignty of the State.

The state can have no authority to authorise by law or to leave unpunished the extermination through medicalised abortion of large groups of children with disabilities such as Down syndrome and spina bifida. The sanctity of the human rights of these children at risk of abortion because of their disabilities is meant to prevail over the sovereignty of the state. Therefore, the state must restore legal protection for these children at risk and must prosecute those who perform the ultimate inhuman act: the extermination of these children. It is a very serious problem.

Senator MOORE—I think it is important to make a statement as chair of the PGPD. I have written to Mr Shelton. I received an email from him yesterday asking for a response and I have provided that to you, Mr Shelton.

Mr Shelton—Thank you. I did not see that before I came here today.

Senator MOORE—As the chair of the PGPD and as Mr Shelton referred to our organisation, I felt I should put something on the record. I was going to do it at the end of the day, but I will put it now. The PGPD has put in a submission to this inquiry. We have used the Australian Reproductive Health Alliance submission as the basis, as they are the research body for our organisation. That is on the public record. In fact, I think the witness stated in her evidence that they provide the secretariat for our organisation.

Mr Shelton—She did indeed.

Senator MOORE—In my response, I pointed out that we put in the same submission. I think it is a bit odd, Mr Shelton, that you would draw out the fact that those two submissions are identical when I have received so many letters and emails based on your website that are absolutely identical. We have not tried to hide it that. We are a voluntary organisation of politicians. We have made statements in this submission. I am happy to respond to those things, but I thought that the previous witness had pointed out that the submission clearly stated our respect for people with disabilities and our feeling that people with disabilities must and do live a full, productive and inclusive life. We argued that there needs to be much more resourcing and funding given to support people who are working with disabilities. That is clearly on page 11 of the submission.

On page 12 of the submission, some particular costs have been included. They are not intended to put a costing on people's lives. The original paper that came out with this proposal talked at length about the cost of this regulation and the Medicare funding. The people writing the submission felt there needed to be something that referred to the cost and the stress that people would face when raising children with disabilities. We did that in particular because, as you would well know, members of the committee, one of the aspects of this particular argument is that, as medical tests have been developed, people are finding out at later times in their pregnancy about genetic issues or conditions that children may develop in the future.

I do not make any statement, nor does the PGPD, about what those decisions should mean to the person who is carrying the child. We are saying that there should be full medical information provided to the woman and her family about the lifespan and the life of the child, and decisions should be made at that stage with that full knowledge. We totally reject the allegation of eugenics. In fact, we understand where that would come into an emotional debate of this kind, but we reject that. The costing in our submission is based on the acknowledgement that there are costs to the Medicare process. We put it in the context that this is another cost to be taken into account when looking at the argument. If any offence has been caused there is deep apology from the organisation. A supplementary submission will made by the Australian Reproductive Rights Alliance to clarify that following the questioning. I do apologise for taking up the committee's time on that point. As Mr Shelton raised it, I thought now was the right time to make this statement.

Mr Shelton—Chair, would I be able to respond to that?

CHAIR—You certainly can.

Mr Shelton—I did read the disclaimer that is in the submission. I state here for the record that I believe that disclaimer is completely contradictory to the thesis of the submission. We do not withdraw any allegation of eugenics. That is clearly what is being proposed here, if you look at any dictionary definition of eugenics.

CHAIR—Thank you.

Senator BARNETT—I must say I am astounded. Senator Moore may wish to make a further statement of clarification or personal representation. I have a copy of the PGPD submission. It is signed by Senator Moore. It says, 'our submission to the committee' and, 'Thank you for the opportunity to present the PGPD's views.' I have just looked through the submission and there is no reference to the Australian Reproductive Health Alliance submission. It has PGPD all over it. It does refer to Jane Singleton but the address is different to the address of the Australian Reproductive Health Alliance, so there is no reference to them. We have had issues recently regarding plagiarism, but, with the greatest respect, this is an entire lift of the Australian Reproductive Health Alliance material. I do not want to take up the time of the committee, but Mr Shelton has highlighted the point to our committee so I am happy to put the questions to him. With respect, there may be merit in having a further explanation. I have just been looking at it, and it is exactly the same. The submissions are the same.

Senator CAMERON—On a point of order, this is has nothing to do with this inquiry.

CHAIR—We can have a private meeting during the break, but we have two witnesses before us who have given up their valuable time, so can I suggest that we put questions to them.

Senator BARNETT—The best way to handle it might be if I put questions to Mr Shelton.

CHAIR—Then we can have a private meeting and if people want to raise any other concerns relating to the submission we will deal with it then.

Senator BARNETT—Let me go directly to Mr Shelton to start with. Mr Shelton, is the submission from the Australian Reproductive Health Alliance exactly the same as the submission from the Parliamentary Group on Population and Development?

Mr Shelton—Yes, it is. The only difference is that the names of the organisations have been changed.

Senator BARNETT—And it is word for word the same?

Mr Shelton—Correct. I might just say too that I have emailed each of the 41 members of the PGPD seeking clarification of their views. I have spoken to one senator, who certainly is distancing himself from the views that are contained in that submission.

Senator BARNETT—Have you had a response from any of the other 41? Do they endorse the submission?

Mr Shelton—Not before I left the office just before lunch to come up here.

Senator BARNETT—Have they been made aware of the submission? Have they signed up to the submission? It does say it has been signed on behalf of—

CHAIR—Thank you. Can we please stay within the terms of reference? I impress upon everyone who has appeared this morning and those who are participating on the committee that we are trying to stay very much within the terms of reference. I have already said that we will have a private meeting where Senator Barnett can raise any issues, and at that time Senator Moore has the right to make any further statements. We have valuable time which is very limited. Can I suggest that we move on to questions other than those trying to address whether or not certain submissions are plagiarised. Can we turn back to the terms of reference, please?

Senator BARNETT—I would be happy to. Mr Shelton, in your submission, on page 5 of 11, you state that you have sourced from the Victorian government department of health the fact that babies are being born alive and then left to die. Have you given any consideration to the legality and the consequences for the medical practitioners involved in such a situation?

Mr Shelton—I am not a lawyer. Our organisation does not have any lawyers in it, although we do seek legal advice from time to time. On this matter I guess our purpose was to highlight the publicly available statistics to the Senate committee. I would have thought that the appropriate people to take action would be law-makers themselves to thoroughly investigate the statistics in this reporting.

Senator BARNETT—Are you aware of or familiar with statistics in other states on situations where babies are being born alive and left to die as part of the abortion process?

Mr Shelton—I am not aware of any statistical data. I understand it is difficult to obtain that, and many submissions have highlighted that fact. I think that is a real flaw in the way that information about abortion is divulged in Australia. The only other instance of a baby in Australia being born alive—that I am aware of—and then left to die is one that was documented in news reports some years ago from the Northern Territory.

Senator BARNETT—You made the point about Gianna Jessen. I had the honour and privilege of meeting with her and being involved with her visit. What is the argument that she makes with regard to a woman's right to choose and her rights? Can you expand on that?

Mr Shelton—Obviously she is a voice in the debate which, as I said in my opening remarks, is extremely rare, because most people who have abortion perpetrated on them do not live to tell the story. She certainly makes the point that, while she respects women's rights, there are rights of an unborn child and she is living proof of that. She asked the rhetorical question: 'If abortion is merely about women's rights, what were mine?' I think that is a powerful question which certainly demands an answer and is one which I think people who make public policy should turn their minds to.

Senator BARNETT—I understand she has a birth certificate.

Mr Shelton—Yes, she does. She has a birth certificate which was signed by the abortionist, who was not present when she was delivered alive, he having injected a saline solution into her mother's womb the night before, expecting a dead foetus to be delivered, but a sympathetic nurse called an ambulance so she received hospital treatment and was able to survive. The supreme irony is that the abortionist, who is a well-known abortionist in America, signed her birth certificate.

Senator BARNETT—Mrs Joseph, you have referred to a number of UN declarations and international treaties and, specifically, you have quoted from the Universal Declaration of Human Rights. You say they 'are entitled to "special safeguards and care" including "legal protection before as well as after birth"', and then you have sourced that.

Mrs Joseph—Yes, that is right.

Senator BARNETT—Can you refer to other international treaties or UN declarations which the Australian government has signed and which you believe we here in Australia should act on and therefore act in a way that would be to deny Medicare funding under this Medicare item number?

Mrs Joseph—Besides the universal declaration, there is specifically the Convention on the Rights of the Child. That says very clearly that the human rights of the unborn child are to be taken into account.

Senator BARNETT—Can you refer to a provision?

Mrs Joseph—It is in the preamble. The preamble governs all the provisions in the convention. What you need to understand is that it is in the spirit and substance that all the great human rights instruments of modern international human rights law must be consistent with each other. They have to manifest a clear and logical coherence. So the preamble to the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, and the International Covenant on Civil and Political Rights all refer back to the universal declaration. It is in the universal declaration that it was recognised. This recognition was actually reaffirmed in the Declaration on the Rights of the Child in 1959, but it was always there. What they were doing in 1959 was just reaffirming what was already clearly understood. Reading through the drafting histories of the universal declaration and of the International Covenant on Civil and Political Rights, I feel there is no doubt whatsoever—I have documented it very, very clearly in my forthcoming book—that it was understood and agreed that human rights, that the right to life, were to be extended to all unborn children.

Senator BARNETT—Finally, on page 3 of your submission, under the heading 'Children requiring more intensive support not gross foetal abnormalities', your language is well chosen. We had some discussion from some earlier witnesses regarding gross foetal abnormalities, and you referred to Professor Lachlan de Crespigny and his advocacy of the decriminalisation of abortion. Are you really advising the committee here that the UN Committee on the Rights of the Child condemns selective abortion—is that the point you are making, the eugenics argument?

Mrs Joseph—Yes, it does. It condemns selective abortion on the grounds of gender, disability, ethnicity and a number of other things.

Senator BARNETT—So that is your key point?

Mrs Joseph—Yes. They are very clear about that, and rightly so.

Senator BARNETT—What would you have the government do? If the government were acting to implement these treaties that they have signed and we have committed to, what would you say we should do?

Mrs Joseph—This is a good first step—to get rid of this funding. After that, I think you have to do a real spring clean of all the legislation. That is par for the course. When you sign a convention, that is what you are meant to do. You are meant to go through each convention and make sure all your legislation is compatible with the principles of that convention. You cannot make an excuse that the states or the territories have a responsibility for the legislation, because that does not cut. Article 50 of the International Covenant on Civil and Political Rights makes it very clear that everything in that convention that the Australian government signed to has to be fulfilled by the individual states in the federation. That is article 50. Where the states and territories have bad laws or fail to provide laws to protect the child before as well as after birth, the first line of defence for human rights is always the Senate and the House of Representatives. It is not something you can pass on. You cannot pass it to the territories and the states and say, 'There you are; you are responsible.' You cannot do that. It is just not valid under international law. It never was—right from the beginning.

Senator BARNETT—Thank you.

Senator CAMERON—Mrs Joseph, you do not have any legal qualifications, do you?

Mrs Joseph—No, I do not. But can I just say that I have had a great deal of experience in advising government delegations at the UN.

Senator CAMERON—On legal issues?

Mrs Joseph—On legal issues in the sense of the language of human rights and the legal implications of that language. That is a very deep area. In that sense, yes, I am qualified to speak and write about international human rights law. In fact, my booklet is being brought out by the leading academic publishers on human rights and humanitarian law in the whole world. I hope it will be available in the Parliamentary Library in maybe January next year.

Senator CAMERON—It is good that you took the opportunity to sell your book.

Mrs Joseph—Thank you.

Senator BARNETT—Are you going to buy a copy?

Senator CAMERON—Probably not.

Mrs Joseph—The reason we are publishing it is that no-one has actually done this before. They have not actually gone into it—

Senator CAMERON—We have limited time and I would ask you, please, to answer the questions I am asking, because it is quite important. Do you have any formal legal advice on the assertions you have made today? If you have, could you provide that legal advice to this committee? You have made a range of assertions about international law.

Mrs Joseph—I cannot provide the legal advice because I am the legal advice. I am the authority in this area, Senator. If you ask around the UN and various delegations, they will tell you that I know my work. I am the authority on the legal rights of the unborn child.

Senator CAMERON—There is no other authority on implications of conventions? Are you saying that you are the only one?

Mrs Joseph—I am the only one who has gone through methodically all the drafting histories and put together exactly what was said about the unborn child and about their legal rights.

Senator CAMERON—I suppose we will have to make a judgement on that.

Mrs Joseph—Of course you do.

Senator CAMERON—I am trying to come to grips with Senator Barnett's assertion that your language was well chosen. I must say that raising the issue of a Nuremberg trial for politicians who may disagree with your point of view I do not think is particularly well chosen. Also the issue of genocide. Can you tell me how this approach in Australia, which has over a period of nine or 10 years about 1,200 abortions, could be genocide?

Mrs Joseph—I am speaking specifically about the systematic abortion of children with Down syndrome in Australia, irrespective of its purported lawfulness under domestic laws, it may well be condemned as a crime against humanity under customary international law. Nehemiah Robinson, who wrote the definitive text in 1960 on the Genocide Convention, identified the difference between crimes against humanity and ordinary violations of a criminal code—

Senator CAMERON—I am sorry, Mrs Joseph, that is not the question I have asked you. I do not want to go back to a 1960s reference. What I am asking you is, how does 1,600 abortions over a period of almost 11 years, for various reasons, equate to genocide?

Mrs Joseph—It equates to genocide in this way. You say only 1,100.

Senator CAMERON—No, I did not say only 1,100; I said 1,100.

Mrs Joseph—Okay. Let us just take that number. The thing is that in the Genocide Convention this is how it was framed. It says that the crime of genocide includes specifically the act of imposing measures intended to prevent births within the group with the intent to destroy it in whole or in part. The way that applies to what you are talking about now is that 95 per cent of children identified in Victoria—in Australia it is 90 per cent, I believe—are being aborted. That is where it comes in: the destruction of a group in whole or in part. You know who wrote much of this? It was Dr Herbert Evatt, Prime Minister of Australia at the time of the Genocide Convention. He made this point very clearly. He said:

We are establishing individual safeguards for the very existence of such human groups—

that is, groups to be protected—

and in this field relating to the sacred right of existence of human groups we are proclaiming today the supremacy of international law once and for all.

Australia has to abide by that. Ninety-five per cent of children identified—

Senator CAMERON—But now we have come back to the original argument. You say we have to abide by it. I would like to see the legal advice on that.

Mrs Joseph—We signed this convention. You have to understand—

Senator JACINTA COLLINS—Point of order, Madam Chair. Can I suggest that we actually asked the department for advice on this point.

Mrs Joseph—Can I just make one more point. You say not to go back to 1948 or 1960 or any of those. But that was when the original conventions were made. Everything that comes out of that, the entire modern international human rights law, depends on that. You cannot change it now. You cannot say, ‘Oh no, we did not mean that. We are going to change it now so that we can accommodate this 95 per cent killing of a group of children who are identified with Down syndrome in Australia.’ It is a problem.

CHAIR—Senator Cameron, we have got limited time left. We are already running over schedule today.

Senator CAMERON—Mr Shelton, you assert that the Australian Reproductive Health Alliance is a radical group. Given some of the submissions you have made here today, I think people who are listening in could come to the same conclusion about your submission—that it is extremely radical. Can you understand how people would see your position as being radical?

Mr Shelton—With respect, I am not sure it is radical to defend the life of the unborn and the disabled, who some would advocate killing simply because they would be a cost burden upon the Australia taxpayer. I do not consider mounting a defence for that to be radical. I think most fair-minded Australians would be with me on that, or at least I hope so.

Senator CAMERON—But you use words like 'blood on their Medicare cards'—highly emotive, radical points of view.

Mr Shelton—That is a phrase that I borrowed from another public figure in this country who was talking about a cause which is very dear to my heart because it also involves the defence of human rights and human life. He made the comment upon return from a trip to west Africa about child slaves being used to work in the fields where they produce cocoa beans to make much of the chocolate which is consumed by people like us here in Australia. He said if we fail to eat fair-trade chocolate—that is, chocolate not made with child slave labour—then we have blood on our teeth. I think it is a fair enough juxtaposition to make a similar conclusion on this issue, so I do not consider it radical. Certainly the figure who made the comments about child slavery and people eating chocolate that is not fair-trade chocolate having blood on their teeth was not derided as radical for that. In fact he was applauded for defending those who did not have a voice in far-flung corners of the globe. There are similar comparisons that could be made with this issue.

Senator CAMERON—So does a woman who, in consultation with her doctor, discovers that she has a severely abnormal child and makes a conscious decision to abort the child in the second trimester have blood on her Medicare card?

Mr Shelton—Anyone involved in that sort of situation is going to have to weigh up the morals and ethics of that, and that is for them to decide.

Senator CAMERON—But you have made the assertion.

Mr Shelton—I am making the assertion that those of us who conscientiously object are being forced to participate in this. I think the idea that we should dispose of or kill children who do not meet a certain standard of ability is something that we really need to seriously consider as a society.

Senator JACINTA COLLINS—While we are on the issue of public funding per se, what would you say about the decision in South Australia in the late sixties to establish a system that solely used public funding to restrict access to abortion services?

Mr Shelton—I am not aware of the instance. I would probably need some more information on what it is you are referring to.

Senator JACINTA COLLINS—The issue here is those who object to public funding being used at all as opposed to the public policy decision that was made in South Australia, which set up certain restrictions to access to terminations and to control that by solely allowing public delivery. Unlike Victoria, for instance, where we have freestanding private clinics, there is none in South Australia. In South Australia you have a higher level of regulation than we do in Victoria, and in South Australia you have better data and reporting. But the moral conundrum in South Australia, to use your phrase, is that there would be blood on the Medicare card because it is publicly funded. Can you reflect on that issue?

Mr Shelton—We do not support abortion being made available unless there is a lethal foetal abnormality or unequivocal risk of life to the mother. The idea that we should have abortions publicly funded or otherwise in a civil society because of disability issues is problematic. I think Mrs Joseph makes some very pertinent points, notwithstanding questions about her legal qualifications, about the rights of a particular group of people in our society.

Senator JACINTA COLLINS—I understand that element. That is quite a different point. I was just wondering if you would reflect on the other point, since we were talking about whether public dollars are the issue per se in terms of how we deal with this. The extension of your current position is that it applies to any of the Medicare items that allow for the delivery of termination services full stop.

I am conscious of some caution with respect to the data that is available in this area right across the board. The point was raised earlier about the mention on page 5 of your submission about the number of live births in Victoria. I want to flesh that out a bit. I suspect that some of those births may well in fact relate to—and you can correct me if, from your understanding, I am wrong—couples who, for instance, have an unborn child with severe foetal abnormality who determine that they want to carry through close to term, who induce close to term and then grieve at the death. That is what the doctors earlier today were suggesting was one way that couples might find more appropriate to deal with the issue of severe foetal abnormalities. Are you able to tell me whether the figures include those types of instances or whether they are definitely all planned terminations in the sense that most people understand that?

Mr Shelton—Certainly the way they are reported is as abortions.

Senator JACINTA COLLINS—Yes, but abortion is a very general term.

Mr Shelton—It may well warrant further investigation by the Senate, but the figures are presented in the context of abortion statistics, so presumably they are referring to deliberate intervention in aborting the child.

Senator JACINTA COLLINS—This is why, when I looked at point 5 in your submission, where you talk about mortality and morbidity, I was not quite clear whether you would include that class of infant deaths or not. What you are saying at the moment is that you cannot, so we can both go and look at it on some other occasion.

Mr Shelton—Sure.

Senator JACINTA COLLINS—I am also conscious of the fact that in one of the states—it may be in New South Wales; I cannot quite recall off the top of my head—because of issues of law, it is essentially imperative that all terminations result in a dead child because if a child is born alive then there is a retrospective application as to the duty of care in relation to that child. So some of these issues differ state by state. Are you aware of that?

Mr Shelton—No, I am not aware of it. I am concerned about comments that have been made anecdotally about intervention to ensure that a child is delivered dead. I guess that underscores the problem surrounding this whole debate.

Senator JACINTA COLLINS—It is quite a bizarre application of the law, frankly, that, in dealing with a pregnancy, you are going to be caught by the law if you allow that pregnancy to deliver a live birth.

Mr Shelton—Precisely, and I think that goes to the heart of the concerns that were raised about the partial birth abortion method, which clearly is designed to ensure that the law is not breached by delivering a dead baby in the most brutal of circumstances.

Senator JACINTA COLLINS—Yes. Thank you.

CHAIR—Can I just clarify something there. In relation to babies where an attempt to abort them was made but the babies were born alive—and your evidence is that they were left to die—isn't there an ethical dilemma for the doctors? I thought doctors swore an oath to protect one's life. Is there no intervention, then, to revive or keep those babies alive?

Mr Shelton—This is what we would love the Senate to investigate. I guess that is why I made those remarks in my opening statement. It should be investigated, both to clarify the figures, as Senator Collins has indicated, but also to ensure that there is proper care being taken. I know that in the United States legislation has been put to the congress to deal with babies born alive after botched abortions. Perhaps we should look at similar legislation in this country.

CHAIR—When you look at the further evidence, not only from your submission but from other submissions, in relation to whether or not unborn babies, at what age of development, actually feel pain, certainly you would have to say that the baby then would have to be in pain.

Mr Shelton—Absolutely, and certainly the evidence and the consensus is very clear that there is pain from 20 weeks—possibly earlier. And that is not from pro-life sources. Those authorities are summarised in our report. In fact, evidence about foetal pain was crucial to the US Congress in its deliberations and its final vote to overturn partial birth abortion. Foetal pain was a critical factor in that. I guess one thing we would add is that, again, if we are going to persist with second trimester and late term abortions in this country, and if that is something that organisations like ours and other concerned citizens cannot stop, then at least we should look at whether or not the foetus should be anaesthetised before it is killed through partial birth abortion or through the dilation and evacuation method that has been detailed in Dr van Gend's submission.

CHAIR—Thank you. Senator Hanson-Young.

Senator HANSON-YOUNG—Keeping in mind that I understand that you have moral objections to the procedures, what is your response to the ideas—and a number of people have put this in their submissions to us—that disallowing this particular Medicare item will not necessarily stop women from going through this process; in fact, it may simply push those terminations later and later? How would you respond to that? If the concern is with doing it this late in the piece anyway, how do you respond to the fact that, if a woman needs to do this, it is a matter of either having to sit on a waiting list for another six to seven weeks before she can get in to a public hospital, or having to save up that money to go and get it done privately?

Mr Shelton—For the sake of $267, given that these procedures vary in cost—there are various estimates—from well over $1,000 to $4,000, I do not think the cost that is attracted by this is really going to be a serious impediment to most women, should they be determined to proceed with—

Senator HANSON-YOUNG—Do you seriously think that $4,000—

Mr Shelton—Sorry—$267, when the total cost is $4,000, I do not think is going to make a huge difference.

Senator HANSON-YOUNG—What about the waiting list? If somebody has been advised by the doctor that the child that she is pregnant with is not well, the child has organs growing on the outside of their body, and she is not responding well to the pregnancy and her own life is in danger, does her being on a waiting list for another six to seven weeks not matter to you?

Mr Shelton—As we said, we object to abortion being carried out where there is no lethal abnormality, and we should not be trying to define—

Senator HANSON-YOUNG—But that is exactly what this disallowance is about.

Mr Shelton—what sort of people are fit to live in this country.

CHAIR—Senator Hanson-Young, with all due respect, if you ask a question, you should at least have the courtesy to let the witness answer, and then you can ask another question.

Mr Shelton—As I said, our concern is the use of abortion for eugenics or for psychosocial reasons. We have come to the view—and this would probably not be a view shared by all pro-life groups—that, if a woman has a foetus with a lethal abnormality or her life is at unequivocal risk, and these things can often be diagnosed accurately these days, those should be the only exceptions. We know that in this country those instances are not the overwhelming reasons abortions are performed.

Senator HANSON-YOUNG—The evidence that we have been given for this particular item, the 520 abortions that were performed last year, is that that is why they were performed.

Mr Shelton—Lethal foetal abnormality?

Senator HANSON-YOUNG—Yes, that people do not—

Mr Shelton—Is that the evidence that you have heard today, Senator, with respect—that the majority of those abortions are occurring—

Senator HANSON-YOUNG—Yes, that people make these decisions based on the medical assertions, not because of some psychosomatic determination. That was the evidence that we were given.

Mr Shelton—I was not suggesting that. You were asserting that the evidence you have heard today—and I have only heard bits of it—is that most of those second trimester abortions occurred because of lethal foetal abnormality.

Senator HANSON-YOUNG—The evidence that we were given was that these 520 abortions that were done last year, and it has been continuing to go down—

Senator BARNETT—Could you advise the committee which 520 you are talking about?

Senator HANSON-YOUNG—They were the ones that were listed in the department's records.

Senator BARNETT—It is 540 for the year to date to August, if they are the figures you are talking about.

Senator HANSON-YOUNG—Okay, 540. I am sorry.

Mr Shelton—I think they are somewhere around 800 a year.

Senator BARNETT—Last year it was 790.

Senator HANSON-YOUNG—So under 600. I do not think it is the numbers that particularly matter anyway. The evidence that has been given by a number of people is that these decisions are made because there is a medical reason. It is not made on a moral judgement. A woman and her family do not make this decision flippantly. Yet you are saying we should be not allowing this to happen and we have blood on our Medicare cards because of a moral judgement.

Mr Shelton—If it is a moral judgement to suggest that some people are fit to live and some are not because of their level of ability or disability, so be it. That is a moral call. May I offer a personal anecdote, chair, in response to the senator's question?

Senator HANSON-YOUNG—I have another question and then if you have time to give me examples you can. Putting your moral objections aside—

Mr Shelton—Whose morals?

CHAIR—Mr Shelton, please let the senator ask her question. Then you will have the opportunity to respond and give your anecdotal evidence.

Senator HANSON-YOUNG—And this is to Mrs Joseph as well because you are presenting together.

CHAIR—They are not presenting together. It is just the way that the hearing went. We have two witnesses to try and best use the time. They are separate identities.

Senator HANSON-YOUNG—Mr Shelton, you can answer and then, Mrs Joseph, you can answer. Putting your moral objections to pregnancy termination aside, what is actually the concern with allowing people to access this particular item under Medicare?

Mr Shelton—The concern is that people have a conscientious objection to abortion being performed in the second trimester, given the brutality of that method and the obvious pain that that causes to the fetuses. Some members of the community feel that for that to happen because of disability, for psychosocial reasons or for economic reasons is wrong and yet they are forced to pay for it—we have no choice. That really plays on the consciences of many of us who believe that children, regardless of their able-bodiedness or otherwise, have every right to enjoy life and the things that we all enjoy. We know indeed in many cases they can do that, and we also know that there are instances where abortions are performed in the second trimester not for reasons of any abnormality at all but for cleft palates and even for economic reasons, as you have all heard at this hearing. That goes to the heart of our objections. If the parliament and the democratic processes say that we will continue to make these brutal practices legal and treat unborn babies in a way that is different to the way we treat animals, if that must be the case, please do not force us to pay for it.

Senator HANSON-YOUNG—That would be the same argument—

CHAIR—Did you want Mrs Joseph to answer that question first?

Senator HANSON-YOUNG—In a moment. I will respond to Mr Shelton first, thank you very much.

CHAIR—I remind everyone that we are way behind schedule. We have another senator who has questions, so could you summarise what you are saying. I thought you asked that first question to both of them.

Senator HANSON-YOUNG—Would you agree, Mr Shelton, that is the same argument people would take for not funding the Iraq war—moral objection, blood on the hands of the taxpayer.

Mr Shelton—Absolutely.

CHAIR—I have to draw the conclusion that that question is way outside the terms of reference and the reason that we are here.

Senator HANSON-YOUNG—No, it is not.

CHAIR—I am ruling that out of order. Do you have another question that you would like to put forward? We are running out of time and there are other people who want to ask questions.

Senator HANSON-YOUNG—Mrs Joseph, could you please answer?

Mrs Joseph—Could you repeat the question?

Senator HANSON-YOUNG—The question is, putting your moral objections aside from abortions, can you please explain what the other objections are to this particular matter.

Mrs Joseph—The objection is that this funding is taking place in contravention of what we have promised under the international conventions. Also, it is taking place without scrutiny. I know we have had so many questions today about the statistics, and yet what is very clear is that the statistics are not available. No-one can tell me how many of the children who are disappearing, who are being disappeared, because they have been found to have Down syndrome have been paid for under this item. As soon as you come to ask, Medicare says, 'It's privacy,' or the doctors say, 'No, it is a private matter between the woman and the doctor.' Yet I know that right from the beginning of the foundation of international human rights law, privacy was not allowed to count when it came to any suspicion that there was human rights violation. You were not allowed to say, 'Oh no, we can't investigate that because it is private.' If there is a suspicion that even one child with Down syndrome is being aborted and being paid for by this legislation, this Senate, the Australian government, has to investigate it and punished it if it is happening. It is not enough to just say, 'Oh, privacy, privacy.' I think you can all quit asking; do not ask anymore. For the rest of the two days, just do not ask about statistics, because it is useless. There is a human rights abuse going on here, or there is a suspicion that there is human rights abuse. I cannot believe that 95 per cent of children in Victoria that have been found to have Down syndrome have been legally aborted and at least some of them qualify for this funding without some abuse having taken place.

Senator HANSON-YOUNG—Mrs Joseph, you are very passionate about human rights issues and I think that is admirable. How do you balance what you are saying with the rights of the woman?

Mrs Joseph—Good question. I balance it by saying that there are certain principles that are just basic to human rights law, and one of them is the principle of indivisibility. That principle says that the abuse of one person's rights cannot be justified by upholding another person's rights. It requires that human rights protection of both the mother and her unborn child be observed. Both the mother and unborn child have equal rights that stem from the inherent dignity and worth of all members of the human family. When the indivisibility principle is applied, the individual state's misperceived duty to provide expectant mothers with abortion services cannot be performed at the neglect of the more fundamental duty to uphold the rights of their children to special safeguards and care, including appropriate legal protection before as well as after birth. The right to life is a supreme right and basic to all human rights.

CHAIR—Can I—

Mrs Joseph—And in deciding how you balance one set of rights against the other there are very clear laws. In general, it is an agreed set of principles that you look at proportionality and you look at necessity.

CHAIR—Senator Hanson-Young, if you have got any further questions, can you put them on notice so we can go to Senator Brown and we can wrap this session up.

Senator HANSON-YOUNG—Sure. My question on notice would be, how do you respond to people who say that they are being forced into pregnancy?

Mrs Joseph—I have written a chapter on this—

CHAIR—That will be taken on notice. Senator Carol Brown.

Senator CAROL BROWN—I have a very quick question of Mr Shelton. You have indicated in your submission that there would be a need to introduce consequential protections, and one of those relates to the unequivocal risk to the life of the mother. Who would you see as making that decision? Would it be the woman's physician?

Mr Shelton—Obviously doctors would need to. In a public hospital, you would also have the added security and scrutiny of ethics committees.

Senator CAROL BROWN—So no different than the situation now?

Mr Shelton—I think it is a little bit. We have used the word 'unequivocal' quite deliberately, just so that—

Senator CAROL BROWN—I am not talking about the wording, but about who makes those decisions. You are not suggesting that that changes?

Mr Shelton—No.

Senator CAROL BROWN—Thank you.

CHAIR—Thank you, Mrs Joseph and Mr Shelton, for not only your submissions but also appearing before us today.

Proceedings suspended from 3.55 pm to 4.15 pm

PESCE, Dr Andrew Francesco, Chair, National Association of Specialist Obstetricians and Gynaecologists

ELLWOOD, Professor David Alan, President, Women's Hospitals Australasia

CHAIR—Welcome. For the *Hansard* record, would you please state the capacity in which you appear today?

Prof. Ellwood—I am here as the President of Women's Hospitals Australasia, representing that organisation.

Dr Pesce—I am here as the Chair of the National Association of Specialist Obstetricians and Gynaecologists and also representing the Australian Medical Association.

CHAIR—Thank you. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has before it your submissions. I now invite each of you to make an opening statement. Upon conclusion of those remarks, I will invite members of the committee to put to you any questions that they have.

Prof. Ellwood—By way of introduction, I am an obstetrician. I am Professor of Obstetrics and Gynaecology at the Australian National University in Canberra and President of Women's Hospitals Australasia, which is an organisation that represents a large number of the larger women's hospitals that provide maternity services in Australia and New Zealand. Many of our members are the tertiary hospitals that provide the services in high-risk obstetrics. I am a practising obstetrician and a sub-specialist in maternal foetal medicine. So I do a lot of work in the area of prenatal diagnosis.

WHA is strongly against any change to item No. 16525 for many reasons, as outlined in our submission. Firstly, we believe that access to safe and affordable services in the termination of pregnancy is an essential part of care for women. 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.

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.

It is also important to point out that this item number is used for other purposes. It is not always used for termination of pregnancy; it is used in circumstances where foetal death has occurred for other reasons and it is also used when serious maternal illness really means that continuing the pregnancy would carry a significant risk to the woman's life, such as in very early onset pre-eclampsia. So, just to summarise: whilst this is an item number that is used relatively

infrequently, we believe it is used in situations where the ability of women to access this item number is essential for their health care and we are strongly against any change.

CHAIR—Thank you.

Dr Pesce—I will not repeat the things that David has already said but I agree with everything he has said. I guess the view of the Australian Medical Association would be that, even though any individual decision on whether a termination of pregnancy should or should not go ahead is often a very difficult decision and has a significant moral element to it, the position that we would take would be: where it is lawful to terminate a pregnancy then we believe as a profession we are obliged to provide that safely and equitably for the population to the extent that we can. Medicare funding is accepted as an equity issue—it is an equitable basis for receiving medical care in this country—and it would be completely inconsistent to decide that, for some reason, a lawful medical treatment should not have access to Medicare funding.

I suspect the reason that we are here is because a lot of people still feel very strongly that termination of pregnancy is not right, and especially that later-term termination of pregnancy is not right. But the vast majority of the use of this item number is not for that. It is for genuine medical conditions: significant foetal abnormalities often inconsistent with life, life-threatening illnesses for the mother, and women who spontaneously go into labour with a dead baby or have induced labour because of a diagnosis of a dead baby. So certainly if there were to be removal of this item number without consideration of that, there would be a whole lot of collateral damage—a lot of unintended consequences. So I would strongly oppose a change to the funding arrangements and removal of 16525 from the Medicare Benefits Schedule.

CHAIR—Thank you very much for your opening comments. Senator Fifield.

Senator FIFIELD—Dr Pesce, one of our witnesses earlier today in their submission—this was evidence from Medicine with Morality, a doctors' organisation—stated that the principal use of item 16525 of the Medicare Benefits Schedule is for abortion. I put it to Dr Dunjey that, when you just use the word 'abortion' in that way, most people who read that submission would take that to mean, I guess, for want of a better phrase, 'abortions of convenience'. He then went on to say that, no, they meant the term 'abortion' to cover all terminations regardless of circumstance but that, regardless, his view was that a majority of terminations under that item number were for psychosocial reasons, which is used, I think, by some as code for abortions of convenience. In your evidence, I think you and Professor Elwood have both stated that the majority of procedures under this item number are in fact for other reasons. Could you take us a little further through those other reasons but also tell us how you account for the discrepancy between those who say that this is fundamentally used as an item of convenience for women who just do not want to have kids, and you who say that the majority of cases are for genuine medical reasons?

Dr Pesce—I cannot understand why they say that. I have been in practice, including my training years, for about 20 years. I have probably come across half-a-dozen cases of mothers requesting abortion for psychosocial or emotional reasons—reasons other than genuine medical complication of pregnancy. I have worked in the western suburbs of Sydney in a public hospital. I now work in private practice, so I could understand that maybe my practice now is not reflective of a lot of society. But I spent 10 years in the public system as a staff specialist and five years as a trainee, and on one or two occasions we had women coming in requesting

abortion that would qualify for this item number. I cannot understand how anyone can say that if they have worked in the specialty. It is just to me a nonsense.

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.

Senator FIFIELD—Thank you for clarifying that. In your submission you also mention:

This largest provider of abortion services after 20 weeks in Australia does not claim against 16525.

A lot of witnesses have given us evidence of their concerns about procedures in private clinics and the circumstances in which they occur. But according to what you have said, even if this item number was disallowed, that would not have any effect on the practices in some of these standalone facilities.

Dr Pesce—The reason I say that is because I know what the charge is. The charge is an order of magnitude or two above the Medicare rebate. The particular individual clinic referred to realises that it is not worth the controversy and the potential scrutiny. Given the fact that there is an identifier under the MBS item number to say that it has to be for certain indications, that provider just does not use it. Your question is: if this MBS item number was withdrawn would it stop access for this service? I presume not.

Senator FIFIELD—You cited a figure of $4,000 as the ballpark figure for costs of procedures in those sorts of facilities. If the Medicare rebate was higher, would it be more likely that it would be claimed by providers such as that?

Dr Pesce—I think at the end of the day the providers would be very, very acutely aware that they have to comply with the regulations and the law. If there is an identifier in there as it is now saying that the procedure could only be undertaken for certain indications and if there was the possibility, whether it was real or not, that they might come under some sort of scrutiny because of going outside the descriptor in the MBS item number, I think they would err on the side of not using it, basically. I still think they probably would not use it whilst it is such a controversial thing.

Senator FIFIELD—I am just playing devil's advocate, although I am not sure who I am playing devil's advocate to. Could there be an argument to actually increase the rebate to see that some of these facilities regularise their practices?

Dr Pesce—If there was evidence that the standard of care was compromised because of lack of financial support then I guess there would be an argument. There are lots of layers and lots of aspects of all the public interest issues here. If there was evidence that standards were less than they should be and it was thought that that might be due to resource problems because of the difficulties with funding then, once again, if a procedure is lawful and if a patient wants a medical treatment and there is a provider who can provide that treatment, I would argue that it is in the public interest that that treatment is provided safely, humanely and equitably.

Senator FIFIELD—Thank you.

CHAIR—I just want to clarify a couple of things before I go on to anyone else. I had brought to my attention a media statement from 27 August in which you are quoted as saying that there is no legal difference between stillbirths and abortions after 20 weeks. You have presented evidence supporting the retention of this Medicare item. Is that also in light of your view that the baby bonus should be paid to people who abort their child?

Dr Pesce—No. I think that—

CHAIR—Also, in relation to women who have had a late-term abortion, you are quoted as saying:

I think it is a very humane gesture from society to say, 'You are going through enough already, we're not going to withhold the bonus'.

Senator CAMERON—That was the *Herald Sun*.

Dr Pesce—I did say that in the context of the way the question was asked. It did not differentiate between psychosocial terminations and other kinds but focused simply on women who were losing babies at that stage. Of course, what you say does not get completely reported in the media. I said that if there is a government department that wants to trawl through all of these item numbers and contact the patient and find out if this was a psychosocial termination on request or if the baby was dead, I think there is going to be a whole lot of unpleasantness and reigniting of psychological difficulty for patients who have gone through severe medical problems, having someone ring them up and say: 'Before we pay your baby bonus, we just want to check—was the baby really dead or was it—'

CHAIR—There is a bit of a difference, I would have thought, between a stillbirth—a baby that dies naturally—and a baby that is aborted and their warrant of the baby bonus.

Dr Pesce—There is no legal difference. That is one of the first things you said. There is no legal difference, once the baby is born, between a stillbirth and an aborted baby. It is still registered as a stillbirth, and that is what I meant by saying there is no legal difference—

CHAIR—Just to clarify and to ensure that it is recorded for the public record: a spokesperson for the Minister for Families, Housing, Community Services and Indigenous Affairs, Jenny Macklin, maintained the baby bonus was not available for aborted pregnancies. Going from a lot of the evidence that we have heard today and the submissions we have read, one of the factors that makes it very hard to make a judgement on this reference is that there are really no statistics

on the reporting mechanisms and processes in place to itemise under this Medicare item. As you represent professional organisations, I ask you both: would you be supportive of the collection of data so that we the community could get an accurate reflection of how many late term abortions are justified through a threat to the mother's life or irreversible abnormality in the child?

Dr Pesce—All data is always good. Data collection is always good. The more we know, the more we can do what we want to do and avoid the unintended consequences of what we might think we are doing. So I think it is high time we had much better statistics and more robust data on this topic in Australia; it basically does not exist.

The only cautionary note I would make is that I think it cannot be linked to Medicare item numbers. Medicare item numbers are a claiming thing for doctors so that we can pay for medical services. It is not a statistical tool to try and find out the subtleties of why we are doing a medical treatment or who we are doing it for. We must protect patient confidentiality. It would be very simple for any institution which was able to claim for any of these services—and they are always performed in institutions—to make it a requirement that they had to, in a de-identified way, provide all of this data, which would give us everything we wanted. We could go into the minutest details of what we need and get exactly what we wanted to know, and not threaten the confidentiality of the patient, who has to go to a Medicare office with an MBS item number where they would say: 'Oh, you had an abortion. Ooh, you had a psychosocial abortion.' Data is good, but you will get a lot better if you actually think about what data you want and have it collected properly and systematically in a de-identified way rather than mucking around with MBS item numbers, pretending you are going to find out things that you do not currently know.

CHAIR—From the evidence we have heard today, there is more regulation around breast implants than there is around terminating the life of a child.

Dr Pesce—I do not work in the other field, so I do not know that I can comment.

Senator RYAN—We have heard conflicting advice today from experts and professionals and other submitters about the procedures used for what might be called post-20 week terminations. I will be as delicate as I can here. Some allege that what might be described as a breech delivery followed by cranial decompression is very common. Others have asserted it does not happen. I was just wondering whether you had experience or knowledge of whether that was performed in this country under this item number?

Prof. Ellwood—I am probably best equipped to answer that. Most late terminations of pregnancy—if we take the definition as beyond 20 weeks, but the same thing applies to terminations of pregnancy between 18 and 20 weeks—in the public hospital system, and the great majority of these would be carried out in the public hospitals, would be done using a method to induce labour. The commonly used drug would be misoprostol. Another drug that is used has the trade name of cervagem. It is a prostaglandin analogue. From my own knowledge of what happens in the tertiary women's hospitals around this country, it is the only method that is used. 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.

Senator JACINTA COLLINS—Restricted to?

Prof. Ellwood—Restricted to one private clinic. That is the only one that I am aware of that actually uses that method.

Senator RYAN—It is not widespread with the use of this item number? Public hospitals of course do not have access to this item number.

Prof. Ellwood—For private patients in public hospitals. Because of the way that tertiary services are organised, many private patients who have reason to access this item number would actually end up in public hospitals because of the qualifiers about serious 'life threatening maternal disease' and 'gross foetal abnormality'. The exception might be for foetal death where somebody who was booked in a private maternity hospital may well have their induction of labour following foetal death in that private maternity hospital. Quite often women who would have access to this item number do actually move into the public hospital system which is why I made the point about continuity of care from the private providers. The methods used, in my experience throughout the hospital system, public or private, would be induction of labour using one of the two drugs that I have mentioned.

Senator RYAN—It was also submitted earlier today that if the third element of this item number had the wording changed from 'maternal disease' to 'significant threat of death of the mother' that would significantly change the behaviour of doctors, who have to fit the claim into the Medicare item description in order to claim it. The argument being that that wording is effectively too loose and it is allowing for it to be applied more widely than it otherwise would if it said 'significant threat of death'. Do you have a view on that? Would that change the behaviour?

Prof. Ellwood—I have a very strong view on that. My answer partly goes back to the Chair's question about data and the fact that we do not have a lot of data that we can actually quote on this. In my experience, having worked in the public hospital system for nearly 30 years and having worked in the area of maternal foetal medicine since the subspeciality began, 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.

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. One example would be severe early-onset pre-eclampsia where there is no prospect of the pregnancy progressing safely to a point where the baby could be born alive and have any chance of survival. There may be some extreme examples of serious maternal psychiatric conditions such as an acute psychosis where termination of pregnancy may be chosen as a method of care. There are very few other conditions, perhaps very severe maternal cardiac conditions, where continuation of the pregnancy would be life-threatening. 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.

Senator RYAN—On the point of gross foetal abnormality we also heard evidence today, which was new to me, that the definition of gross foetal abnormality was something that could be observed with the naked eye. I think 'macroscopic' was the term used. Could you provide further information on what might qualify? We have heard claims that it could be a hair lip or a

cleft palate. What would quality as a gross foetal abnormality? Does something have to become, for lack of a better way of putting it, a more dangerous or threatening abnormality the later a pregnancy progresses in order for this procedure to be undertaken?

Prof. Ellwood—We would need to differentiate between above and below 20 weeks' gestation because the approaches vary with gestational age and depend on whereabouts in Australia you are. For example, in Western Australia, beyond 20 weeks there is the requirement for the case to be considered by a medical committee appointed by the Minister for Health. In the ACT, for example, at the hospital where I work, requests for termination of pregnancy beyond 20 weeks are considered by an ethics committee before that goes ahead. It is also commonplace in New South Wales and Victoria for there to be a review of the request for termination by a multidisciplinary review panel. The reasons for the request are considered very seriously by those bodies in whichever jurisdiction you are in. My interpretation of the phrase 'gross foetal abnormality' really means a significant or severe foetal abnormality. The idea that it is something that is visible to the naked eye is nonsense. We use technology, ultrasound, genetic testing and metabolic testing these days. In my experience, it is not anything to do with whether or not this is something that you can see with the naked eye.

Senator RYAN—So gross refers to the degree.

Prof. Ellwood—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. And this brings me back to the Chair's question before. One of the problems about data collection is definition. Is it a termination of pregnancy if you are simply inducing labour early in pregnancy when the baby has a condition that is incompatible with life? For example, anencephaly in the foetus, which is incompatible with life after birth: should that be classed as a termination of pregnancy if you end the pregnancy at 24 weeks as opposed to waiting until 40 weeks?

There are many situations where a continuation of the pregnancy for purely obstetric reasons may be detrimental to the health of the mother. It is very difficult to give birth to a baby with anencephaly at 40 weeks gestation. It is a lot easier to give birth at 24 weeks gestation. Should that be classed as a termination of pregnancy? I do not believe it should be.

Senator RYAN—You mentioned earlier the potential to use the item number as a private patient in a public hospital. Can you make any observation about the percentage or number of such procedures in a public hospital that might be public versus private patients in this field? I know you don't have data.

Prof. Ellwood—I can only really say that from my own personal experience. I have a clinical practice, which is based in a public hospital, but I am referred a lot of patients for secondary and tertiary opinions by private providers. It is quite common I think for women who were going through the private system and, for whatever reason, choose to have a termination of pregnancy in a public hospital. It is quite common for them to be admitted as public patients, so the item number would not be used anyway. But I think the ability for private providers to have continuity of care for these women in extremely difficult circumstances is very important, and it

certainly does get used for those purposes. I would be guessing: it might be 10, 15 or 20 per cent, that kind of order.

Dr Pesce—There are a few dimensions to this. At our public hospital, we actually had to remind our visiting medical staff who practise both in the private and the public hospital that they should not differentially book the woman into the public hospital. There is a temptation to do that because you have resident medical officers and registrars, who can supply the medications and do the examinations et cetera, so you do not have to keep coming in every three to six hours over the weekend. There are some incentives to book private patients into the public hospital which should not be there, but they do exist.

Also, more recently, TGA approval can be sought for mifepristone. If you are going to induce labour in the second trimester, it is much more efficient—shorter labour, shorter interval to delivery, lower incidence of retained placenta—to pre-treat with mifepristone. Even though it is theoretically TGA approvable, the hoops you have to jump through are so huge. Our public hospital has done it because one specialist in the hospital spent three years with multiple submissions to get approval. Each time it has to be approved by the ethics committee—there are lots of checks and it is all done properly. There are so many obstacles that the private hospital just is not going to do it. There maybe reasons why private patients may then be booked into the public hospital, because they can access a more evidence-based, up-to-the-minute treatment that is not available because of restrictions on supply of the medication.

Senator RYAN—Of course, but many—

CHAIR—Senator Ryan, with all due respect, we have set a time limit. A number of other senators have questions. Could you put your remaining questions on notice; otherwise, other senators are not going to get the opportunity.

Senator CAMERON—Professor Ellwood, we have had submissions today saying that genocide is taking place in the hospital system and that genocide is of unborn babies with Down syndrome. Do you have any comment on that statement?

Prof. Ellwood—Down syndrome is a common reason for requesting termination of pregnancy for foetal abnormality. It is now much more commonly happening at the end of the first trimester following the first trimester screening programs that are in place. It is quite an uncommon indication for second trimester termination or late termination of pregnancy because women who would choose to terminate a pregnancy for Down syndrome have usually accessed the first trimester screening. It is not a very common diagnosis now for second trimester termination.

Senator CAMERON—Do you believe that psychosocial justification for abortion is reasonable?

Prof. Ellwood—I think it depends on what you mean. The term ‘psychosocial’ is a definition that is used to categorise a choice that some women would make. I would concur with Dr Pesce’s opening remarks. In my clinical practice, it is extremely uncommon for a request to be made for termination of pregnancy outside of the qualifiers that are used for this item number. I do not believe I can give an answer to your question that really does justice to the reasons why a woman may choose not to be pregnant in the absence of a serious foetal condition or a life-

threatening maternal illness. I would imagine there would be some circumstances in which I would support the request and some in which I would not support the request. I think it is an individual decision between the woman and her doctor.

Senator CAMERON—Do you have any evidence of what has been described in submissions here today that cruel and gratuitous child destruction is taking place in our hospital systems?

Prof. Ellwood—I think that is so far from the truth that it is laughable.

Senator JACINTA COLLINS—Dr Pesce, there is one question I asked in a private briefing that we have had which has not been covered in your submission, which for the record would be helpful. Can you tell us—and I know it can only be an anecdotal indication, and perhaps the professor might be able to add to it—what proportion of these claims on the Medicare item might be spontaneous, as opposed to induced labours?

Dr Pesce—My feeling in my practice is that about half of them would be for women who come into labour early, in the second trimester—

Senator JACINTA COLLINS—Up to 20 weeks, for the record.

Dr Pesce—The second trimester is after 13 weeks. If it is before 20 weeks, it is a miscarriage; if it is after 20 weeks it is premature labour, in technical speak.

Senator JACINTA COLLINS—Can there be a different item number for—

Dr Pesce—No. One of the problems is that there is an item number for the delivery of a baby and there is an item number for the management of second trimester labour. The common practice would be that if it were just for a 16-week to 18-week delivery spontaneously then I think it would be charged under the 16525 item number rather than the obstetric item number, which is meant for the delivery of a live baby. I think that probably somewhere between one-third and one-half would be spontaneous miscarriages/premature labours associated with bleeding or because of a dead baby.

Senator JACINTA COLLINS—Would that be your impression, Professor, from your experience?

Prof. Ellwood—It is very difficult, because the data sources include all public and private patients and where the item number may or may not be used. I was just doing a rough calculation. If we look at births which are registered—and you need to be beyond 20 weeks to be registered as a birth—between 20 and 24 weeks gestation, about one per cent of births are in the gestational age window. On the most recent figures, that is about 2,700 births a year in Australia. That would include late terminations of pregnancy; it would include spontaneous preterm birth between 20 and 24 weeks; and it would include cases where there was a stillbirth and induction of labour. I think the number of times this item number is used is about 800, but that 2,700 figure includes all births in the public sector and the private sector. I think that Dr Pesce's answer is probably a reasonable ballpark figure. It would be used quite often to cover spontaneous births. Whether it would be late, second-trimester miscarriage or early, preterm labour, I think it would

be used quite often, particularly in the private system, because many of the terminations for foetal abnormalities are done in the public system, for which that item number is not used.

Senator JACINTA COLLINS—Reflecting further on Senator Cameron's question when he was talking about our hospital system, I am focusing particularly on the arrangements in Victoria and the recent debate in Victoria. I highlighted one example of a woman who claimed that she went to a private, freestanding clinic after she had a severe gross foetal abnormality identified because she did not want to go through the trauma of an ethics committee, but then equally her experience from the private, freestanding clinic was that the quality of care or the standard of services was very poor. In New South Wales or in the ACT you do not face this issue or this problem of people exiting the public system because there are private, freestanding services that will perform late-term terminations as an alternative.

Prof. Ellwood—There is no private freestanding clinic in the ACT that would perform late terminations or even earlier second trimester terminations of pregnancy.

Dr Pesce—Nor in New South Wales.

Senator JACINTA COLLINS—In response to Senator Cameron's question, if we included, as we have referred to before, the one provider of partial birth terminations, would your answer be the same?

Prof. Ellwood—Sorry, I do not quite understand your question.

Senator JACINTA COLLINS—His question was about assertions to this committee that there are medical practices generating—I have forgotten the exact words—severe foetal pain and distress in their practices. He limited the question to the hospital system. I am now expanding it to include the one clinic that we are aware of that does practise partial birth procedures. If we included that in the question, would you have concerns?

Prof. Ellwood—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. I am personally not in favour of the partial birth abortion method. I think we have extremely good medical methods for inducing labour in the second trimester and they are the methods that we use in the public hospital system.

Senator JACINTA COLLINS—On that point, is one of the issues that managed labour in the circumstances we are describing essentially needs to occur in a hospital setting, whereas generally we are allowing an alternative to occur through very limited regulation?

Prof. Ellwood—It would certainly be true to say that freestanding clinics which do not have the ability to admit patients would be unable to carry out terminations of pregnancy using the medical methods that I have described.

Senator JACINTA COLLINS—Which you would describe as best practice?

Prof. Ellwood—Yes, I believe they are best practice.

Senator JACINTA COLLINS—I am conscious of the shortness of time, so I will explore these questions at a later time. Thank you.

Senator BARNETT—In terms of the private clinics—and I am happy to take this in confidence if you prefer—do you know how many there are and where they are?

Prof. Ellwood—I guess I would need you to clarify the question. Private clinics providing what service?

Senator BARNETT—Item 16525.

Prof. Ellwood—I do not know which private clinics would use this item number. As Dr Pesce has already pointed out, the qualifier for this item number—for intrauterine death, gross foetal abnormality or life-threatening maternal disease—probably does not fit the practice of the private clinics, so for that reason they may not use it.

Dr Pesce—I think it depends on the gestation. There would be multiple private clinics which would be able to provide surgical termination of pregnancy services into the second trimester. They would have their own individual cut-off marks—16 weeks, 18 weeks, 20 weeks or whatever. That would not fit under this item number because it is a surgical evacuation of a gravid uterus and that would come under a different one. So, in terms of inducing labour, given the fact that once you do that you are obliged to care for the woman, it would imply admission possibly for 18, 24 or 36 hours. I do not think these day facility type operations can do that. I had a patient who—

Senator BARNETT—That is why I am asking you. They are pretty much in the capital cities. Are they outside any capital cities? Are you aware of any outside a capital city?

Prof. Ellwood—I am personally not aware of any outside of capital cities. I am only aware of one clinic, which is the Victorian clinic that offers termination of pregnancy beyond 20 weeks gestation.

Dr Pesce—I believe that specialised clinics would exist only in major cities. In various regional areas there might be some doctors who believe that they have to provide a service. They will make their own arrangements, but it will not be a specialist clinic that does it. They will just do it within their admitting rights at whatever facilities they work in.

Senator BARNETT—Do you think they could do that safely and ethically in those places?

Dr Pesce—It depends on what gestation you are talking about.

Senator BARNETT—Post 21?

Dr Pesce—It would depend on the facility.

Senator BARNETT—Professor Elwood, you said that you did not support partial birth abortion. Why is that?

Prof. Ellwood—I said that I believe that the medical methods of induction of labour are best practice. They are the methods that I am familiar with myself.

Senator BARNETT—Why don't you support partial birth abortion, which is what you just said to our committee? I am asking you the reason why you say that.

Prof. Ellwood—I am concerned about the surgical risks from that method. I would have to say I am not familiar with the method. I have never practised the method or actually seen it done, so my answer is as a specialist in the field but not with any direct experience.

Senator BARNETT—But you are an expert and a specialist in the field.

Prof. Ellwood—I am.

Senator BARNETT—Can you describe the method for us?

Prof. Ellwood—My understanding is that a method is used to dilate the cervix. There are different approaches that can be used, either using drugs or using mechanical devices. Then the foetus is extracted piecemeal from the uterus. That is my understanding of how the method is done.

Senator BARNETT—Dr Pesce, how would you describe it?

Dr Pesce—There are various methods used. My understanding of partial birth abortions is that labour is induced to the point where the cervix is significantly dilated and then, to allow extractions, the largest part of the baby, being the head, is decompressed using a special instrument, which we had discussions about before—

Senator BARNETT—But we are on the record now, Dr Pesce, and that was a private briefing. This is for the record. It is for the Senate.

Dr Pesce—There is a specialist instrument which perforates the foetal skull, drains the spinal fluid, allows collapse of the foetal skull and then allows extraction of the baby. The reason why that would be considered would be that a lot of women would prefer to go to sleep and wake up not pregnant when they are going through this. I agree with David in that I do not think anyone would agree that 'gross' just means something that is physical. It has to be a significant deformity with significant impacts on the health. Say I have a patient whose baby has gross foetal deformity and she says: 'I want to terminate pregnancy. Can you do a caesarean? Can you cut me open and take the baby out?' I would say: 'We can but it is not in your interest to do that. Even though it is distressing to have to go through labour and give birth to a baby that is dead, it is really in your interest for subsequent pregnancies and your general health that we induce labour and let nature take its course that way rather than do a physically traumatic operation.'

Senator BARNETT—I want to ask about that and we are a bit tight on time, so in terms of inducing labour could you respond, Professor Elwood? You said that was the normal procedure

that you follow. Could you outline the prostaglandin process to us? In the normal course of events, is it normal best practice that the potassium chloride is injected into the heart of the baby?

Prof. Ellwood—The most common method now of induction of labour in Australia would be to use Misoprostol, which is a tablet that is put into the vagina every six hours, or another drug, Cervagem, which again is used as a pessary every six hours. Essentially the method is very similar. The practice of potassium chloride injection is quite varied across the country. There are some practitioners who would do that only in the event of a later termination of pregnancy, beyond 24 or 25 weeks gestation. There are others who would do it beyond 20 weeks.

Senator BARNETT—What would you describe as best practice? You have talked about best practice.

Prof. Ellwood—It is not done in the ACT. I do not know that it is possible to say what is best practice when there is such variation in practice. If we look at international experiences, the Royal College of Obstetricians and Gynaecologists in the UK has stated that it is best practice to perform a potassium chloride injection for terminations of pregnancy beyond 24 weeks gestation but does not specify under 24 weeks gestation.

Senator BARNETT—So there are a variety of practices used, notwithstanding your views regarding best practice.

Prof. Ellwood—There are a variety of practices.

Senator BARNETT—So the potassium chloride is injected into the heart and kills the baby immediately?

Prof. Ellwood—It stops the heart very quickly, yes.

Senator BARNETT—In what proportion for post-20-week abortions? Is it half of those cases or one-third or three-quarters? Could you assist us there?

Prof. Ellwood—If you said what proportion beyond 20 weeks, I would say it becomes more common the further on in gestation you are. But I do not have any figures that I could use. I would say it is quite common beyond 23, 24 weeks gestation for potassium chloride to be given. It is very uncommon before that gestation.

Senator BARNETT—Let us just focus on post 20 weeks. Where it is not used, the baby is born and in most cases would the baby be born alive and then die within a short time because it cannot live outside the mother?

Prof. Ellwood—It depends upon the gestational age. Closer to 20 weeks, it is very uncommon for the baby to be born alive. Closer to 24 weeks, it is more common and the baby would die very quickly after that.

Senator BARNETT—How quickly at 24 weeks?

Prof. Ellwood—At 24 weeks, usually within minutes. In some cases it may be measured in a number of hours—one or two hours.

Senator BARNETT—What would happen to the baby in that instance?

Prof. Ellwood—In general, the baby would be wrapped and cared for in the same way as any other baby and given to the mother.

Senator BARNETT—So at 24 weeks the baby is born alive and it is not unusual that the baby would live for a couple of hours and be wrapped and left there to die? That is not unusual, based on your advice in evidence?

Prof. Ellwood—It is not unusual in circumstances where pregnancies are terminated at 24 weeks gestation. But the termination of pregnancy at 24 weeks gestation is very uncommon.

Senator BARNETT—They have just legalised it in Victoria, so we know—

Prof. Ellwood—That does not necessarily mean it will change the frequency with which it happens.

Senator BARNETT—No; indeed. And your view on pain? Do babies feel pain at 20 weeks?

CHAIR—I am sorry, Senator Barnett; that will have to be your last question.

Senator BARNETT—I will make that the last question. What are your views on pain post 20 weeks?

Prof. Ellwood—I think I have already answered that question. I do not believe we know.

Senator BARNETT—So the baby at 24 weeks is born and is there for a couple of hours and you are not sure whether that baby is experiencing any pain? You do not know the answer to that question?

Prof. Ellwood—I do not know the answer to that question, but I am not sure that we are doing anything to cause the baby pain if we are wrapping the baby and giving it to its mother.

Senator BARNETT—The baby is given to the mother for those two hours?

Prof. Ellwood—Yes, that would be quite common practice.

Senator JACINTA COLLINS—We did not go into any detail about the statistics from Victoria about live births. I have subsequently pulled out the reporting, and we are talking about a range of terminations for congenital abnormality. Are you generally talking about the sorts of conditions you were describing before, where parents are making decisions about a baby that has a condition that would be incompatible for extrauterine life and that in some instances the couples choose to induce labour earlier than full term, a baby is born and then given to the parents to grieve?

Prof. Ellwood—Yes, it is very common. I guess you could describe it as palliative care for a foetus that has no prospect of survival, and that is not going to change whether the baby is born at 24 weeks or 38 weeks or 40 weeks.

Dr Pesce—My input into this at the moment would be to say that the prospects of survival after 24 weeks occurs in spontaneous physiological premature labours, and not uncommonly babies are born alive and they die soon after. My experience is not as extensive as Professor Ellwood's, but whenever I have induced labour with misoprostol or mifepristone there has been a different pattern of uterine contractions and I have never seen a baby born alive after such terminations, although I cannot say it never happens. Statistics from Victoria for 2006, as you are aware, show that when the terminations of pregnancy were performed for congenital abnormalities, there were no babies that were not stillborn.

Senator JACINTA COLLINS—If the diagnosis is wrong, what then is the duty of care in those circumstances? If a baby is born prematurely, on the basis of a diagnosis that turns out to be incorrect, would a baby just be left to die under those circumstances? Or are you then talking about applying whatever care and attention can be to preserve the life of that child?

Prof. Ellwood—Firstly, the practice of prenatal diagnosis with ultrasound and other technologies, genetic technologies, it is now very advanced. The certainty about the diagnosis prior to termination of pregnancy is one of the most important considerations. What may be in doubt is the prognosis in cases where there is an obvious severe abnormality, but it is unclear what that may mean in terms of chances of survival or quality of life. Of course, that is not ever going to be known straight after birth. I suppose a very gross example would be where ultrasound has said there is severe spina bifida and the baby is born and the baby does not have spina bifida. Is that the kind of thing you are talking about?

Senator JACINTA COLLINS—It could be.

Prof. Ellwood—I have never ever known that to happen and it would be unthinkable these days that it could happen; the diagnostic tests that we have are so accurate.

Dr Pesce—It is actually much more common where the disability and the impact is not completely known, and the parents have to make a decision with the full knowledge that the baby may be severely affected to the point that it will die. It might be severely affected and survive and then die soon after unless it gets multiple invasive surgeries. It might not even be that severely affected at all, but that is a question that only the parents can decide. There is a lot of discussion about this. If there is one person who has the right to decide whether or not she is going to carry her pregnancy and continue to carry her pregnancy, it has to be the mother. It cannot be me, even if I am a doctor. I can advise her, but it is not my decision. With respect, it cannot be doctors with strong moral convictions. I am sure they are motivated by the very best of intentions, but it is not them. With respect, I do not think it is the Parliament of Australia. If there is one authority which can determine whether a woman is going to continue with her pregnancy, surely it has to be the woman.

Senator JACINTA COLLINS—The other question that we need to consider in that context is: who decides, when a live birth occurs—let us say the woman deals with the issue of her

pregnancy, but the consequence of that pregnancy is another life—the duty of care and treatment of that life. That is the other issue.

Prof. Ellwood—I will perhaps try and answer your question, if I may, in a slightly different way, which is that quite often we deal with uncertainty about babies that are born at the borderlines of viability, let us say at 24 weeks gestation: many babies will be able to survive with significant intervention—neonatal intensive care—but many babies will not survive. Quite often there is a discussion that takes place between the parents and the neonatologist, prior to the birth, about whether or not resuscitation should be offered. As a doctor, I believe I do not have a duty of care to a patient, to the neonate, that says I should strive to preserve life when it is futile—and that may well be the case at, say, 23 weeks gestation or 22 weeks gestation, whereas at 25 or 26 weeks gestation the outcome for most neonates born in good condition is now very good because neonatal intensive care is extremely sophisticated. There is a grey zone where sometimes decisions that might be made in advance of birth may be revised after birth because the baby is bigger than expected or looks to be more mature than expected, in which case, yes, there is a duty of care to provide whatever support you can to that baby. But I think the situation you are describing—where, immediately at birth, it becomes evident that the diagnosis was wrong—is extremely unlikely to happen, given the way that we approach prenatal diagnosis.

Senator MOORE—A number of people today have drawn out the difference between the hospital situation and the private practice situation, and that has come out throughout the questioning and also through some of the answers and submissions we have had. One of the points that was made today was that there was a view that mothers and families were not being able to make full decisions—that they were not being given full information by practitioners. It was general, but I think it was focused particularly on private practitioners, and I think the inference was that, when a woman had a significant choice to make, particularly late-term—even though this inquiry ranges all the way through, we are talking late-term mainly—they were not being given sufficient information on which to make their decision and were not capable of being able to take in the information that they were getting at that time. There was a view that perhaps doctors were being less than open, and taking a pragmatic approach—that their job was to terminate rather than to do anything else. Do either of you have a comment on that process?

Prof. Ellwood—I have a very definite comment on that process, and I think it is important to look at the different situations in which women may come to the decision to choose termination of pregnancy. In general, women who are accessing or requesting a termination of pregnancy that would apply under this item number have a wanted pregnancy where they have been presented with an unexpected outcome, which is that their foetus has an abnormality, or they have a significant maternal illness, or, indeed, the foetus has died. But in general they have gone from expecting a good outcome for their pregnancy to a situation where something has happened to change that, and it would be practice in the public hospital system for that woman to be given extensive information and counselling: input from skilled obstetricians, genetic counsellors, paediatricians, social workers—whatever is required to ensure that she is fully informed about what is going on. That is a different situation from that of somebody who, because they do not want to continue their pregnancy for other reasons, approaches a private provider and says, ‘I would like to terminate my pregnancy.’ I do not work in that system, and how the private provider approaches counselling is something I cannot comment on; I have no direct experience of that. But in the public hospital system the counselling that is provided is highly skilled and extensive.

Senator MOORE—The department gave evidence this morning that they had received no complaint and there had not been any formal audit of the process under this item number. Their evidence was that the responsibility was with the practitioner—that, when the doctor actually completes the form to say that they are claiming under this item number, the expectation is that that practitioner fully knows the process that he or she is following and it is their process. In terms of complaint: within the AMA and also within the hospitals process, if doctors are not fulfilling that requirement is there a complaint process that other doctors or patients can use to say, 'We believe this doctor is not fulfilling their responsibilities'?

Prof. Ellwood—Answering from my own experience, but this applies to most of the tertiary hospitals that I am familiar with: all cases of late termination of pregnancy in the ACT go through a multiprofessional ethics committee. Those cases are also reviewed at the departmental morbidity and mortality meeting that takes place on a monthly basis. And all women who go through a late termination of pregnancy are followed up through a perinatal loss clinic, which I run. They also have ongoing input from a social worker. So if there were concerns, we would have lots of ways of knowing about those concerns. Of course, patients have access to health complaints commissioners in all states and jurisdictions.

Dr Pesce—There are a couple of things I would add. If there is not a lot of counselling being done, often it is because the patient is pressuring the provider to do things quickly because they are distressed by the whole situation. They believe they have definitely made up their mind and counselling is not going to make any difference. I believe that most providers would go to great lengths to make sure that they had fulfilled their duty of care to make sure the woman understood everything, including the psychological implications, and just to start that healing process—the grieving of the loss and all of that that happens. I have seen times where it has been done quickly, but I believe that is because the patient really insisted on it.

One of the problems is: a patient comes to you and wants a termination, they need a psychological review, it is a Friday afternoon, the first appointment with a psychologist that they can get is in two weeks time—and that is in Sydney. Imagine if you were in Brewarrina or somewhere else. Unfortunately, a lot of these decisions have to be made on the basis of the infrastructure which is available to provide best practice and, unfortunately, we do not have that all of the time. Like anything in medicine, there are compromises made, I am sure. I do not think they are made cynically and they are not made avariciously because we want to make money from more terminations. I think they are genuine attempts to make the best of a very difficult situation. In New South Wales it is a requirement—even in my private hospital, I cannot admit a patient for a second trimester termination of pregnancy unless I have documentation of the abnormality and I have to provide them with a copy of the ultrasound or the amniocentesis. I have to have documentation that I have received advice from two other doctors that they agree that it is an appropriate thing to consider termination of pregnancy.

Senator MOORE—That is New South Wales law?

Dr Pesce—Yes, that is in New South Wales. That is after 20 weeks.

CHAIR—Senator Brown has some questions which she will put on notice because we have run out of time. I thank you both for your submissions and for appearing before us. I thank my

colleagues for their cooperation. I am sorry that we have run late: I understand you have planes to catch.

Committee adjourned at 5.23 pm