COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

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

THURSDAY, 30 OCTOBER 2008

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SENATE STANDING COMMITTEE ON

FINANCE AND PUBLIC ADMINISTRATION

Thursday, 30 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, Cameron, Collins, Eggleston, Fifield, Fielding, Fierravanti-Wells, Hanson-Young, Moore, Polley, Ryan and Troeth

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

Committee met at 9.02 am

CHAIR (Senator Polley)—The committee is continuing 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 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 service-receiving payments under this item, the cost of those 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 and 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.

[9.03 am]

MENEY, Mr Christopher, Director, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney

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. I invite you to make a short opening presentation.

Mr Meney—Thank you for the opportunity to appear before this committee. I am appearing on behalf of the Life, Marriage and Family Centre of the Catholic Archdiocese of Sydney and would like to reserve the right of the bishops of Sydney to further clarify any comments which I make today. In my position as Director of the Life, Marriage and Family Centre and drawing on my experience in family and parent advocacy and in bioethics, I make the following submission.

The Life, Marriage and Family Centre is an agency of the Catholic Archdiocese of Sydney that has been established to extend the research, policy, educational and pastoral activities the church undertakes with respect to life, marriage and family issues. The Catholic Church has a great and ongoing tradition of caring for pregnant women and their families. Catholic agencies have long dedicated significant resources to provide maternity services, crisis accommodation and pregnancy counselling and practical support, and we continue to be involved as a significant non-government provider of these vital services for the wider community.

Catholics hold strong beliefs about the dignity and value of every human being, especially those who are most vulnerable. We maintain that proper social relationships must always strive for the good of every pregnant woman and her unborn baby. Sometimes this may require a radical self-giving and a willingness to generously respond with support for those who are suffering and facing a difficult pregnancy. In such situations, a proper response is one of solidarity which encompasses care and encouragement for the parents who are suffering rather than the deliberate killing of their child.

Abortion performed for any reason and at any stage of pregnancy is always the tragic and unjust taking of innocent human life. The Catholic Church works and prays for the day when greater respect for human life and the necessary support for pregnant women and their families will see the abortion of a human being as unthinkable. At the same time, we recognise that any reduction in the number of abortions would be a positive outcome for mothers and children. Disallowing item 16525 to stop Medicare funding of second trimester abortions in private abortion facilities would be a small but significant step towards this goal. It is expected the majority of second trimester abortions would then take place in public health facilities where there is likely to be greater scrutiny and accountability of healthcare practitioners engaged in second trimester abortion. This could result in a decrease in the number of abortions performed for psychosocial reasons. Victoria's survey of perinatal deaths for 2006 shows that this is an all too common indication for late trimester abortions. Ninety-eight unborn children were aborted between 23 and 27 weeks gestation for maternal psychosocial reasons. Forty-two post-20 week abortions resulted in the delivery of a live-born child who died shortly afterwards. Since 2001, of

the 581 late abortions done for psychosocial reasons only four were done in a public hospital, the rest by private operators.

This arrangement may also decrease the number of second trimester abortions which are performed because the unborn child has a disability. This is because one likely effect would be that parents would receive a better quality of counselling and support. Within the public hospital system, the medical, nursing and counselling staff who care for parents and their unborn children are more likely to have greater knowledge, experience and awareness of the various conditions and disabilities and know how and where parents can access treatment and support for their child. Parents will hopefully be less likely to make the decision to terminate the pregnancy once they are fully informed about their unborn child's diagnosis. This would include receiving information about positive treatment options and the support available for children with conditions such as cleft palate, spina bifida and Down syndrome.

Public hospitals are also better placed to provide the specialised and often intensive level of post-procedure counselling and support that these abortions occasion. The grief, loss and regret that women can experience after an abortion is real and well documented. There is evidence that second trimester abortions for reasons of disability are high risk in terms of women developing subsequent mental health problems. These mothers often very much love and want their babies. In many cases, they are women in their 30s and 40s who have waited, hoped and looked forward to having a family. A study published in the British Medical Journal found that 77 per cent of women aborting a disabled baby experienced an acute grief reaction and 46 per cent were still symptomatic and requiring psychiatric support six months later.

The recently published book *Common Ground?*, which reviewed Australian attitudes to and social data on abortion, comments that 'decisions during crisis in pregnancy need time and opportunity to reflect on the complex factors involved. Of particular moment in the accounts of post abortion grief is the sense of a forced choice through pressure from others or from circumstance'. The current system makes it less likely that parents will have adequate time and opportunity to receive the help and support they need to accept their unborn child's diagnosis and to move ahead with the pregnancy. While it is normal and natural for any parent to fear not being strong enough to cope with a sick or special needs child, it is incumbent on us as a society to ensure that safeguards are in place so that a pressured decision to end the child's life is not made—a decision they may regret deeply and painfully for the rest of their lives.

Julia Anderson is one mother who publicly shared her story about the life and death of her son Andrew, who lived to just six months. She reflected:

> For us there was never any reason or any question of abortion. It may sound strange, but I didn't even think of it because to me he was already our son. I had already felt him moving inside me for months. He was our child—as deserving of our love and protection as any of our other children. Abortion was just not an option we thought of for Andrew. Sadly, we learned from our doctor that of four Downs Syndrome babies diagnosed in utero in the same month as Andrew, we were the only couple proceeding with the pregnancy.

The introduction of a new Medicare item to cover rare circumstances such as intrauterine foetal death and procedures unequivocally necessary to prevent the death of the mother would ensure that women whose unborn child dies from natural causes in utero continue to receive appropriate care and assistance.

This motion is about restricting access to second trimester abortions. But this would be ethical, social and healthcare policy, which is in line with community standards and good healthcare practice. It has the potential to restrict the abortion of unborn babies for psychosocial or eugenic reasons, improved pre- and post-procedure counselling and support for women, and restriction the physical and psychological adverse health effects that women may incur as a result of late-term abortion.

Whilst considerations of patient privacy are valid and should be given their proper weight, they can never outweigh the seriousness of ending the life of an unborn child. This is especially so when the unborn children who are most affected by this Medicare item are those with a disability—a vulnerable group of persons who have a special claim on our care, protection, love and support.

Someone might argue that over 700 abortions per annum is only a small fraction of the 80,000 or 90,000 abortions performed every year. Yet, if 700 babies were dying in utero of natural causes each year because of a lack of Medicare funding, we would surely see prompt action taken by the government and the community to save these lives—even if there are 'only' 700. Every life is precious and of equal value. Our laws educate our children about human life and express our values as a society. Removing this Medicare item 16525 would be a small but significant step forward in expressing our conviction that unborn children, especially those with disabilities, should be valued, cherished and safeguarded and their parents supported, comforted and encouraged to give them life.

The church is committed to the truth. We want people to know the reality of what is going on. We want to have a good public discussion about the increasing likelihood that unborn children experience pain and suffering during an abortion. We want to challenge those people who are ideologically committed to the idea of access to abortion on demand at all costs. We are genuinely concerned about the reluctance of our public health officials and those involved to speak publicly about these issues sometimes. Contrary, perhaps, to the public perception, we are an organisation that most wants to talk about medical, biological and personal realities of what is involved. Every parent wants their baby to be healthy, and our hearts go out to all those families who receive the news that their unborn child may have a disability or defect. But the current system provides inadequate safeguards against a mother being pressured to abort, and we should substantially improve these safeguards in whatever way we can.

At present, Medicare item 16525 allows second trimester abortions to be obtained in private clinics, with less likelihood of adequate counselling, information and support being offered to the parents about their child's condition and the positive treatment options and emotional and practical supports available. Whilst moving these cases into the public hospital system does not guarantee these abortions will not occur, it is likely it will result in a reduction in abortions and more parents choosing to keep their babies. Giving parents more time and information that will help them to adjust to the news and to discover this great gift that is their child is always a positive step. Deep down, we know that if there is some small way we can reduce the number of children aborted in the second trimester we are obliged to try to do so. Every child whose life is ended by abortion represents a tragic and irreplaceable loss not only to their mother, father, siblings and grandparents but to the whole community.

Removing item 16525 will hopefully increase the chance for children with disabilities to survive to birth and bring joy and love to their families, in spite of their disability or illness. This will be a positive outcome for the family and the community. Creating a Medicare item number for women whose children die in utero and for procedures necessary to protect the life of the mother would ensure that appropriate care and assistance continues to be available for these mothers. Thank you for the opportunity to speak today. I would be happy to answer any further questions from the committee.

CHAIR—Thank you very much.

Senator FIELDING—Thank you for your succinct submission and your opening remarks. In your submission you comment on the attitudes to people with disabilities. Yesterday, we heard from some groups who were keen to point out and argue that people born with a disability are a big cost on the community. Do you think it is a concern that there is such an emphasis on cost but not on the benefits all people bring to our community? Are you concerned that a person's disability can so define them that we forget their other characteristics and their value on the whole?

Mr Meney—I think the whole nature of a community means that people are given the support that is necessary for their particular circumstances. All of us go through life at different stages requiring different levels of social support. Some require early medical assistance and expensive support at an early stage; others might require it later. It would be an important part of what we are trying to do as a society in Australia to say that everyone should have the opportunity to have the best support that can be made available for them. I think that we can be quite clinical sometimes in looking at people and thinking that certain sorts of attributes or abilities are of less value. I think that it is very important for us to remember that many of the contributions made by people in our community come from people whose parents may very well have decided not to have them were their disabilities detected in utero at an early stage. Some of them have led very flourishing lives, and those contributions to the community from those people may not have been forthcoming. We can never predict exactly what wonderful gifts people can bring forth in terms of their capacities. I think it is very important for us to be respectful of that. As a society, we should encourage all members of the community to look at individuals in terms of people who have great gifts. Though they may have different statures and levels of insight, they are able to do something which is of value for us as a society. It is also an opportunity for us to grow as people. Because we can journey with them, we can do things with them. We can experience what it is to be human in a more full and rich way. We cannot do that if we are looking for some pure model of what the human person should be.

Senator FIELDING—Do you think there are enough resources provided to women facing difficult pregnancies? This obviously links in with some of the work that your group does.

Mr Meney—I think there could always be more support put into our public hospital system to give people time and opportunity to reflect on the circumstances—information about what sort of treatment options are available and levels of support that could be given to them. We know that in some cases people are aborted because of a cleft lip or a cleft palate. It is a terrible thing to think that somebody's life is not worth living because they have something which can easily be remediated through modern surgery. I think we have to get the message out to people that as a society we welcome anyone and there are lots of things that can be done in terms of the support

within the public hospital system that are not necessarily available in private clinics, which are perhaps more geared towards the provision of a specific service and making a profit out of it.

Senator FIELDING—Thank you.

Senator MOORE—I have only two questions. I think you have covered it, but I just wanted to get further clarification on one point. My understanding of the position of your organisation is that you are opposed to abortion at any time in any circumstance. Is that right?

Mr Meney—That is correct.

Senator MOORE—Your argument on this particular item is just an attempt to minimise access to abortion because you are opposed to it as a concept.

Mr Meney—Our argument would very much be inclusive of the fact that it would restrict the numbers of abortions, and it would do that by providing an opportunity for women to have greater levels of support or opportunity if the procedures were offered only in public hospitals.

Senator MOORE—On that basis, you have data that it would reduce the numbers?

Mr Meney—It is reasonable to say that the level of support that is available in the public hospital system is vastly different to that provided in private clinics, owing to their structure and the resources they put in.

Senator MOORE—I take the point that that is your position. Can you provide to us the evidence about cleft palates being used as the basis of an abortion? I just want to have it on record.

Mr Meney—In 2003, at least three babies were aborted in Victoria after 20 weeks gestation solely because they had a cleft lip or cleft palate and lip with no other disabilities.

Senator MOORE—Where is that data from? It is not in your submission and I just wanted to get that on record.

Mr Meney—It is from Riley and Halliday, *Birth defects in Victoria 2003-04*, Victorian Perinatal Data Collection Unit, Department of Human Services, Victoria.

Senator MOORE—And that is the most recent source, 2003?

Mr Meney—It was published in 2006. They were talking of cases in 2003-04.

Senator MOORE—Okay. I just wanted to get that down. It has been thrown out a couple of times and I just wanted to have it listed for our evidence. Thank you.

Mr Meney—Is very difficult. Often, you do not get a lot of data on why abortions are performed, and we think that is a significant problem in our public health system at the moment. The limited data we do have seems to come from Victoria, but it would be good if other public

health jurisdictions also provided more accurate data on exactly the reasons why abortions are performed.

Senator MOORE—In your evidence this morning you made the point that, if there were one item still there for people who were accessing abortion in the particular legal ways that they could, you would not like it but that could still continue. But you said the impact on privacy was such that, if there was an item that allowed that process, that if it was clear that access to abortion was item XYZ, your view would be that the problems around privacy around that item would not be as great 'as the rights of an unborn child'.

Mr Meney—Correct. We say that if there are issues to deal with regarding privacy, although it is important, we need to improve our procedures; we do not need to abort children.

Senator MOORE—Thank you.

Senator FIFIELD—I am just following up on Senator Moore's question in relation to incidents of termination as a result of cleft palate. Does the document that you were citing relate to procedures in public hospitals in Victoria? Or is it just saying that there were occasions where that was the case?

Mr Meney—The document says that three babies were aborted in Victoria after 20 weeks gestation. This is the public health department data provision services. I do not have the information indicating in what circumstances the abortions were done, whether they were done in private clinics or not. But that was the reason why they were aborted.

Senator FIFIELD—We had evidence yesterday from Dr Pesce and Professor Ellwood—the first is chair of the National Association of Specialist Obstetricians and Gynaecologists and the latter is a professor at Canberra Hospital. Both indicated that where there is an abortion proposed post 20 weeks citing this item number that they, as a matter of course, go to the hospital ethics committee. They would have great difficulty envisaging, in a situation where someone had a missing digit or a cleft palate, that that circumstance would lead to a termination. Are you aware of any other instances where what we would all agree are minor imperfections have led to terminations?

Mr Meney—The difficulty we have is trying to get the data which indicates that to be the reality. We do know that there are many reasons why women have abortions, but with respect to the specific abnormalities or disabilities that children may have that are the pretext for them seeking an abortion, we do not have a lot of data on it and I think that is a major problem for us. The rate of 80,000 to 90,000 abortions per year would suggest that there are a lot being conducted for psychosocial reasons and many perhaps for—

Senator MOORE—Those statistics are not all second trimester, Mr Meney.

Mr Meney—That is true.

Senator FIFIELD—I am following up on that point on psychosocial reasons where you say moving second trimester terminations into public hospitals will hopefully decrease the number of abortions performed for psychosocial reasons. Given that we are specifically looking at this

Medicare item number, the two witnesses I referred to earlier said that they are not really aware, in the hospitals where they practice, of abortions post 20 weeks for psychosocial reasons. Do you have any evidence or data that you have come across that would indicate that there are terminations for psychosocial reasons post 20 weeks under this item number?

Mr Meney—No, I do not have that information at hand.

Senator FIFIELD—I just want to get clear in my own mind, when the term 'abortion' is used, people mean different things and you say, 'Abortion performed for any reason and at any stage of pregnancy is always tragic and an unjust taking of human life'. Some doctors who have appeared before us have used the term 'abortion' to cover any termination, for any reason, in any circumstance, essentially including a stillbirth or a gross foetal abnormality which is incompatible with life. When you use the term 'abortion' are you using it in the broad sense or in the narrower sense of what might be termed 'abortions for a reason of convenience' of one sort or another?

Mr Meney—I am using the term 'abortion' in the sense of the unjust taking of human life. If a life has already ceased to exist as a result of an in utero death then any procedure which results, which might be classified medically as an abortion, would not be regarded in the same framework ethically because the life is no longer there. In the same way if a child were in a uterus which was extremely cancerous and the mother were in danger of imminent death and the uterus had to be removed to save the life of the mother, an unintended consequence of that double effect would also be for the life of the child to be lost, but that would not be a direct intention.

Senator FIFIELD—And in the case of a foetal abnormality which is incompatible with—

Mr Meney—There are certain circumstances where we know children are going to die before or soon after birth and that is certainly accepted. That is a terribly tragic situation. Life is precious and even if we know someone is going to die tomorrow it does not mean we can kill them today.

Senator FIFIELD—Thank you. I just wanted to get some more specificity on what you meant by that phrase.

Senator CAMERON—Mr Meney, you indicated that if this bill were passed by the Senate it would be a small but significant step towards a goal. What is that goal?

Mr Meney—The goal would be for the community to appreciate the preciousness of all human life and to do whatever we can as a community to move forward in giving appropriate levels of support to women in difficult circumstances and to encourage fathers and others who are around those women to recognise that they have a responsibility to also support them—so to move forward in reducing the number of abortions.

Senator CAMERON—Would that eventually mean that there would be restrictions on a woman's choice to undertake an abortion?

Mr Meney—I think there are many things that go on within the society which the Catholic Church would not necessarily go along with, and abortion is one of those. We live in a democratic society where parliament adjudicates the ways in which the society will be governed, but we maintain that we have a responsibility to promote those things that we think will encourage the flourishing of that society. The promotion of the idea that all life is precious and that abortion might eventually be regarded as unthinkable, in the same way as slavery in this country would now be regarded as unthinkable, we would think would be a very positive step.

Senator CAMERON—In the same way as society has said that you cannot own a slave, women would no longer have a choice to have an abortion. Is that a proper analogy?

Mr Meney—It took the society quite a while to come to the point where the parliament decided that that was the proper and just way in which the society should be operating, and I would imagine that it may take some time before the parliaments in our own country move towards that and accept that as a conclusion.

Senator CAMERON—When you say 'accept that as a conclusion', do you mean 'accept that women would be denied a choice through the parliamentary process'? Is that what you are saying?

Mr Meney—I am saying that people elect parliamentarians to have their views represented and then those parliamentarians may come to a view on what sorts of procedures will be made available, permissible and allowable in the country; that that will be something that the parliament rules on.

Senator CAMERON—But you are here trying to influence parliament.

Mr Meney—I would imagine everybody coming before the committee is trying to do exactly the same as I am.

Senator CAMERON—But, when you are seeking to influence parliament, you are trying to influence parliament to make decisions that would deny a women the choice to have an abortion. Is that correct?

Senator BARNETT—On a point of order, Madam Chair, the senator has asked this witness the same question for the fourth time but using different words. I ask you to draw to his attention the point that you made earlier in terms of timing and focusing on the key issues.

CHAIR—Thank you for your point of order. I will remind people of the limited time available. We have about five minutes left and there are other senators who want to ask questions. And we had to remind senators yesterday about the way in which they phrase questions.

Senator CAMERON—I am just trying to find out what Mr Meney means by a 'very positive step' towards the goal. I am simply asking: is that goal to deny women choice? It is simple—yes or no?

Mr Meney—The goal is to promote a society which would come to regard abortion as unthinkable.

Senator CAMERON—If you are evading it, that is okay. You raised the issue of psychosocial abortions. What is your definition of a psychosocial abortion?

Mr Meney—The term 'psychosocial' is understood to mean there is no medical problem with the mother or the baby but the parents request abortion because of economic or emotional distress.

Senator CAMERON—So is emotional distress not a medical problem? Is that not an illness?

Mr Meney—There are degrees of emotional stress. If there is no medical problem as such with the mother or the baby, this is the term that is used to describe the circumstances which would provide the pretext for the abortion.

Senator MOORE—The pretext or the reason?

Mr Meney—Or the reason.

CHAIR—I want to quote from the evidence of the Australian Reproductive Health Alliance, who gave evidence yesterday. I am not sure whether you are aware of it but it is an organisation that has appeared before many committees in relation to these types of issues. In the summary of their evidence, with regard to changes to this item under Medicare, they said 'it would remove women's access to a legal medical procedure'. I think it would be fair to say that on the record yesterday they contradicted that. But it is really interesting because they also go on to say 'it would have a negative impact on the emotional and mental health of women'. I am interested in your feedback, because generally this organisation, if you are talking about the issue in general of abortion—and I know we are not here to debate that—put a counter argument as to whether there is no mental health impact on women who choose to terminate at whatever stage of the pregnancy. So here in the argument they have submitted that there would be emotional and mental health effects on women if they are not able to access in the private system a termination during this stage of their pregnancy.

In light of the evidence you have given in your submission, I was wondering whether you want to comment on that. I would have thought that if you were going to terminate a baby, that would cause mental health issues for the individual no matter what the condition was for the baby or whatever the motivation was for the termination. Yet they are quoting it as having a huge impact in relation to having to go to a public hospital for this procedure.

Mr Meney—I would just like to make two comments. The first would be that the New Zealand study by Professor Fergusson, published in the *Journal of Child Psychology and Psychiatry* in 2006, found that 42 per cent of women who had abortions had experienced a major depression within the last four years, almost double the rate of women who never became pregnant. The risk of anxiety disorder also doubled. Women who had abortions were twice as likely to drink alcohol at dangerous levels and three times as likely to be addicted to illegal drugs compared with those who carried their pregnancies to term. The study concluded that those having an abortion had elevated rates of subsequent mental health problems, including

depression, anxiety, suicidal behaviours and substance abuse disorders. This association persisted after adjustment for confounding factors.

Senator MOORE—Are you aware that that particular study has been subject to a lot of contradicting evidence subsequently? It is perfectly reasonable to quote it but I think that, in the interests of fairness on record, I would like to say that the Fergusson study has been subject by international bodies to questions since it was produced. I am sure you are aware of that.

Mr Meney—I am aware of it. I am aware of the questions that have been put. To date, I am not aware that anybody has discredited it as an appropriate and fair study.

Senator MOORE—There is considerable evidence, Mr Meney, and in this situation—

Senator BARNETT—On a point of order, Madam Chair, the witness is responding and is expressing his view and you are putting a submission, which with respect is disagreed with certainly by people around this table. If you are putting a view, that is fine but the witness has responded and has expressed his response to that.

CHAIR—Thank you, Senator Barnett; thank you, Senator Moore.

Senator FIELDING—Chair, on the point of order: the witness was responding and was interrupted halfway through.

Senator MOORE—I apologise, Mr Meney. I thought you had finished. I thought you had quoted Fergusson as your response. I would never have jumped into your evidence on purpose.

CHAIR—I appreciate the points of order. It was my question and I was waiting for the remainder of the answer, but I take on board Senator Moore's right to make assumptions and submissions in relation to the response. Would you like to continue, Mr Meney?

Mr Meney—I would like to quote one woman who is reflective of those in the *British Medical Journal* study where 77 per cent of women aborting a disabled baby experienced acute grief action. She described it thus:

> When we went to the parents' support group the other couples said they blamed themselves for not being strong enough to deal with an abnormal child. When they said this, it was like a dagger through my heart, because I knew it was true for me, too. I cried for two solid days, but I had to face my guilt. Those feelings are there, and if you don't get them out, they eat away at you.

I realise that this is one woman's story and there are many, many women's stories that need to be listened to. But the reality of the difficulty of that circumstance is important for us to reflect on.

CHAIR—Thank you.

Senator BARNETT—I will be brief. There has been a considerable amount made of the issue of the descriptors in item 16125, in particular gross foetal abnormality, which you said was being used to include cleft palate and other conditions correctable by surgery. The other descriptor in question is that of life-threatening maternal disease, which you said is used to include

psychosocial reasons. In making those claims you used evidence from Victoria. Do you have any other evidence to support the proposition that that descriptor is used to include psychosocial reasons? Can you respond to those propositions?

Mr Meney—I have not got data at hand with reference to how many are done for those particular reasons, although we know that there are substantial numbers of abortions done each year and a group of them would be for those reasons. What I would say is this: if it is 50 children, 50 lives are worth saving. I realise there are important issues to do with the privacy of women. I realise there are important issues to do with women needing support. But I think there is an opportunity for us to nudge things towards a direction where those women will be given a greater opportunity to reflect, get more support and ultimately, I hope, make a decision to keep their child.

Senator BARNETT—But your key proposition to our committee is that those two key descriptors in this item number, gross foetal abnormality and life-threatening maternal disease, have been misinterpreted, are loopholes and have been—how would you say it in terms of your concerns?

Mr Meney—I think those descriptors can be somewhat elastic in their interpretation.

Senator BARNETT—Can be or are?

Mr Meney—I think they are elastic in how they are applied by different doctors in different circumstances.

Senator BARNETT—Thank you.

CHAIR—I thank you, Mr Meney, for appearing before us and for your submission.

Mr Meney—Thank you very much.

[9.44 am]

RISCHBIETH, Dr Peter, Immediate Past President, Rural Doctors Association of Australia

STRATIGOS, Ms Susan, Policy Adviser, Rural Doctors Association of Australia

Evidence from Dr Rischbieth was taken via teleconference—

CHAIR—Welcome. I will continue and hopefully the doctor will be able to join us. Information on parliamentary privilege and protection of witnesses and evidence has been provided to you. The committee has before us your submission. I invite you to make an opening statement or comments and at the conclusion of your remarks I will invite members of the committee to put any questions. Would you like to make an opening statement?

Ms Stratigos—I hope Dr Rischbieth who is our immediate past president and a clinician, which I am not, will join us shortly. I would like to say that, basically, our position is one of wonder as to why the question of deleting this item has arisen. Medicare is a funding system; that is all it is and it is a system to fund medical procedures which are considered to be necessary. It is not an arena for any other social or legislative change. Changing or deleting this item number will in fact have no effect whatsoever on the legislation in the jurisdictions of Australia which relate to the termination of pregnancy. I use the word 'abortion', if I may answer a question you asked a previous witness, to refer to the termination of pregnancy for a medical reason, which would be the reason that terminations occur so late in pregnancy.

There are Medicare item numbers, I remind you, which make the distinction between a necessary medical procedure and a non-necessary medical procedure. When a Medicare item exists it is because a medical procedure is regarded as necessary. If for example we take plastic surgery, there is a Medicare number to provide care for people who have been burnt or need plastic surgery for medical reasons, however, if you want to have plastic surgery as an elective process because you like to have it, that is not covered by Medicare. That is our point. If there is a medical procedure that is deemed to be necessary then it should be covered by Medicare which is a funding mechanism.

CHAIR—As I understand, Dr Rischbieth is finishing up with a patient, so hopefully he will be able to join us very shortly, and of course we would prefer that he puts his patient's care before ours.

Senator EGGLESTON—I am a member of the Rural Doctors Association of Australia in Western Australia and of course Australia wide. How difficult is it to arrange terminations of pregnancy in regional areas?

Ms Stratigos—It is pretty difficult to arrange a termination of pregnancy, say, at 20 weeks gestation. It is pretty difficult anywhere because it has to go normally through two medical practitioners and an ethics committee. In that sense it is not something that is ever undertaken lightly by the hospital where it would be performed or by the service providers and I would like to add here that it is not a process that would ever be undertaken lightly by a woman.

I agree with the previous speaker. It is very hard to get data on motivation. Medicare data does not give you the reason why a procedure is being performed. For example, if your leg is broken the Medicare item just relates to attention to that leg, it does not say whether you fell down the stairs or fell off a horse, so it is very difficult to know why a number is used but, in this case, I am not aware of late termination ever being undertaken without great pain and distress to all concerned.

CHAIR—Dr Rischbieth is now on the line. Good morning. Would you state the capacity in which you appear.

Dr Rischbieth—I am a registered medical practitioner, GP obstetrician at Murray Bridge in South Australia and immediate past president of the Rural Doctors Association of Australia.

CHAIR—Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. You have the opportunity, if you wish, to make an opening statement, and at the conclusion of your remarks we will continue with questioning.

Dr Rischbieth—Thank you very much for allowing me submit evidence. This decision to withdraw item 16525 to enable rebates to follow for women who are having this particular service is not a good thing, we believe, for health services for women who have this very distressing event when they may have a foetal abnormality or a significant medical condition that may threaten their own life. I have been involved in looking after women in this arena for over 20 years with my colleagues in Murray Bridge, and we recognise this very distressing event when a woman has an ultrasound or a blood test that has a significant outcome which may lead, if there has been an intrauterine foetal death or a significant foetal anomaly which is not compatible with life, to the woman requiring an extensive counselling process before a decision is made for termination. This decision, certainly in rural areas, is made usually with the doctor who is the significant carer. They may have been involved in the care of other pregnancies or they may be the family doctor, but in many cases they would also be involved in hospital procedures working with their other colleagues, both specialist obstetricians and GP proceduralists.

This decision to counsel women to undertake a second trimester termination is a very traumatic one for the woman. If this item number were removed, that would often mean that the significant medical carer, their particular GP or obstetrician, may not be able to undertake that care locally in their community. They may have to travel a long way away from their family to have that care in a public hospital. This would significantly disadvantage those rural women who already would be translocated away from their family network and support systems and, often, the medical carers who provided services for them for many years.

CHAIR—Thank you very much. Senator Eggleston.

Senator EGGLESTON—I wanted to establish how difficult it is in regional areas to obtain an abortion, not so much mid-term and late abortions but abortions done before, say, 12 weeks.

Dr Rischbieth—This can again vary very much around Australia, but there has certainly been a decrease in services available locally for many women in their area because of the downgrading of hospital theatres and the deskilling of some of the rural and regional theatre

areas, medical practitioners and theatre staff. Already there are many women travelling to Adelaide. Certainly in our region it may be a distance of up to 300 kilometres to access an operating theatre where even a first trimester termination is performed. There are already significant issues for women having to leave their home and their families to access that care, and this is caused currently because of the downgrading of many rural hospitals and the loss of rural proceduralists.

Senator EGGLESTON—What about other facilities such as ultrasound and the psychiatric and counselling services in your area?

Dr Rischbieth—Again this is very variable across regional Australia, but, as senators would be aware, there is often poor access to social workers and mental health workers in many parts of rural and remote Australia, so often the decision to undertake a termination needs a number of appointments with the family doctor or the normal GP or proceduralist. It is not something that is embarked upon lightly or on a one-visit basis. There are many women who do have access to some of the counselling services through the units that provide terminations. There are some units that will provide same-day services for country women. They will come down in the morning having already had a prereading and counselling over the phone, talk to a social worker or mental health worker in the morning and then have the procedure later on in the day. There are many country areas were accessing a first trimester termination is very difficult, but there are certainly a number of units where there is the capacity to undertake care for second trimester terminations in many parts of rural and regional Australia, and therefore we believe those services should be supported for these women so they do not have to travel too far to access this important service.

Senator EGGLESTON—Thank you.

Senator JACINTA COLLINS—Dr Rischbieth, we are told that in South Australia provision of termination services is essentially restricted to prescribed hospitals. Can you describe to me how these units operate? Are they operating out of rural private hospitals? How are they functioning?

Dr Rischbieth—I cannot talk on the full basis across South Australia, but I believe there has been a retraction of termination services in a number of rural hospitals. Certainly there are more services being done in the major metropolitan and teaching hospitals or in specific public units that are attached to public hospitals. Our hospital in Murray Bridge stopped doing those a number of years ago and that caused great distress to those women who had to travel over 100 kilometres just from our town and often another couple of hundred kilometres to access us. I am afraid I cannot give a full commitment as to what other hospitals in rural South Australia are doing first trimester terminations. I can only speak with authority on our region, which has a population of about 50,000 people.

Senator FIELDING—I was interested in your comments on page 2 of your submission on how the disallowance might have an impact on low-income women. I think I am right in saying that, to access item 16525 for a second trimester abortion, rural women would have to use a private abortion clinic or a private hospital. Is that correct?

Dr Rischbieth—No. There are facilities in a number of centres to perform these types of second trimester terminations where there are protocols in place and where they can be done by experienced GP and specialist obstetricians who have had experience in this procedure. Access is one of the key issues. Many rural women do not have the financial resources, if those services are not available locally, to travel to Adelaide or to one of the few major centres where that could be done. There are already some financial constraints for many patients in rural parts of Australia who do not access cancer treatments, specialised services and treatment for diabetes and heart disease because they cannot afford to get to the centres that provide those services. Again, if this service were contracted further then more rural women would be disadvantaged.

Senator FIELDING—But wouldn't the cost of the abortion under item 16525 also mean a fair bit of out-of-pocket expenditure on top of that?

Dr Rischbieth—Certainly that would be a key issue. If it was not claimable under the Medicare system then the patients may be forced to pay this privately themselves. If it was done in a public hospital then that probably would not be an issue. But if it was done in the private sector then they would not be able to claim a Medicare rebate.

Senator FIELDING—That is what I was getting at. For the 16525 to be claimed there would be other fairly significant costs associated with that.

Dr Rischbieth—Absolutely. There would be theatre fees of maybe $500 to $800 a day and some inpatients costs as well if the woman has to spend a night or two in hospital, laboratory tests, ultrasounds and anaesthetic fees. There would be considerable out-of-pocket expenses if this was not a claimable Medicare item No.

Senator FIELDING—What I am trying to get at here is that the actual cost is a lot higher if you are going to claim that one anyway. I am just trying to think it through. You were saying that this would be a problem for low-income people, but there is already a problem if they are claiming under item 16525. I do not understand your argument.

Dr Rischbieth—The argument is that, if this were removed under the Medicare item and they still wanted to go ahead and have the procedure done, they may have to seek that in a private hospital where they may have to pay the full amount. The anaesthetic and the theatre fees would not be covered under Medicare potentially.

Senator FIELDING—Do you know how many rural women claim under the 16525 each year?

Dr Rischbieth—I am afraid I do not have access to that information. That would be available through the HIC, I would imagine.

CHAIR—I advise senators that I will be moving on after a couple of questions because we have limited time.

Senator CAMERON—The committee heard evidence yesterday that terminations are being carried out that are resulting in cruel and gratuitous child destruction. Have you witnessed any cruel and gratuitous child destruction in your experience?

Dr Rischbieth—My experience has been involved in caring for women who have been going through a situation in labour where there is an intra-uterine foetal death or significant malformation. Often many of the women go through a labour process with a foetus that is already deceased or a foetus that is non-viable when delivered. I have not seen any evidence of cruelty that I would describe in those terms. That has been my experience from working both in the national health service in the UK and in Australia over the last 25 years.

Senator CAMERON—Other witnesses have made this statement, 'Why should the public be forced to contribute money through Medicare for deranged adults to go to doctors to have such babies killed on demand, killed by a method so cruel that you could apply it to animals without prosecution.' Have you had any experience of this statement that has been made to this committee?

Dr Rischbieth—I have not had any appearance of that type of situation. My observation is that often this situation is very distressing for the women emotionally because of the loss of the foetus or the significant abnormality. It is distressing emotionally for the mother, but I have not seen any evidence of the comments that you describe.

Senator CAMERON—Do you have any views on whether psychosocial reasons are legitimate reasons to access this payment?

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

Senator CAMERON—Have you had any experience of being asked to terminate for a cleft lip and, if so, what checks and balances would be in place to deal with that request?

Dr Rischbieth—I have not personally had any experience with those requests. My understanding would be that the investigations, including ultrasounds and blood tests, would try and ascertain whether this was the clinical abnormality and whether there were any other heart or systemic organ problems that may be associated with that abnormality. I have not had any personal experience.

Senator CAMERON—Does a cleft lip normally point to other problems?

Dr Rischbieth—There are sometimes some associations with other medical conditions, but my understanding is that you may not necessarily counsel them to have a termination only on the grounds of a cleft lip or palate alone.

Senator CAMERON—Could there be a termination after a cleft lip has been found that has resulted in other abnormalities being found?

Dr Rischbieth—I have no experience in that to comment fully.

Senator FIERRAVANTI-WELLS—Your submission makes reference to many rural women. Can you tell me how many women you are talking about?

Dr Rischbieth—I do not have the exact number of women involved in this particular process. As I say, you would have to go through the Health Insurance Commission to get that particular data. However, I speak from my own personal experience of providing care to the women—giving them with anaesthetics, having the procedure done, looking after them as a family doctor. This is mostly in the first trimester scenario. At our local hospital, we have about 350 deliveries a year and we would have, say, one or two intra-uterine foetal abnormalities or foetal deaths that would require termination at some stage, and we are involved in that care in collaboration with our colleagues both in Adelaide and here locally in Murray Bridge. I am afraid I do not have the full data on a nationwide basis, but certainly from our own experience in our region it is certainly a situation that we see. It is uncommon, but it would certainly impact on many women every year.

Senator FIERRAVANTI-WELLS—Just going from the information in your submission, because of the fact that women in rural areas in Western Australia have to go to other areas to have the procedures done, in effect we are talking about the financial difference rather than actually having the procedure itself?

Dr Rischbieth—Yes, certainly with the financial implications of having transport and travelling and ultrasounds, consultations are significant for many women if they cannot access them locally.

Senator HANSON-YOUNG—Either of you could answer this question. We have heard from other witnesses that disallowing the item 16525 will not necessarily stop women from going through this procedure. Reading through your submission, what I would infer from what you have written is that some women will have to delay the process even further. Is that your feeling of the situation if the item was disallowed?

Dr Rischbieth—I think our feeling is that this is a very traumatic time for the women emotionally and there may be a number of barriers for them to receive treatment once they have had the diagnosis made. They have a number of factors that they have to take into account—some of them will be: do they have the procedure at all, do they have it done locally, do they need other tests or investigations, what costs will be involved—and so the removal of this item number will add an even greater complexity to what is already a very traumatic event for them and their families. I guess in our submission we are trying to put across the message that removing this item number as a Medicare item number would in fact make it even more traumatic for women who are already in severe crisis and distress because of what has happened to them and their bodies.

Ms Stratigos—Can I just add to that, as you asked us both for comment. This being a procedure which is never undertaken lightly and with great distress and difficulty, there is no evidence whatsoever that removing the item from the Medicare schedule would decrease the uptake of the procedure.

Senator HANSON-YOUNG—Is there any clinical evidence to show support for disallowing the item?

Dr Rischbieth—No, there is not at this particular stage.

Senator HANSON-YOUNG—We heard from the department yesterday that they have not received any complaints from anyone in relation to the overuse or abuse of this particular item. How would you respond to accusations that practitioners have been using this item liberally and willy-nilly?

Dr Rischbieth—I do not have any personal experience of seeing this particular item number being used willy-nilly. As I have tried to describe, this decision to undertake the procedure is made after considered judgement and discussion with the patient and often with a number of practitioners being involved. My understanding would be, talking to our colleagues in rural Australia and our specialist colleagues, this is a decision to undertake something that is not taken lightly and needs considerable discussion with the patient and with other health professionals.

Senator HANSON-YOUNG—I know you have had some other questions put to you about access to first trimester terminations as well, but, sticking to this particular term of reference, would most of these women—who would be counselled and given advice from their practitioner to undertake a termination—have reached this point in pregnancy thinking that they would be having this child?

Dr Rischbieth—Certainly the expectation for most women when they first have a pregnancy test and an early ultrasound is that they are going to have a normal, healthy baby. It is always very distressing when they are told otherwise after they have an ultrasound or blood test which shows a potentially life-threatening problem, or an ultrasound that shows a foetus has died. The expectations are that pregnancy is not a sickness, it is a normal healthy event, and when something goes awry like what happens in this situation then there is a lot of counselling and advice needs to be undertaken with the woman as the shock of the clinical diagnosis and the decision to offer her that termination service is discussed.

CHAIR—Senator, can you make this your last question so that we can move on? You can put any other questions on notice.

Senator HANSON-YOUNG—Sure. So in saying that, the decision to undertake this procedure is purely a medical one. It is not something that somebody waits until they are 16 or 17 weeks and says, 'Actually, I'm sick of being pregnant.'

Dr Rischbieth—No, I have had no experience with that type of request. That would be most unusual.

Senator JACINTA COLLINS—Going back to your experience with termination techniques, do you have experience with partial birth abortion?

Dr Rischbieth—I have experience with induced labour to deliver a foetus that has died—an intrauterine foetal death. I am not sure whether that is—

Senator JACINTA COLLINS—No, the partial birth technique is the one that involves crushing the cranium predelivery.

Dr Rischbieth—No, I have not. I have only seen that in the NHS 30 years ago.

Senator JACINTA COLLINS—Okay. I am just trying to put into context your answers to Senator Campbell's questions earlier in terms of what techniques you have had exposure to. Have you knowledge of terminations conducted involving the injection of potassium chloride into the foetus?

Dr Rischbieth—No, I have not had any personal experience of that.

Senator BARNETT—What is your definition of 'psychosocial'?

Dr Rischbieth—Psychosocial encompasses many different criteria. The psychological wellbeing of a mother and a woman who has a sense of happiness and ease and comfort so that if someone has distressing issues which may be affecting their family life, their relationship life, their attitude towards the world, their maybe having problems with anxiety or depression issues—it encompasses many different criteria to try to have a level of psychosocial wellbeing, so there are many factors that go into contributing to that particular state. I will leave it at that.

Senator BARNETT—What is your definition of 'gross foetal abnormality'?

Dr Rischbieth—I guess that is a situation where there is an abnormality which will be incompatible with a long life. They may mean major heart, brain, kidney, stomach and digestive tract organ dysfunction which may be diagnosable using ultrasound techniques during pregnancy. Or significant genetic abnormalities that can be discovered on amniocentesis.

Senator BARNETT—Right, so it includes Down syndrome?

Dr Rischbieth—That would be one of the genetic abnormalities there may be a consideration for, but not necessarily so.

Senator BARNETT—What about cleft palate?

Dr Rischbieth—My understanding is that would not be considered a major condition which is incompatible with a healthy life.

Senator BARNETT—So you would not consider that a gross foetal abnormality?

Dr Rischbieth—Again, it depends on the level of the cleft palate. Plastic surgeons or the oral surgeons would be more able to define that, but again that would not be high on my list of reasons for termination.

Senator BARNETT—It has been on a list of terminations in Victoria; it has been referred to as a gross foetal abnormality and one of the reasons for termination. Are you aware of that?

Dr Rischbieth—I was not aware of that particular incident in Victoria, no.

CHAIR—You have been very clear in your support for retaining this Medicare item, but I was wondering: we had evidence given to us yesterday by an obstetrician and a gynaecologist that there are occasions when aborted babies are born alive and are then left to die. You have never experienced that? You have no knowledge of that?

Dr Rischbieth—I have in extreme prematurity babies born at 22 weeks. These are not at termination but extremely premature infants that are born.

CHAIR—I specifically asked about evidence yesterday that there have been unsuccessful terminations where the baby has survived and then died. Do you know whether or not autopsies are performed on those babies?

Dr Rischbieth—I am not aware of what happens in that situation.

CHAIR—Would you be in support of additional data? I take on board the necessity to protect patients' privacy, but wouldn't it serve the interests of the medical profession and the community to have more data collected so that we could have a rational debate?

Dr Rischbieth—I think it is very important to have adequate data about many of the medical scenarios that patients and the medical and nursing profession are involved in. Any decision about autopsies needs to discussed and clearly thought about by the woman and the service providers. There certainly would be a good reason to have autopsies to confirm if there were significant foetal abnormalities, and I think autopsies would be offered to many women once they have the procedure.

CHAIR—There have been varying degrees of evidence in relation to the sort and accuracy of the data that has been presented to us. Would it be fair to say that without proper analysis it is impossible for anyone to say that there are terminations being carried out in this country that are unnecessary based on health reasons?

Dr Rischbieth—It would be beneficial for everyone concerned if autopsies were offered and able to be undertaken. That would make the picture a lot clearer for the woman, the family and the people providing the service.

CHAIR—I thank you both for appearing before us and for your submission.

Dr Rischbieth—Thank you very much.

[10.17 am]

de CRESPIGNY, Associate Professor, Lachlan, Private capacity

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. I invite you to make a short opening presentation.

Prof. de Crespigny—Like the previous witnesses, I contend that women need access to mid-trimester pregnancy termination. The written submission of Dr Susie Allanson and I focuses mainly on term of reference 2(d) 'the effects of disallowing this item', but I would like to touch on a couple of the others in the next few minutes. We contend that the proposal to disallow this item is discriminatory and potentially harms women who have a range of medical problems. Opposition to women accessing abortion should be best addressed through state and territory law, not by such discriminatory funding.

The attitude that obstructions need to be put in the path of women to stop them rushing to have abortion later in pregnancy is not only wrong but demeaning of women. I have been in practice in prenatal testing for 30 years and have seen repeatedly firsthand how the diagnosis of foetal death or abnormality affects couples hoping to raise a family. It is invariably their worst nightmare. I contend that any attempt to make their lives even harder at this dreadful time is cruel.

The majority of Australians, including the majority of all religious groups and GPs, support women's access to termination. Gestational age is not a significant consideration for Australians in formulating their views on abortion. The community accepts a wide range of reasons that a woman might seek an abortion, including later in pregnancy. Discriminatory funding potentially limits access for many women, and we have heard about some of that just now. Some women may be denied care that they are legally entitled to. Current practice is already unfair and discriminatory, as we have heard, given low Medicare rebates for second trimester termination and the centricity of services. Removal of funding would add to the discrimination against women who are at a time in their lives when they are most vulnerable.

For health reasons, occasionally women do need access to termination later in pregnancy and, in terms of the item number, the first group is those who have intrauterine foetal death. If untreated, these women risk complications including infection and clotting disorders with potentially serious sequelae. Disallowing the item runs the risk of causing serious health risk and potentially risk to the lives of such women. Secondly, removing this item would deny Medicare benefits to women with life-threatening maternal disease who either need a second trimester pregnancy termination or indeed need induction of labour with the goal of having a healthy outcome. This is not just an item for pregnancy termination. Thirdly, in foetal abnormality, terminations are nearly all performed after the diagnosis of a foetal abnormality in the second trimester of pregnancy.

Virtually all Australian women request testing for foetal abnormality, and the vast majority do request termination in the presence of a major abnormality. Removing this item would cause

serious harm to the health of such women. In addition, it would be inequitable to provide a Medicare rebate for first trimester abortion and deny it in the second trimester. Women requesting second trimester termination inevitably have pregnancy problems and, in terms of an issue raised just recently, women in the second trimester of pregnancy have made a decision that they wish to have a baby. They go for prenatal testing at this exciting time of their lives and disaster has struck. This is not something that people enter into frivolously. It is against everything that they are seeking.

Medicare's objective is to assist in improving health outcomes. Rather than removing the item number, the committee should consider recommending increasing the rebate to provide equitable access to this vital medical service to women from differing socioeconomic groups. In addition, a proposal from Dr Sally Cockburn, who you will be hearing from this afternoon, should be supported. Rebates should be available for lawful abortion but not unlawful abortion. The differing laws in the states and territories are incompatible with item 16525. It should read: management of second trimester labour that is lawful in the state or territory where it is carried out.

The current item does not allow rebate for many lawful abortions, yet it will pay for some abortions that are unlawful in some jurisdictions. For example, in Western Australia somebody at 21 weeks seeking an abortion after the diagnosis of a gross foetal abnormality, if she does not go through the termination committee, would be having an unlawful abortion, yet it would be claimable under Medicare. Likewise, with the discussion recently about the definition of a 'gross abnormality', for some women with a major abnormality their doctor may be concerned that the Health Insurance Commission would not consider it gross, so women can miss out because of that.

I conclude my introduction by urging the committee to reject the proposal to disallow funding for item 16525. The item should be better funded and it should be able to be claimed for any lawful abortion in the relevant jurisdiction.

CHAIR—Thank you very much for your opening comments. I will start before I hand over the committee. Do you actually perform mid trimester terminations?

Prof. de Crespigny—I do not perform any medicine at the moment—I have recently retired—but I will take that over the last 30 years. I am an obstetrician but I have not practised in obstetrics for a long time. My whole practice is in prenatal testing, so I do not induce labour. On the question of potassium chloride use, yes, it is used in some cases and, where it is used, it is used under ultrasound control. I am involved in such cases. Potassium chloride is used where there is a multiple pregnancy with an abnormality or high multiples—those sorts of situations. It is used under the recommendation of the Royal College of Obstetricians and Gynaecologists in London, who would say that this procedure should be carried out for terminations from 24 weeks. To my knowledge, it is routinely done across the country. In this sense, yes—and on a very, very occasional basis I am called upon to give potassium chloride, but, as such, I do not carry out abortions as they are usually thought of; inducing labour and so on.

CHAIR—Would you give us your definition of gross abnormalities in a baby.

Prof. de Crespigny—I do not know what the definition is. I do not see how it could be defined. It may be interpreted as being more severe than a major abnormality, which I think a lot of doctors have some feel for, but, again, these are very loose terms. The problem with having them in a Medicare item is that doctors do need to clarity. They need clarity about exact gestational ages; and they need clarity about exact wording, and often that is missing. It is not a word that I would ever use so I could not define it in this setting.

CHAIR—In relation to your opening comments—and I cannot remember your exact words to quote you—I think the inference was that the community will accept abortion at any stage of a pregnancy. You obviously clearly believe that.

Prof. de Crespigny—I have demonstrated that. A Crosby Textor study did a survey of Victorian and other Australian women recently and demonstrated that, and I can provide the results for you.

Senator FIFIELD—I must say, Professor, you look too young to have just retired.

Prof. de Crespigny—Not from my end.

Senator FIFIELD—The evidence of some of the witnesses who have appeared before us has left the impression that the 700 or so terminations that occur under this item number each year are mainly for psychosocial reasons. I think the term 'psychosocial' is used by some as code for terminations of convenience. A number of witnesses have also left the impression that most of these procedures occur in dedicated private clinics. Your evidence indicates that most of the procedures under this item number occur in private or public hospitals, I think you state your submission. I just want to get your view as to how many, in your professional experience, of these procedures are for psychosocial reasons. We have heard evidence from some of your other professional colleagues that they have not encountered, post 20 weeks, a request for a termination for psychosocial reasons in the institutions that they practise in. I am wondering what your professional experience has been.

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

Senator FIFIELD—And it is a minority of a fairly small number of terminations anyway?

Prof. de Crespigny—Yes, it is less than one per cent after 20 weeks. The law has risen in Victoria to 24 weeks. To me there is no acceptable reason to define 20 weeks as any sort of upper limit except that it is a nice round number and people can remember it. It has no other sort

of standing. I am not proposing that the 20 weeks be the cut-off that any of us should use, but that is the way these particular figures are presented.

Senator FIFIELD—Thank you for that. I was interested in your written submission where you went through the history of 16525 and noted that the Health Insurance Commission advised in 1997 that it would no longer accept claims for item No. 35500, gynaecological examination under anaesthetic. Could you take us through what that item number covered and what the rationale was for the Health Insurance Commission no longer accepting that item?

Prof. de Crespigny—Unfortunately, the co-author of that, Susie Allanson, could not be here today. She has more direct experience and could answer that. I see that the college of obstetricians is the last group on the program today. Since I am not personally carrying out these, I am sorry I do not feel that I am the best one to respond.

Senator FIFIELD—That is fine. The same would go for further discussion of item No. 35643, would it?

Prof. de Crespigny—Yes, it would.

Senator FIFIELD—Again this may be one that you think is best directed elsewhere: do you have view as to what the rebate for 16525 should be increased to and what the benefits of that would be?

Prof. de Crespigny—I do not have a figure in mind. It is a small portion of the common fees that women face when they are having such terminations. It is a minuscule one. I also know that Sally Cockburn wishes to address this this afternoon. It is just a small proportion what women are asked to pay and it is our contention that it is too low.

Senator FIFIELD—I will direct those questions to your other colleagues.

Senator RYAN—I was wondering if you could go into an explanation around the definition of 'psychosocial' and how severe a condition might be for it to qualify for a procedure post 20 weeks, given the obvious health risks to the mother as well.

Prof. de Crespigny—The psychosocial I would take to be carried out in the absence of a major foetal or maternal indication of abnormality or ill-health. I do not have a clear or precise definition beyond that and what has been said earlier this morning. Certainly in the absence of foetal abnormality is the common situation. In discussions with the clinic in Victoria that provides a lot of these, they have said they are very impressed with the indications and the reasons that women come with for such a request. 'Psychosocial' can be seen as a slightly demeaning term, but they do have very young women, women after incest and a lot of drug affected women. Indeed, the nurse who runs this clinic has informed me that she has never actually seen somebody present who she does not contend and agree has very major reasons.

I think it comes back to what I was saying before about women who do not wish to be pregnant having that choice earlier on in pregnancy and in this case, if they did not present earlier on, it tends to be for very good reasons. It is a terrible thing for women to go through. No woman would choose to stand up for a later termination of pregnancy. Any suggestion that

women do this on a trivial basis is just contrary to the facts and I think does not respect Australian women. That is a general response, I guess.

Senator RYAN—To your knowledge, is it the person or clinic performing the termination that makes that judgement? Obviously this is a serious medical decision, given the risks you outlined earlier and the gravity of the decision. If someone presented to a public hospital or to a clinic and requested such a procedure would they be referred to an expert psychiatrist to make the assessment, or is the assessment made by the person or people performing the procedure?

Prof. de Crespigny—In general terms the later the pregnancy termination is being considered, the wider the consultation. That is certainly routine in hospitals and so on. In private practice it necessarily involves more than one doctor—the referring doctor, the obstetrician and the doctor carrying out the ultrasound, for example. The particular clinic that does most of the psychosocial terminations in Victoria specifically gets a second opinion from a psychologist or psychiatrist in all terminations beyond, I believe, 16 weeks as a routine policy. That is not from somebody on their own staff. So my answer is yes.

Senator RYAN—Thank you.

Senator MOORE—Professor, can you repeat that process around the 16 weeks? I am sorry, I missed it.

Prof. de Crespigny—In general terms, there is no legal requirement in Victoria for doctors carrying out a termination for psychosocial reasons to get a second opinion or whatever, but the clinic in Victoria that does most of these and is the referral base for a lot of interstate people does make it a policy—and has for some time—of getting a psychological or psychiatric assessment of women presenting after approximately 16 weeks before they will agree to do the termination.

Senator MOORE—Thank you.

Senator RYAN—If, to use what I understand was the correct terminology yesterday, the breach and cranial compression method was not used—and we were informed it is only used in one place in Australia; I am not sure where that was—for a later stage termination, are any efforts made—and, if not, I am interested in why not—to save what may be a viable delivered baby at that point? What I am really after is at what point, if someone requested a late second trimester termination, which—from my understanding—would make the foetus quite viable, would the interests of the unborn foetus and the mother be balanced in determining what procedure was used to terminate the pregnancy or to induce labour?

Prof. de Crespigny—To my knowledge, and I believe it is true generally, the procedure of so-called partial birth that is carried out on a live foetus is not done in this country. I am not aware of it having been done for many years in this country. I mentioned before that the Royal College of Obstetricians and Gynaecologists in London suggest that foetal awareness is possible on a very gradual basis but nevertheless starts to get central connections from around 24 weeks. From this time it is routine practice anywhere that I know for potassium chloride or some similar technique to be used for foetal reasons to ensure the absence of foetal pain and also in the interests of the woman herself and the staff.

Senator RYAN—Why is potassium chloride used post 24 weeks—I understand that babies born at that point have a reasonable chance of survival—as opposed to inducing labour and achieving the aim from the mother's point of view of ending the pregnancy, but not destroying the foetus?

Prof. de Crespigny—If the goal of the procedure is pregnancy termination then medically it should be ensured that pregnancy termination is carried out, indeed legally perhaps also because if the baby is born alive there are responsibilities for treatment of the baby after birth, so from 24 weeks if the procedure is a termination of pregnancy then that is what it should be.

Senator RYAN—So termination of pregnancy is not met by the end of the pregnancy; it is also, in your mind, the destruction of the foetus at this point?

Prof. de Crespigny—What I am saying is if by termination of pregnancy we mean late abortion—and clearly the terminology can get a bit fuzzy, but let us use the word abortion—if the procedure being planned is technically that of an abortion, then the procedure should not end with a live birth and so therefore this sort of procedure should be carried out. I would say that most of the termination procedures would end in a baby born that is not alive anyway, but not all of them.

I think it is really important also to be aware that the majority of women having a termination post 20 weeks are doing so for serious abnormality, the majority of them dreadful abnormality, and this means that they are not viable. This means that with a major heart abnormality, for example, they will not live at 24 weeks. So I do contend that it is false to say that 24 weeks is viability; that is for very healthy, normally structured foetuses.

Senator RYAN—But it may be for the psychosocial—

CHAIR—Senator, I have got a long list. I hate to cut people off, but if you need to put a question on notice then please do so. I have to move on to Senator Collins and then we are going to Senator Hanson-Young.

Senator JACINTA COLLINS—The senator has already covered some of the areas I wanted to explore but I might explore in a bit more detail. Professor, are you aware that there is a vast amount of research that suggests contrary to the Crosby Textor research?

Prof. de Crespigny—There is a vast amount of research. I am not sure what you are referring to as contrary to their research.

Senator JACINTA COLLINS—I am referring to your opening statement that gestational age is not a significant factor in Australians' views about abortion.

Prof. de Crespigny—I would be interested in looking at the evidence you are referring to. The reason we did the study is because of the absence of good studies, and I would be interested in reading and discussing it with you.

Senator JACINTA COLLINS—There are some very good studies done by the Australian Institute of Health and Welfare that I could refer you to rather than Crosby Textor, for instance.

Are you aware of any of the instances that we have been discussing today and, indeed, yesterday about late-term terminations with respect to cleft palates and harelips?

Prof. de Crespigny—Yes, I am aware of some. It depends what you mean by late term. That is not a medical term, but if the question is 'Am I aware of people having had terminations after that diagnosis?'—yes.

Senator JACINTA COLLINS—Were there any other complicating factors or would this be solely because of those indications?

Prof. de Crespigny—It is a mixture. For most people in that situation, it would be because of other complicating factors—not universally, but the vast majority. Could I go on to say that it is important in the case of any abnormality that we do always, and particularly in this type of abnormality, inform women that there is an often unclear but increased risk of other abnormalities which we cannot detect before birth. So when we talk about a termination for cleft lip and palate, yes, it depends on the lesion and a whole range of other things, but at the end of the day it is the uncertainty of the syndromal diagnoses that may not appear till after the birth that often are important to women.

Senator JACINTA COLLINS—The three cases that are reported in Victoria that were mentioned earlier: would they have been reported as only involving cleft palate and harelip or would there be some other indication? If there was another indication, would they have been reported under that other indication?

Prof. de Crespigny—I am sorry, I am not sure which three cases you are referring to.

Senator JACINTA COLLINS—2003-04

Senator MOORE—2003-04 from Victorian statistics.

Prof. de Crespigny—In the maternal mortality figures?

Senator JACINTA COLLINS—Yes.

Prof. de Crespigny—I do not run that service, but the classification of abnormalities in Victoria is a highly reputable service. If there were other demonstrable abnormalities, I would have expected them to be recorded. I believe I am right in saying that when they look at the abnormalities they are classified under the abnormalities, so there would be more abnormalities in that list than there would be foetuses terminated. But I would certainly believe that the figures would be reputable.

Senator JACINTA COLLINS—Can you take me through why the British college recommends what is essentially foeticide post 24 weeks regardless of other factors?

Prof. de Crespigny—If a woman requests pregnancy termination/abortion then the outcome should not be a live birth because that is not the goal of the procedure. In addition foetal awareness is possible, albeit in a very limited way, according to their assessment from around 24

weeks and finally for the staff managing them it is a very difficult, distressing time clearly for the family most of all but also for staff and so on in general. It is for those three purposes.

Senator JACINTA COLLINS—That is not the legal situation in Britain is it? It is not solely related to whether a woman requests it regardless of other factors about the foetus?

Prof. de Crespigny—I am sorry I missed that.

Senator JACINTA COLLINS—In Britain is it exclusively an issue of a woman's request as to whether a foetus up to any gestational age can be terminated?

Prof. de Crespigny—Until 24 weeks, yes, on their request. After 24 weeks it is only if there are specific indications. One of those indications is a serious abnormality. With a serious abnormality termination can be carried out up to 40 weeks.

Senator JACINTA COLLINS—But it would need to involve a serious abnormality?

Prof. de Crespigny—There are a number of indications but that is one of the legally accepted indications for termination after 24 weeks.

Senator JACINTA COLLINS—I am grappling with the same issue that Senator Ryan is which is, if you are talking about a healthy foetus, what basis is there for terminating such a foetus if it would be viable to survive having at the same time terminated the pregnancy.

Prof. de Crespigny—Very often, certainly in the women I see, they have major abnormalities, sometimes incompatible with life but often associated with severe disability. If one inflicts gross prematurity on them on top of that most would not survive but many you would expect to have additional handicaps because of that. As I mentioned this is a procedure, this termination of pregnancy and it does present legal concerns apart from these other concerns if the foetus is born alive and so it is to prevent that outcome.

Senator JACINTA COLLINS—I understand that is the case for instance in New South Wales. It is not so in other states. It is that legal responsibility is attached to the life of a foetus if it is born alive retrospectively. I understand that is an issue. It is quite a bizarre legal concept in my mind. But if we move on from that one, would you be concerned with a termination of pregnancy solely related to an indication, for instance, of a harelip at 32 weeks involving foeticide?

Prof. de Crespigny—As I mentioned before termination of pregnancy with the passing of weeks is entered into increasingly reluctantly by pregnant women, doctors and hospitals. There are amazing barriers to women, aside from the law, having access to pregnancy termination. I have not seen or heard of the case you are describing. I would be very, very confident that given the number of people who are involved in this decision making it is not as simple a thing as a harelip at 32 weeks. Maybe there are other abnormalities; maybe there are other maternal considerations. I have never seen a woman though who does request termination later in pregnancy for what would seem to be a trivial reason. Indeed, I am always amazed at women who are presented with the most shocking stories, the most shocking outcomes later in pregnancy and termination of the pregnancy does not cross their mind. They would not consider

it. So indeed to me the situation is the opposite. Women are responsible. Women do not request termination for trivial reasons and I would be very confident there were extenuating circumstances if one was done at 32 weeks.

Senator JACINTA COLLINS—The final question I have is in relation to the accuracy of some of the pretesting diagnoses. What capacity do we have to understand whether a diagnosis done through pretesting is actually accurate, after a termination of a pregnancy? Is there any process? If I can take you to, for instance, the controversial Victorian case that we are all aware of, what was the outcome in that particular case?

Prof. de Crespigny—Doctors are always very, very keen to encourage women to have a post-mortem after termination, particularly in the presence of a foetal abnormality where there was not a chromosome abnormality with it as well. The medical profession do push very hard for that for two reasons: (1), as you are suggesting, to confirm the prenatal diagnosis and to make sure there were not other abnormalities there as well and (2) because it can have implications for future testing. Perhaps the cleft lip—to use the example you used—was part of a general syndromal thing, which means that that couple is at risk of having that abnormality, which not only has a cleft lip but also has, let us say, a severe intellectual handicap or whatever else which is not detectable prenatally. So the post-mortem examination is to maximise the benefit. It must be done with the parents' consent. In the absence of parent consent, then often encouragement is made to do a non-invasive post-mortem examination with imaging techniques et cetera. So it is in everybody's interests to get maximal information, and I think it is absolutely routine that that is done.

Senator JACINTA COLLINS—Is that reported, though?

Prof. de Crespigny—That would, certainly in Victoria and I presume elsewhere, go on the list of diagnoses on the final post-mortem. The post-mortem is—

Senator JACINTA COLLINS—But is there any collected reporting of those outcomes?

Prof. de Crespigny—Again, in Victoria there is, and there is to varying extent throughout the country. I am not the best one to tell you exactly what is happening in the various parts of the country.

Senator JACINTA COLLINS—And the Victorian dwarfism example: what was the outcome of that autopsy?

Prof. de Crespigny—It is public knowledge that in that case the couple refused termination of pregnancy.

Senator JACINTA COLLINS—I am sorry? The pregnancy was terminated.

Prof. de Crespigny—Yes. Did I use the wrong term?

Senator JACINTA COLLINS—Yes.

Prof. de Crespigny—I am sorry. After the termination of pregnancy the couple refused a post-mortem examination, is what I meant to say.

CHAIR—Being very much aware of the time, I will go to Senator Hanson-Young, then Senator Cameron and Senator Barnett, and I am proposing that we conclude as close to five past 11 as possible.

Senator HANSON-YOUNG—We have heard over the last day and a bit that obviously some people have a moral objection to pregnancy termination. No-one has actually been able to give any clinical evidence as to why we would be disallowing this item. There seem to be other issues involved as to why we would, and I take that on board. Do you think that disallowing this item would necessarily stop women from going through the procedure?

Prof. de Crespigny—If it was the successful in doing that, that would stop poor people and potentially rural people accessing termination but, of course, it would not affect the vast majority of people. When women seek termination sometimes they need very large amounts of funds and it is amazing the lengths they will go to to get those funds. So the short answer is that it would be terrible to think that somebody with a major indication for abnormality was put off like this. I would like to think they would get access through public hospitals and elsewhere. Our public hospitals are so overloaded that is increasingly very difficult. I think it is a frightening prospect that people would be unable to obtain it. I suspect that the majority would somehow get it, with delays and with anguish. To see women pushing around seeking treatment at this uniquely stressful time in their lives is very, very difficult for everyone associated with them.

Senator HANSON-YOUNG—Say a woman has been counselled and advised that this procedure is an option and that she will have to do it through a public hospital and be put on a waiting list if this item is disallowed. She is 17 or 18 weeks pregnant and thought she was going to have the child, but realises things are not as rosy as she thought they were 10 weeks ago. There is a debate amongst the committee and the witnesses about the psychosocial impact. Surely that becomes more evident on top of the medical reasons if a woman has to wait for a procedure.

Prof. de Crespigny—Absolutely. I see people come back in their next pregnancy. Very often after this situation where there is a wait, and it is common for there to be a wait, the sad thing is that instead of their focus being on the sad events that they have been through, their focus is on the bad treatment during their wait—how they were messed around and then eventually referred to another centre. These management issues become the focus of their distress rather than the most distressing that thing that they have been through. I think that is very sad for them in the long term in that they cannot focus on what they should be focusing on—healing over a really bad situation.

Senator HANSON-YOUNG—What processes do women go through with their practitioners before making a decision to go forward with a procedure?

Prof. de Crespigny—If we are talking about a second trimester termination, the later it is the wider the consultation. Whichever abnormality is detected then there would tend to be, for example, an obstetrician and a person doing the ultrasound examination and making the assessment. Many would see a geneticist and many more would then go along to see the relevant

paediatrician, be it a plastic surgeon, a cardiologist or whatever is relevant for that abnormality. They have very wide consultation. It is a huge decision. It is one that women take reluctantly and they seek the maximum information as they make their decision. That involves getting all these perspectives about the likely impact from geneticists and paediatricians and so on. The consultation is always very wide and done as quickly as possible.

Senator CAMERON—The committee has heard evidence that there is cruel and gratuitous child destruction going on. Have you witnessed any cruel and gratuitous child destruction?

Prof. de Crespigny—Far from it. The answer is no. In the state where I work, I am very confident that giving potassium chloride and such measures which are very rapid, almost immediate, and carried out as a routine do not happen amongst doctors in Australia.

Senator CAMERON—A doctor gave this evidence and the doctor also made this comment, 'Why should the public be forced to contribute money through Medicare for deranged adults to go to doctors to have such babies killed on demand, killed by a method so cruel that you could not apply it to animals without prosecution.' Do you have any experience of that or could you comment on that?

Prof. de Crespigny—I have seen no evidence of any cruel treatments at all. Australian women, as I mentioned, virtually universally, seek prenatal testing. Where there is a major abnormality, the majority do seek pregnancy termination. This is something that Australian women and, also, elsewhere around the world do seek as a routine. To deny them would be very difficult. I know of no such cruel outcomes.

Senator BARNETT—In terms of the post 20-week abortions, you referred to the process of injecting potassium chloride into the heart of the baby, which kills the baby and then the abortion process continues. You have also referred to the other process where—I assume by the use of prostaglandin or something else—an induction occurs and the baby is born alive and left to die. Can you explain the second process to the committee and under what circumstances that process occurs?

Prof. de Crespigny—Again, if they do not happen by potassium chloride then I do not see them. I do not carry out those procedures, but since potassium chloride or some similar technique is used routinely from around 24 weeks, which is the time of viability, then that must be very uncommon because the practice of using potassium chloride is basically universal.

Senator BARNETT—The use of potassium chloride?

Prof. de Crespigny—Yes, from 24 weeks.

Senator BARNETT—That is for the purposes of killing the unborn baby and then the birth continues after that? But I am talking about post 20 weeks. I would like you to describe the process for an abortion using your figures pre 24 weeks. Can you describe it to the committee?

Prof. de Crespigny—It does vary. Some people would similarly use it, in which case because one is not looking at foetal awareness or foetal pain that is not the issue. The issue then is for the

sake of the pregnant woman and the staff that might be offered. But in general terms, it is not routine before that time and—

Senator BARNETT—But what is the process for an abortion prior to 24 weeks.

Prof. de Crespigny—There are two processes. As you are suggesting, one is inducing labour and the second one is a D&E type of procedure, a destructive procedure, which is commonly preceded by laminaria tents or some way of priming the cervix initially, so often the combination—

Senator BARNETT—Can you describe the D&E process?

Prof. de Crespigny—The D&E process is again not something I do. But I do know that the clinic that carries them out does routinely use laminaria tents first and they then offer an anaesthetic and I understand that very commonly, in about 90 per cent of cases, delivery is imminent at that time and the others have the uterus evacuated.

Senator BARNETT—Can you describe the process where an induction occurs and the baby is born?

Prof. de Crespigny—I am not sure what you are seeking. I would have to highlight again, this is firstly not an area I am involved in—

Senator BARNETT—You said there were two processes. You are here as an expert for the committee. We heard yesterday that babies are born and born alive and then they are put in a blanket and comforted for a period of time. Sometimes it is a few minutes and sometimes it can take up to two hours and maybe longer. Is that your understanding?

Prof. de Crespigny—I feel it is important that I limit my comments to areas that I am directly involved in and I know that that information would be available to you this afternoon through the College of Obstetrics. I do not personally carry it out. There would be a variety of procedures. I presented this submission and came here today because I believe that prenatal testing and the outcome are pivotal to so many, to three-quarters of the women.

Senator BARNETT—You are aware of it being done?

Prof. de Crespigny—Terminations occur—

CHAIR—If the witness does not have any experience in that area we need to move on.

Senator BARNETT—I have one final question. Moving on to another area, you referred in your opening remarks to the legal responsibilities for caring for the baby once it was born. Can you clarify that for us? What legal responsibilities do the doctors and nursing staff have for the baby once it is born?

Prof. de Crespigny—I was referring to the fact that after birth, depending on the situation, depending on the management, there are potential charges of murder and manslaughter if the

baby dies. I am saying that it is the recommendation of the British college and is also the widely held view that if termination is carried out, if it is beyond foetal viability, they are to be used.

Senator BARNETT—Thank you.

Senator FIERRAVANTI-WELLS—Professor, can I take you to pages 2 and 3 of your submission. And can I say for the record I find your comments quite objectionable. You have basically asserted that those who do not agree with you hold extreme and radical views. As a senator in this parliament, I find those comments really quite objectionable, and in fact I find it ironic that on the one hand you are criticising—

Senator CAMERON—Chair, I raise a point of order. The witness has come here in good faith. He has put a position and I do not think we need commentary about the witness's position to this committee. The commentary is not related to the inquiry.

Senator FIERRAVANTI-WELLS—Well, it is.

CHAIR—Can I rule on the point of order, because we have limited time. I think I have been fairly balanced in terms of commentary in relation to other witnesses, but I draw your attention to the time, Senator Fierravanti-Wells, and request that you ask your question.

Senator FIERRAVANTI-WELLS—I notice that, in the two or three paragraphs that go from page 2 to page 3, on the one hand you make comments about the removal and the disallowance purportedly based on religious beliefs, but two paragraphs later you say that the very removal of it would be contrary to 'our society's religious or secular values of compassion'. My question is: how can you justify the criticism on the one hand and then on the other hand argue that the disallowance of the item is not consistent with our society's religious or secular values of compassion? I find your argument totally in conflict.

Prof. de Crespigny—Surveys of Australians and others of all religious groups indicate that Australians do believe that women should be able to make choices in relation to termination of pregnancy. So the first one is a comment on some of the religious presentations such as you are hearing here, and the second one is a comment on the studies that are reporting the attitude of different people who present themselves as being part of religious groups and the way they respond to these questions.

Senator FIERRAVANTI-WELLS—Professor, the evidence that has been presented and will be presented over two days is a balance right across the spectrum of different views. If you have specific information—so-called 'religious' as you have just referred to—I would dearly love to see it. Could you please take that on notice and provide it? If you are going to make those sorts of assertions, I would like to see the basis upon which you make them. Thank you.

CHAIR—Thank you, Professor, for appearing before us and for your submission.

Proceedings suspended from 11.08 am to 11.22 am

EGAN, Mr Richard John, National Policy Officer, FamilyVoice Australia

TIGHE, Mrs Margaret Mary, President, Right to Life Australia

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has before it your submissions. I invite you to make opening statements. Mrs Tighe, would you like to start?

Mrs Tighe—Certainly. 'Abortion is not a normal medical procedure but rather the purposeful termination of a human life.' Those were the words of the US Supreme Court in 1980, when they were dealing with a challenge to the Hyde amendment, which had been passed in the US Congress—it has been going on for many years now—curtailing federal government funding of abortion in the United States. Although the US Supreme Court had in 1973 done away with all of the abortion laws in that country, when they had to deal with this matter they came to the conclusion that there was no compulsion for governments to fund abortions because, as they said, it was not a normal medical procedure but the purposeful termination of a human life. I maintain that the carrying out of abortions is nothing to do with providing good health care for women in the community; rather, I believe it can and often does result in poor heath, both mental and physical. At the same time, more importantly, it does involve the killing of an unborn child.

The principal of funding something is to share responsibility for that act itself, and I do not think any of you would deny that. I am sure that the government would not agree to fund anything which it strongly disagreed with. So it is somewhat akin to he who provides the gun for a homicide being guilty also. You might think those are strong words; nonetheless, the reality is that we are talking about the killing of an unborn child. By funding abortion—and we are speaking here about late-term abortion specifically—the Commonwealth is involving itself in the procuring of abortions in this country.

If I could just take you back—none of you were in parliament in those days—in 1973 the McKenzie-Lamb bill was before the federal parliament. That bill was a private members bill moved by David McKenzie, then the member for Diamond Valley, and Tony Lamb, then the member for La Trobe in the federal parliament. The Whitlam government was in office at the time. That bill sought to legalise abortion in the Australian Capital Territory up to 16 weeks of pregnancy. That was in the days when there was no legislative assembly in the ACT and the federal parliament had more responsibility for the territories—more than they do now. That bill was overwhelmingly defeated in a vote of 98 to 23, yet, funnily enough, later that year the abortion items were slipped into the medical benefits schedule. Yet the federal parliament had given its opinion of abortion on demand.

As you possibly know, this was challenged in 1979 by the Lusher motion, which was narrowly defeated. It was the amendment of Barry Simon, the former federal member for McMillan, which was successful in ensuring that the funding of legal abortions in the states would continue. I think it is very important that you reflect upon the history relating to this. Since then Western Australia, Tasmania and the ACT have decriminalised abortion, and Victoria has recently decriminalised abortion up to birth.

Mr Egan—In my opening remarks I would like to address the terms of the item which deals with the management of second trimester labour with or without induction in three instances, which have been much discussed in the last two days. On intrauterine foetal death, I think the committee can safely conclude that all submitters to this inquiry are in agreement that Medicare funding in the event of managing second trimester labour for an intrauterine foetal death brought about by natural or accidental causes is a worthy thing and certainly should be provided for. I understand that is also the position of the proponent of the disallowance motion that this committee is considering. I have nothing further to say on that matter.

It is even more apparent to me having had the benefit of listening to other witnesses than when I made my submission that the term 'gross foetal abnormality' has no fixed definition. We heard from the department of health representatives yesterday that 'gross' in their view means macroscopic, visible to the naked eye. That could include Down syndrome, because there are some external features that can be picked up by ultrasound; a missing digit; and so forth. We were told, though, by other expert witnesses that it never occurred to them that that meaning of gross would be the one to apply in this circumstance and that they interpreted gross in one common dictionary meaning of 'serious or grave'. Others have suggested that gross means something close to lethal or at least incompatible, as one witness said this morning, with a long life. Another witness, who is an expert in prenatal testing, said that gross is not a word he uses in this context and so could not define it. My conclusion is therefore that this term is quite inappropriate in the Medicare schedule. That does not of course solve the social policy question, which is whether the Commonwealth should be funding abortions for foetal disability. In my submission, such abortions are by definition discriminatory: the child is to be aborted because it has a disability.

Australia has recently ratified the Convention on the Rights of Persons with Disability and undertaken the obligation to ensure that all its laws, policies and practices are in accordance with the terms of the convention. The convention includes a right to life for the disabled. Measures which inflict death on an unborn child solely because of disability, or measures which fund such procedures, are clearly in conflict with the convention.

In relation to the third plank under which this item may be claimed, life-threatening maternal disease, again we have had a range of definitions from the expert witnesses. The department of health asserted that this item included maternal psychosocial indicators where, in the clinical judgement of the doctor, such indicators posed a threat to the mother's health. I was taken by the word 'health'. This approach seems to reflect the position in the law under some judicial decisions in some states, and in Victoria prior to the recent changes to the law, that an abortion might be lawful where pregnancy posed a significant threat to the mother's physical or mental health. Other expert witnesses told us that psychosocial indicators had no clear definition at all.

In my state of Western Australia abortion is lawful up until 20 weeks of pregnancy simply on the request of the mother. There is one freestanding abortion clinic run by an international abortion provider which provides abortions up to 20 weeks. My personal communications with that clinic have established to my satisfaction that they do not require any reason for the abortion and that simply the woman requesting it will suffice. I have also established that they charge $1,285 for an abortion at 16 to 18 weeks, and that is after the Medicare rebate which the doctor will claim directly. I cannot say for sure whether they are claiming under this item, but it does not seem to me they could claim under the other abortion related item in the Medicare schedule,

35643, because that deals only with suction curettage, and such abortions cannot be performed on a foetus at 16 to 18 weeks. So, if they are claiming a Medicare item, it may well be 16525. These abortions therefore hardly even fit into the category of psychosocial indicators, being simply abortion on request, and do fit into the terms of this inquiry.

CHAIR—Thank you very much.

Senator TROETH—Mrs Tighe, you mentioned in your opening remarks that abortion is not a normal medical procedure. In that case, why do you think, to name two, the Western Australian and Victorian parliaments, which surely reflect community opinion, have moved to decriminalise the practice?

Mrs Tighe—They have decriminalised the practice, for sure, but we are talking about whether or not it is a normal medical procedure because, as the US Supreme Court said 'It is the purposeful termination of a human life.' The most eminent foetologist in the world, the late Professor Sir William Liley, was a New Zealander who, sadly, died in 1985. He was world renowned for the work he had done in saving the lives of babies with Rh factor disease. He developed a means of transfusing them in the womb. He first developed the technique of amniocentesis, which was meant as a life-saving measure. He said it was a matter of great sadness to him that it was being used for search and destroy methods. He said that the only thing medical about abortion today is that doctors are asked to procure them. He said, 'Give me a woman with a terrible heart, terrible diabetes, bad psychosis, rotten kidneys and I can get her through the pregnancy.' He also put up a certain amount of money at his hospital, the National Women's Hospital in Auckland, for any doctor to claim if he could say that he did have to procure an abortion to improve a woman's health.

If a woman is progressing through the pregnancy and she develops some condition which is going to be life-threatening to her, it will usually show itself late in the pregnancy. The aim of a doctor who does not want to kill the baby is to terminate the pregnancy early and try to save that baby's life. He does not want a dead mother and he does not want a dead baby. The baby is taken to the intensive care nursery and every effort is made to save that baby's life. I think it would be very instructive to talk to some obstetricians who have delivered thousands of babies and have never found it necessary to carry out an abortion.

It is a matter of one's perception of things. What is playing a major part in this funding of late-term abortions and the passage of the legislation in Victoria recently is the embracing of eugenic abortions in this country. It is an absolute disgrace that the best that we can do for children in the womb who are diagnosed with disability is to destroy them before birth. What we are doing is discriminatory because on the one hand we are using federal and state funds to provide good health care for babies in the womb—and that is only right. There are babies in neonatal intensive care nurseries who are sometimes smaller than babies who are going to be aborted. On the other hand, if it has been decided that child is not wanted then it is considered appropriate to provide funding for that as well. It is just so full of inconsistencies.

Consider this: when a mother who is having a baby, and who is at 20 weeks or later, is involved in a traffic accident and the child is killed, that child is included as part of the road toll. It has been that way for some years now in Victoria. You cannot have it both ways. Is it a desirable for a person to prevent that child's death because it is part of the road toll and we are

trying to reduce the road toll? On the other hand, if it is decided that child is not wanted then it can be got rid of. I do not believe it is a normal medical procedure.

Senator TROETH—Where do you get the figure from on page 2 of your submission where you say that approximately 98 per cent of children diagnosed in the womb as having Down syndrome are aborted?

Mrs Tighe—I do not have the reference with me, I would have to send it to you.

Senator TROETH—Yes.

Mrs Tighe—But the reality is that is the case. They were official figures from the state of Victoria just a few years ago. Nobody who believes in that—

CHAIR—Can I just clarify that we had evidence yesterday from a number of witnesses—

Senator TROETH—I am not going to go on with this point, but I was not here yesterday, so I would like to hear if Mrs Tighe could send it to the committee. That would be very good.

Mrs Tighe—I certainly shall.

CHAIR—Could you take that on notice for us?

Mrs Tighe—Yes, I will.

Senator TROETH—I gather from page 2 of your submission that you believe Australia is more than comparable to Nazi Germany.

Mrs Tighe—Not to the fullest extent. I know that people are very sensitive to any mention of that word 'Nazi'. I am talking about the fact that for some years prior to the—

Senator TROETH—I am well aware of that, but I am interested in why you compare Australia to 1930s Germany.

Mrs Tighe—I do not compare Australia to that as such. I am comparing the removal of the disabled before birth with the practice that was carried out in Nazi Germany before they began to exterminate the Jews. I was in Europe in the 1980s. I was visiting somebody in Holland, and I saw a promotion for a film which was a documentary and was going to be shown from a Frankfurt TV station. As we all know, the Nazis kept very good records. And here in the documentary was this process of little children, all with Down syndrome, being cared for by women whom they used to call the butterfly nuns. The documentary was about the fact that all of those children had been killed.

Senator TROETH—I do not doubt the evidence from Nazi Germany—

Mrs Tighe—But I do not believe that we are like Nazi Germany. We do not have concentration camps. We do not have jack boots. Nonetheless, in this particular area there are

similarities. By embracing the removal of the disabled before birth we are embracing the principle of life not worthy to be lived, and that is the bottom line.

Senator TROETH—My last question is about your comment in relation to the mental health of mothers who undergo an abortion. I am well aware of the Fergusson study in New Zealand which is often used by groups, but the American Psychological Association has reviewed 20 years of evidence in relation to abortion and mental health. In its report dated 13 August 2008 it has concluded that the risk of mental health problems is no different for women terminating a pregnancy or carrying it to term. It also found that women who experience miscarriage, stillbirth, death of a newborn or termination of a wanted pregnancy due to foetal abnormality have equivalent negative psychological reactions but these are fewer than in women who deliver a child with life-threatening abnormalities.

Mrs Tighe—I will just respond to that. The Royal College of Psychiatrists recently acknowledged that women may be at risk of mental health breakdowns if they have abortions. The college warned that women should not be allowed to have an abortion unless they are counselled on the possible risk to their mental health. This invalidates claims made for decades that the risk to mental health of continuing with an unwanted pregnancy outweighs the risk of living with the possible mental health consequences of having an abortion. The American Psychological Association recently published the report that you were talking about.

Senator TROETH—That is correct.

Mrs Tighe—But on 23 August 2008 *the Lancet*, published a report opposing the American Psychological Association report which stated:

> ... the fact that some women do experience psychological problems after a termination should not be trivialised. ... Women choosing to terminate must be offered an appropriate package of follow-up care, which includes psychological counselling when needed.

Induced abortion is also associated with an elevated risk of suicide, but if I can speak about it in practical terms, I have spoken to a number of women—and it may surprise you that they would contact our organisation—who are grieving after their abortions, particularly recently in Victoria, when there was a debate about the legislation. It is very sad to speak to some of them. One of them, in particular, was a 15-year-old who is now studying law. She had an abortion simply because her boyfriend could have been facing a charge of carnal knowledge; he was quite a bit older than she was. That abortion has given her hell to this day. I can send you her testimony if you would like to read it—

Senator TROETH—No, I believe you.

Mrs Tighe—As well as that, we have other women phoning us and telling us of the way their abortion has affected them. The reality is that a third of the calls that come into the pregnancy counselling service our organisation funds come from women who are suffering following their abortions.

I am not saying that all women are going to have breakdowns following abortion. But a very significant proportion of them do, and I think that by funding abortions you are really helping to

provide poor health for a whole category of women in the community. Not all of them are affected, I agree with you—they will put it aside—but on the other hand there is a very significant proportion who are affected and it is very sad to talk to them. I think it would be very beneficial for some of you to listen to some of these women. The reality is that they do not go back to the places where they had their abortions to complain about how it has affected them or to seek help. That is the last place they want to go to.

Senator TROETH—But there are other counselling organisations that do provide that sort of counselling—very supportive counselling—so I put it to you that there are two sides to the coin.

Mrs Tighe—I am not sure about that, Senator Troeth. You tell me who they are. I am talking now about the Royal Women's Hospital—and I realise that Medicare funding does not affect them—and I have not forgotten a woman who rang me one day telling me about her abortion. She had it simply because she and her husband were stretched for money. They already had a couple of children and the second child was quite ill. The GP said, 'I'll arrange a termination for you at the women's hospital.' They went there and they were earnestly sitting in front of one of the leading obstetricians and gynaecologists at that hospital—not the previous gentleman who was here—and telling him the reasons why they were thinking of taking this terrible step and he just put his hand on the desk and said, 'You don't have to tell me all that. You're pregnant and you don't want the baby.' She subsequently persisted and persisted with that case and she won damages, both from him and from the hospital. So, believe me, there are a lot of people who are very sadly affected and I do not know where they can go to get this counselling other than coming to organisations that would not provide for abortions. Where do they go? Do they go back to the clinics? Do they go back to Grundmann's clinic in Melbourne, back to a fertility control clinic? Of course they do not.

Senator TROETH—There is an organisation called Support After Foetal Diagnosis of Abnormality and there is also one with the acronym SANDS, which I imagine provides the same—

Mrs Tighe—SANDS I have heard about. Isn't that for sudden infant death syndrome?

Senator TROETH—They deal with that sort of problem.

Senator CAMERON—Mr Egan, I notice that you have been paying attention to the hearings over the last couple of days and in addition to your submission you have made some comment about the witness statements that have been made here. Do you agree with the statement that was made yesterday that abortion is being carried out in Australia and it is basically cruel and gratuitous child destruction?

Mr Egan—Yes. In my view the methods of dilation and evacuation, which involve ripening the cervix so that forceps can be inserted and the baby torn to pieces—a leg or an arm off first—would certainly count as cruel child destruction. That method is used, I believe, at freestanding abortion clinics in this country up to 20 weeks of gestation. I would certainly count that as cruel.

Senator CAMERON—It seems to me that we have two clear and different views coming forward, and I am trying to come to grips with them. We have one view from the medical profession, who have predominantly and overwhelmingly disagreed with this type of analysis

that you are putting forward in your statement, and then we have the other view, which is the faith based evidence that has been coming forward which is quite radical in terms of its analysis of what is a legal position. Why is there such a big disagreement between the overwhelming majority of practitioners in this area and the faith based groups that are coming here?

Mr Egan—I would reject your dichotomy. My understanding, for example, was that Dr Lachlan Dunjey, giving evidence yesterday, tabled the supportive signatures of roughly 150 medical practitioners, many with very eminent qualifications indeed. Certainly the submission from Medicine with Morality did not make any reference that I am aware of to any religious beliefs but staked out a fairly mainstream position on medical ethics that has held sway in Western civilizations for centuries. I would reject your dichotomy. In terms of the evidence I think there has been a practical confusion with some doctors who are providing a limited second trimester abortion service in public hospitals and who—I take their evidence on face value—would not readily countenance an abortion for psychosocial indicators in the second trimester or at least not post 20 weeks. I think that is leaving out of the picture the freestanding abortion clinics that offer abortion in the second trimester. I am certainly very aware of the one in Western Australia. I know for a fact and it has nothing to do with whatever religious beliefs I may or may not have that that abortion clinic, as it is permitted to do under Western Australian law, offers abortion on demand using the dilatation and evacuation method up to 20 weeks potentially fundable by this Medicare item. I cannot agree with your dichotomy, but I accept that there are certainly two different perspectives and the committee has the job of sifting the evidence and putting the whole story together.

Senator CAMERON—Is it the method of abortion that you are concerned about or abortion per se.

Mr Egan—I am absolutely concerned with abortion per se. I think the scientific evidence that the unborn child is one of us, a human being, is overwhelming. I do not understand any system of ethics that thinks that it is permissible for one human being to kill another innocent human being who is not an aggressor or posing any direct threat to them or to someone else they are trying to protect. On that basis I see every abortion as unjustified and so certainly the funding of it. I have mentioned abortion methods because you asked me a question about cruelty.

Senator CAMERON—I am not criticising you for your response. Do you agree with the comment that was made earlier that this would be a good first step towards a wider banning of abortion?

Mr Egan—This is not a step towards banning abortion. It is a step towards defunding it. My understanding is that the Commonwealth responsibility is limited to funding, so it remains a fight in the states and territories. I certainly participated in the debates in Western Australia when abortion was legalised there in 1998. It would be my position that I would have preferred and would still prefer the laws to be restored so that abortion was a criminal offence. That is not a secret.

Senator CAMERON—Is it your view that there should be no freedom of choice for a woman after consulting with a doctor to undertake an abortion?

Mr Egan—I tend to agree rarely in this instance with Germaine Greer who observed that abortion is the last non-choice for women in a long line of non-choices. I think that the tired old rhetoric of a woman's right to choose—the Betty Friedan school of feminism—has somewhat been mugged by reality and overtaken by women's accounts of their experience of abortion. It is well documented in the pro-life feminist literature.

Senator CAMERON—Have you seen any evidence or have you attempted to find out any views of women who have undertaken an abortion and who have come out of that process saying that it was good for their health and their mental status and it was something they had to do for their wellbeing?

Mr Egan—I am certainly aware that women say those things. That is hardly contestable. In terms of the anecdotal literature, of course—women telling their own stories—there are stories on both sides of the argument. I think the job of those interested in public policy is to listen to all those stories and to sift them and to see what rings true. I think the weight of evidence is shifting in terms of the scientific literature towards establishing the adverse mental health outcomes of abortion. I think Professor Fergusson's study has been subjected to some fairly trite critiques, in my view, because they raise points that he himself acknowledges. Fergusson does not claim that this is a definitive study. In fact, at the end of his study, he sets out several things that should be explored further, and that is quite correct. All Fergusson is asserting, as the Royal College of Psychiatrists has now asserted, is that we do not know enough yet and the benefit of the doubt needs to be given—that is, that women do need to be advised that there is a substantive body of evidence that abortion may have adverse mental health outcomes. I think that would be a fair statement of the position. Naturally those in favour of the pro-life position are going to more frequently quote Fergusson and those in favour of an unrestricted woman's right to abortion are going to quote studies on the other side. But I think that if we are all being fair about it we would say that the question is still in the balance and women deserve the benefit of the doubt—to be told that there may well be adverse mental health outcomes to it.

Senator CAMERON—But there also may not be.

Mr Egan—Well, of course, there may not be. Even if Fergusson's study and the others are rigorously established, and even if the Finnish study, which is population-wide data that shows a 238 per cent increase of risk from suicide, accident or homicide in the year following an abortion, as opposed to women who have not been pregnant in the prior year—even if those things are confirmed, obviously the individual woman would still be weighing up why she wants the abortion against these risks. But she ought to be informed of the risks. As Mrs Tighe has pointed out, there have been women in this country who have sued successfully and received significant payments from doctors and hospitals for not warning them of the risk of adverse mental health outcomes.

Senator CAMERON—If there is not enough support for women who have undergone an abortion and may suffer some mental anxiety or illness arising from that, should we look at providing more funding for women who have undergone abortions to minimise the trauma that they may have following an abortion? Should we actually look at trying to resolve that by increasing funding to assist those women?

Mr Egan—I think there is certainly room for more counselling services in this area. Exactly how they are funded and who is best placed to run them are complex questions. As Mrs Tighe indicated, there are difficulties with those who have a connection with the abortion industry providing those services because, to some extent, they are seen as the cause of the problem. But, in general, certainly services should be provided for women who have experienced adverse outcomes from abortion.

Senator EGGLESTON—I would like to go to term of reference (c) and the last dot point, where it says: 'Do you have any views on the clinical practice arising in relation to services provided under item 16525 in the private sector?' In this hearing there seems to be a lot of discussion about what is a reasonable ground for a mid-to late-term abortion. Some of the cases that have been quoted have ranged from anencephalics, children without anything above their eyes and no brain, to babies with cleft palates, a condition that is quite treatable these days, effectively, by plastic surgery. To clarify some of this confusion, would your organisation be of the opinion that the introduction of legislation—national legislation, perhaps—for the protection of the rights of the unborn child would assist in clarifying the legal position, especially with respect to doctors performing these abortions but, in general, clarifying the indications for mid-to late-term abortions? Would you support the introduction of legislation that?

Mr Egan—I made some references in both my submission and opening remarks to the recent ratification of the Convention on the Rights of Persons with Disabilities, and it does seem to me that a consequence of that is that the Commonwealth has undertaken a formal responsibility and pledge to the international community to protect the rights of disabled persons on the same basis as any other persons. So it seems to me that, if there is a Medicare item offering payment for abortion specifically on the grounds of disability, that provision is in direct conflict with the non-discrimination obligations and indeed with the whole tenor of federal discrimination legislation.

There are at least some practitioners and experts who would say that correctable things like cleft palate are grounds for abortion. There was a big controversy about this in Britain several years ago when, I think, an Anglican minister who had cleft palate raised public awareness of the fact that, under the British system, abortions for cleft palate were taking place. I identified in the 2003-04 Victorian birth defects register that there were three abortions for cleft palate with no other complications. The tables there make it quite clear. There is cleft palate with other complications and there is cleft palate only, and it is clear there were three abortions on that ground.

Senator, with others, I have followed the cases of abortion for people of short stature and been absolutely appalled at the fact that anyone would consider that a ground for an abortion. I have a friend who has Down syndrome. The birth defects register for 2003 in Victoria shows that 72 per cent of all persons with Down syndrome are being aborted. That ties in with the figure of 90 per cent—we have had various figures: 90, 94 or 95 per cent—of those who are identified. Obviously, some are not identified. But the fact is that we are aborting nearly three-quarters of children with Down syndrome. My Down syndrome friend holds a part-time job at Murdoch hospital. She goes to gym twice a week. She loves singing. She comes to various groups I am involved with. She is a delightful woman who recently took long service leave after 10 years. The fact is that we are aborting Down syndrome children. In Victoria, the 72 per cent aborted in that year included 65 per cent pre 20 weeks and seven per cent post 20 weeks. So certainly I think we need to change this. I think the term 'gross foetal abnormality' should simply be

removed from this Medicare item. There is no justification, in my view, for abortions on the grounds of disability.

Senator EGGLESTON—Of course, signing a treaty does not make it law in Australia until it is incorporated into our law.

Mr Egan—I understand the way treaty law works.

Senator EGGLESTON—And the signature on a treaty does not take precedence over domestic law, but while it is obviously desirable to protect the disabled what I was specifically aiming at was that the rights of the unborn child should be protected. Turning to Mrs Tighe, at the beginning you talked about the Nazis and I suppose what you were referring to was the T4 program, under which—

Mrs Tighe—The prewar program?

Senator EGGLESTON—The T4 program, under which children with various abnormalities and so on were put to death by lethal injection.

Mrs Tighe—The T4 program—I do know that name.

Senator EGGLESTON—I do not really think Australia is going down that pathway, quite. However, yesterday when we heard from officers of the Department of Health and Ageing there seemed to be a suggestion that this definition of a severely abnormal baby which might be given as grounds for mid- to late-term terminations might be interpreted very widely. I suppose at the crux of your statement at the beginning was a question of whether or not our society is moving towards a more eugenic view of the world and whether we are, step by step, moving towards a view where we remove people who are seen to be genetically inferior or not genetically perfect. Would you like to comment on whether or not you think that is a genuine sociological change?

Mrs Tighe—That is the point I was attempting to make. I know when you mention the word 'Nazi', people think, 'She's off the planet!' But I have not forgotten the sight of those little Down syndrome children in that documentary who they explained had all been exterminated. Of course we are moving towards that. It costs more to care for people with disabilities in the community—we all know that. The other thing is the euphemistic language that surrounds this practice. They will have grieving ceremonies for women who have had these sorts of abortions and they try and equate them with stillbirths. I know, for example, at one of the hospitals in Melbourne they have these ceremonies not just for the women who have had stillbirths but for the ones who have had their babies aborted, and they encourage them to hold them and say goodbye to them and things like that. That, to me, is absolutely sick because they have signed the child's death warrant. Unfortunately, because of this climate we are living in, I think a lot of women are badly affected by this. Their minds are massaged by this talk that 'you couldn't cope'. The big argument is: 'It's not fair to that little child.' That is the most compelling argument: 'It's not fair to that little child to bring that little child into the world.' People are seduced by these arguments. I believe a lot of the people have been seduced in that way. So, little by little by little, we have slid a long way down the famous slippery slope. There is no doubt about it.

When you think about the famous case in Melbourne, which I believe was very instrumental ultimately in the government putting up that terrible legislation, that child possibly had dwarfism. There was a journalist working in the press gallery here for the *Age* and she was a short statured person. There are a couple I know in Melbourne who would have loved to have adopted that child. It is such an insult to people in the community who are walking around with a disability to say, 'We've got to get rid of these people.' Say a woman gave birth to a child and six weeks later presented to the GP or the obstetrician to see how the baby was going, and the doctor said: 'I'm sorry, there is something wrong with the baby; we didn't pick it up before or straight after birth, but I think that your child might have dwarfism.' If that woman said, 'Oh, I can't cope with that; I'm going to kill myself,' how would we behave towards her? We would say: 'No, hang on, we're going to get you help. We know it's a terrible shock for you. It's going to be terribly hard for you to cope,' and there would be counselling et cetera. If she then persisted and persisted, and she and the husband said, 'We can't cope with that child; we don't want that child,' would we kill that child? No, we would not. But that is the climate we are living in today, so I believe that it is slowly but surely growing.

Senator HANSON-YOUNG—This is a question to both of you, so I guess you can take it in turns to answer. I completely understand that you object to abortion per se. You have already said that; you have put that on the record. Putting that aside, how do you respond to evidence presented to this committee that disallowing this particular item—and that is what we are talking about; let us stick to the terms of reference—

Mrs Tighe—Yes, I know.

Senator HANSON-YOUNG—on the Medicare schedule is not necessarily going to stop women from going through this procedure and that in many cases, as the evidence has been presented, it may actually prolong the time it takes for a woman to go through the procedure and therefore it is done later in the pregnancy as opposed to earlier. How do you respond to that?

Mrs Tighe—By providing medical benefits for something like one of these abortions you are really putting the icing on the cake. You are saying to the people in the community, to the women having abortions, to the families, whatever, 'It is of benefit to you to have this abortion and therefore we will use healthcare moneys'—health care moneys which should be used to provide good health care for all Australians—'and we will apply them to the removal of your child.' So I believe that, by government funding something, it is giving a message to the community and encouraging the practice. It may not actually stop a number of these abortions—not initially; it would not. But nonetheless it is, I believe, a first step that should be taken, to be saying to the community: 'Hang on—we should not be funding these because they are the purposeful termination of a human life; for whatever reason, that child is being killed.' So that is my response to that.

Senator HANSON-YOUNG—Mr Egan?

Mr Egan—In practical effect the rebate is $200 for an in-hospital treatment—$203 now, under the 2008 schedule—or $225 for an out-of-hospital treatment. The price for a first half of the second trimester abortion, as far as I can ascertain it, is at least $1,285; I have not been able to find a cheaper one than that. So I would agree that removing that rebate is unlikely to have an effect, because I think $200 compared to $1,200 is probably not going to be a deciding economic

factor for any woman. So it is difficult to see how that creates the barriers that people have been suggesting—

Senator HANSON-YOUNG—Can I just jump in there?

Mr Egan—If you want to clarify something, for sure.

Senator HANSON-YOUNG—I know that you have participated in witnessing the proceedings over the last day and a half, and I guess the evidence that was given was that moving that option—particularly in rural areas—and for women to perhaps need to go through the public health hospital system means that barrier is there because of the waiting list.

Mr Egan—It does not necessarily move them to the public hospital. I think this is a bit of a misapprehension in a sense, because all it does is remove a $200 rebate from a $1,400 operation so you are paying $1,400 now for it instead of $1,200. I really cannot see—

Senator HANSON-YOUNG—But some people's fortnightly pension—

Mr Egan—I appreciate that $200 for some people is a lot of money, but I do not think it is the deciding factor in whether you go to the nearest abortion clinic that is offering these, wherever that might be.

Senator HANSON-YOUNG—No, that is right; the evidence is that that does not change the decision to undergo the procedure—it prolongs it.

Mr Egan—Nor where you go for it, I think. And in fact the women who are resorting to the private abortion clinics and getting this Medicare payment are doing it because the terms on which they want the abortion are not provided at the public hospital. As many of the witnesses from public hospitals have said, they are not offering abortions for maternal psychosocial indications in the second trimester, and that is what the private clinics are offering that the public hospitals are not. I just think there are some category confusions in these assertions that this is putting barriers in the way of women.

Senator HANSON-YOUNG—Can I just turn to your submission. Under point 5 you have the effects of disallowing the item. At 5.1 you talk about ending official approval of second trimester abortion—which, I would argue, is a bit of a furphy because women can still undertake the procedure through a public hospital, which is, of course, publicly funded. You then make that point again down in 5.5. So even just in that section you seem to contradict yourself in terms of what message this is sending to people.

Mr Egan—No, I am looking at the terms of the item, and if the Senate were to vote in favour of a disallowance of this item there is no doubt how that would be read publicly. Publicly that would be read as: 'A majority of the Australian Senate think there is something wrong with taxpayer funding of second trimester abortions; presumably that therefore means they think there is something wrong with second trimester abortions.' So—

Senator HANSON-YOUNG—So you agree that this is a discussion about abortion as opposed to whether it should be funded publicly or not?

CHAIR—Can I just remind you, Senator, to allow the witness to complete his answer.

Senator HANSON-YOUNG—Sorry.

Mr Egan—No problem. The mechanics of the thing are to do with funding but, clearly, the decision is based on how one assesses the validity of second trimester abortion. It is certainly possible that someone could conclude that, apart from perhaps some very narrow indicators, abortion in the second trimester is not for valid medical reasons and therefore should not receive Medicare funding. You could hold that position and believe nonetheless that it should also be legally available. That is not my position but it is a logical coherent position. That is the position taken by those people in the US Congress who year after year pass the Hyde amendment which denies federal funding for abortions while the same numbers will not pass a law proscribing abortions. Clearly, in the US Congress, there are a number of people who think abortion should not be federally funded but should not be illegal.

Senator HANSON-YOUNG—Putting your moral objection to abortion aside, what clinical evidence do you have to support the disallowance of this item?

Mr Egan—What we have established in the two days of hearings is that for this item, which on the face of it is provided for a very narrow range of indicators, there is no shared understanding of what those indicators mean. At least some practitioners who provide abortions and claim under this item number interpret gross foetal abnormality to mean any foetal defect whatsoever however trivial, interpret life-threatening maternal disease to mean simply that a woman does not want to be pregnant and that not wanting to be pregnant can be understood as posing sufficient threat in itself without any other compounding factors to her mental health and therefore, by extension, be called a life-threatening maternal disease. I think that has been well established over the hearing. I am not saying everyone shares that view but there are practitioners who share that view. It is plain at the freestanding abortion clinics claiming this item number for second trimester abortion that they agree, as they do, to offer an abortion to a woman at 16 or 18 weeks pregnancy without requiring any reason or without even inquiring what the reasons are, simply on demand. That is how freestanding abortion clinics operate. They are not into asking for reasons.

In Western Australia you do not have to give a reason. The law was changed in 1988 so that if a woman requests an abortion, it is to be provided. The abortion providers in Western Australia, the freestanding clinics, see themselves as simply offering an on demand service. There is no inquiring as to whether there are any other medical justifications for the abortion up to 20 weeks. In WA, unlike Victoria, there is a law that prohibits post 20 week abortions and they are, interestingly, permitted for a grave clinical condition in the foetus or the mother. There has not, as far as I can ascertain, been a single abortion post 20 weeks in Western Australia for any grave clinical condition in the mother. The reported literature from the panel that approves them shows that all the abortions are for foetal disability. I conclude from that there is, in a well-run public hospital system, no reason to abort for maternal health conditions post 20 weeks.

Mrs Tighe—I sent this article round to all the senators some time ago and I have it with me again today. This was published in the *Age* in 1998, which was 10 years ago. Let me assure you that things have not improved in relation to the rights of unborn children since then. I think this gives a very graphic account of the situation not just in the public hospitals but in the private

area of these late-term abortions. You can see the graphic illustration. It was not Right to Life Australia who prepared this; it was the *Age*—surprise, surprise. I do not think that they would have prepared it today but they did then.

I was present in 1994 at a conference held by the Royal Australasian College of Surgeons in Melbourne, with all the august former presidents looking down from their portraits, and I could not believe what I heard. Dr Grundmann was describing how he carried out late-term abortions later than anybody else in Australia. He described, blow by blow, what he does. He had learnt the procedure in the United States, and he described how he inserts laminaria into the cervix and the woman has that in overnight because it will swell up and open the cervix. When a woman is having a baby nature closes—

Senator HANSON-YOUNG—Madam Chair, on a point of order—

Senator TROETH—Madam Chair, on a point of order—

CHAIR—I can foresee what the point of order would be—that they do not like the evidence and that you are digressing—

Senator TROETH—Madam Chair, I have a legitimate point of order.

CHAIR—Senator Hanson-Young had my call first.

Senator HANSON-YOUNG—Thank you. Mrs Tighe, I was just going to redirect you back to my question, and that was—

CHAIR—Sorry: your point of order was that Mrs Tighe was digressing and now Senator Troeth has the call on the point of order.

Senator TROETH—I would be interested to know if Senator Hanson-Young considers the evidence that Mrs Tighe is using as an adequate response to her question.

Mrs Tighe—Just repeat the question; sorry.

CHAIR—Can I just rule on the point of order—and that is, according to the standing orders of the Senate, you cannot direct a witness on how to answer a question. Therefore, the question has been put to the witness and how she deems to respond to that is entirely up to her.

Senator HANSON-YOUNG—I would put it to you, Chair, that perhaps the witness has forgotten what the question was, because she was about to ask me.

CHAIR—Mrs Tighe has the call.

Mrs Tighe—Do you want to repeat the question, Senator Hanson-Young?

Senator HANSON-YOUNG—Thank you, Mrs Tighe. My question was: what medical evidence do you have to support disallowing this item, putting the moral objections to abortion aside?

Mrs Tighe—It would depend on who you are getting the medical evidence from. You cannot put the moral objections to abortion aside because it is not a religious belief; it is a reality. You are talking about killing a child and you cannot put that aside. If that was not the case, it would be none of my business. As I said, it depends on who you get the medical evidence from. The reality is—and this is contained in this article; I will not read it out—that there are a significant number of social reasons why women will seek late-term abortions and they are covered in this article. The other thing is that in the state of Victoria recently we decriminalised abortion up to 24 weeks, no questions asked, and then after that up to birth if, in the opinion of two doctors, it is necessary because of psychological, physical or social reasons. So it is open slather. The reality is that, in continuing to fund these abortions, you will be funding even more of them because of the passage of the law in Victoria. In a way, when the Commonwealth continue to fund these procedures, they are really giving their assent to them. There is no doubt about it—they are.

Senator HANSON-YOUNG—My final question is: what type of medical expertise do either of you have?

Mr Egan—I have no medical expertise, but I follow this as a very interested layman and have done for probably 23 years.

Mrs Tighe—My so-called medical expertise is that I have been a pharmacist—and I know that is not like being a doctor. I guess it was really my gut instinct when I first became a mother, when I realised that I was having a baby. As well as that, I have always had a very strong sense of injustice. I cannot stand the thought of somebody more powerful picking on somebody who is not so powerful, and I do apply that to other aspects of my life too. That is why I have been very opposed to abortion. I think it is unjust. Finally, I would just like to say this: I know a number of people who could have been the victims of abortion. Some members of my extended family are children of single mothers and some older ones are adoptees, and I think to myself, 'Wouldn't it have been tragic if they had never been born?' Their mothers could have easily sought an abortion. I see what a marvellous contribution they are making to the world. One classic example—although I would not be voting for him if I was in the United States because he is pro abortion—is Barack Obama. There is a classic example when you think of his background. His mother was a single mother and had to pass the baby to the grandmother et cetera. I think that every person is deserving of our respect and we should not be killing people because we consider them to be a problem, whatever the circumstances.

Senator HANSON-YOUNG—Thank you, Mrs Tighe. I agree that each person needs to be given respect, and I guess that is why I support a woman's right to choose, but that is just for the record.

Senator JACINTA COLLINS—I want to go back to the discussion we were having earlier about what I think we can conclude is relatively contestable research into mental health issues in this area. One aspect of this which I think gets lost in the debate and which I think is far less contestable—and I would like you to reflect on this—is that there are some well-understood indicators of risk in relation to assessing a person's desire to proceed with a termination. Would you agree with that?

Mr Egan—Certainly. I do not have the citations at my fingertips, but my recollection from the literature is that adverse mental health outcomes are certainly more likely in second trimester abortions.

Senator JACINTA COLLINS—No, that is not my point. If I recall correctly, the South Australian legislation requires certain procedures if a woman is understood to have a pre-existing mental health condition. There are a range of other indicators that are likely to highlight in a woman's circumstance whether she is likely to then, subsequent to a termination, have an adverse mental health outcome.

Mr Egan—Certainly coercion would be one of those.

Senator JACINTA COLLINS—That is right.

Mr Egan—The evidence for coerced abortions is mostly anecdotal, of course, because it comes down to individual stories, but in a lot of women's stories you read about the boyfriend or husband, or the parents in many cases—

Senator JACINTA COLLINS—But you are not well aware of the literature in this area?

Mr Egan—I have certainly read plenty of the stories that talk about this and am aware of some of the literature that analyses the various at-risk conditions. It is certainly the case that the freestanding abortion clinics—again, on the evidence of those people I know who have been through an abortion in those circumstances—are not in any way screened for those sorts of indicators.

Senator JACINTA COLLINS—It might be a question that I will need to put on notice—

Mr Egan—I did write a paper once on abortion following incest, and it is certainly the case there that, where the perpetrator is the one who arranges the abortion, the reaction of the woman to the abortion is indeed very complex. It is a very distressing situation where you see abortion clinics prepared to abort in those circumstances.

Senator JACINTA COLLINS—It is probably a question I should put this afternoon to the college. But certainly contrary to the discussion about mental health issues generally I think it is well understood professionally that there are significant contraindications to terminations and that our public health policy system needs to be dealing with them. This was one of my concerns with the debate that occurred in the Victorian legislation, where concerns about ensuring that counselling was offered were characterised as claiming that counselling would be compulsory. I think it is critical that counselling does need to be offered, and particularly in these freestanding private clinics.

CHAIR—I have a couple of questions to follow on, if I may, in relation to evidence and submissions we have received that allude to the cost to the community of supporting children with disabilities from those who are championing the cause. I would suggest that the medical fraternity thus far are actually calling for an increase in this funding, yet they cite reasons of the cost to society of having to raise an individual. A ground to terminate a baby's life is the fact that it could increase the financial burden on the family.

I am interested in your views on that aspect. Obviously you have appeared before us and your submissions are saying it should be disallowed, but I am interested in your views in relation to the financial burden presumably held by the community and the families of the disabled. Could we not take that one step further and foresee the medical fraternity perhaps suggesting that we should look at terminating people who are ageing and are a burden on the health system?

Mr Egan—Economic arguments—

Mrs Tighe—Of course.

Mr Egan—for selective destruction are, unfortunately, not uncommon. I would have to seek the reference but I think I recall that some of the papers discussing the uptake of genetic testing for Down syndrome in Australia do an analysis of the cost savings to the community of successfully identifying and subsequently terminating a certain percentage of Down syndrome children, comparing the cost of that to what is saved. It is curious that some of these reports almost gloss over the actual fact that the Down syndrome baby is aborted. It is like: 'We have identified and we have reduced the birth incidence of Down syndrome.' So you move straight from prenatal testing to a decreased incidence of birth, and gloss over that this involves actually ending the life of a child.

I think that economic rationalist approach to the savings from people who perhaps cost the community more than others is always concerning when it is even alluded to. I think it is natural that, where that is alluded to, there be a strong and vehement reaction of protest from anyone whose sensibilities are still intact. The disabled make an enormous contribution to our community. They are admirable in the way they overcome the particular challenges that life has dealt them. I find it terribly sad that abortion for disability is being just so routinely offered to women in the community. I think that many families are missing out on the blessing of the disabled child and what they might bring to the family. If you talk to the brothers and sisters of people who have got disabilities, while there are obviously costs involved in that to family life and so on, many of them value very much the person who was allowed to be born.

Mrs Tighe—You did refer to that principle being applied at the other end of life, Senator Polley?

CHAIR—Yes.

Mrs Tighe—I do not want to introduce red herrings—I have possibly done that a bit today. You are quite right about that. Some years ago there was a report from the Economic Planning Advisory Committee of the former Keating government which suggested, amongst other things, that the elderly should be made aware of refusal of treatment legislation where it had been passed in certain states. The authors of that report—I have forgotten who they were now—were indignant that they were thought to be suggesting something improper. But why would you be especially reminding the elderly about this, that now there was the right to refuse treatment? The inference was that they did not want them to be hanging around so long. Interestingly, in the state of Oregon in the United States, where they have physician assisted suicide, there were two cases reported recently of patients who were terminally ill with cancer. Each of them had requested the use of a new drug, which was very expensive. I do not know how much longer they had to live, but the response from the state health department was for them to seek palliative

care instead and that there was always physician assisted suicide. That was in two cases. That is an example of little by little.

Senator MOORE—Can we have a copy of your paper on the issue of incest? You did mention the complexities there—

Mr Egan—Sure, yes.

Senator MOORE—In your summation—you are opposed to abortion in that case as well?

Mr Egan—Abortion for incest, yes. I think that my conclusion in the paper—

Senator MOORE—I have read a lot of your work, as you know, but I have not seen that one.

Mr Egan—The conclusion was that abortion in the case of incest, on the data that we do have, complicates recovery from incest. Those who go ahead and have the child have a better recovery process. I am happy to track that down. Shall I give it to the committee or to you, Senator?

Senator MOORE—If you go through the secretariat, they can put it forward. That would be lovely.

CHAIR—As there are no further questions, I thank you both for appearing before us today and for your submissions.

Proceedings suspended from 12.36 pm to 1.31 pm

CHAIR—I want to clarify a couple of things before I call the next group of witnesses. One of those things is the interpretation of perceived comments I made on points of order in relation to the previous witness. The intention of my comments was to instruct both the committee members and the witnesses, particularly, that my responsibility as chair is to ensure that we stick to the terms of reference—any evidence should relate to the term of reference—and to make sure that people are succinct in their responses to the questioning. I just wanted to clarify that. If anyone took offence to my comments, I can ensure you that there was no intention other than to try to keep the hearing on course, as we have done over the last day and a half.

As chair of the committee, I would also like to put on record my concerns in relation to an article that appeared yesterday, 29 October, in the *Sydney Morning Herald* under the headline 'A good year for making babies: late abortions uncommon, figures show'. It implied that the reason this committee is taking evidence on this issue relates to the make-up of the committee. Can I make sure that it is reported on the record that in fact it was a decision by the Senate to refer this reference to this committee, the Senate Standing Committee on Finance and Public Administration. The reason it was referred to this committee is that the Medicare funding issue relating to this item comes under the Department of Human Services. I would like to assure the public and have it placed on record that the reference to this committee was not based on the makeup of the senators. It was purely a decision of the Senate.

[1.33 pm]

COLEMAN, Mrs Marie Yvonne, Chair, Social Policy Committee, National Foundation for Australian Women

MOULD, Dr Janet Wendy, National Foundation for Australian Women

COCKBURN, Dr Sally, Private capacity

CHAIR—Welcome. 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 and, at the conclusion of your remarks, I will invite members of the committee to put forward their questions.

Mrs Coleman—The National Foundation for Australian Women is an independent, non-politically aligned feminist organisation which works in a number of ways to advance the wellbeing and status of Australian women. We have a range of activities, apart from those of the social policy committee. We have had a policy position on sexual and reproductive health issues developed over some little period of time. Our basic position is that issues in relation to reproductive health decisions are essentially for the woman—and partner, where that is appropriate—to make, taking into account the best available professional medical advice. We have made a submission, which we understand is strictly within the terms of reference of the committee, in which we have outlined, as we understand it, the description of what the item covers. We note that the Medicare data are not adequate for making estimates of the numbers of abortions which occur in Australia. I will not go on about that. We have made some comments about the legal position regarding this particular procedure—an item in state and territory legislation—which I think is much more comprehensively covered in the submission by the Commonwealth department of health.

We have made some brief comments about what we see as the effects of disallowing this item, which we understand to be the primary purpose of this inquiry. We have made the point that the removal of the Medicare rebate for a lawful medical procedure would not be consistent with the availability of rebates for other lawful medical procedures. We note that were this item not to be available, some women would be forced into delaying decisions because of their economic circumstances and/or geographic location. We note that although the number of women affected by the circumstances covered by this item is small, their circumstances are particularly distressing. We make the final comment that we know the procedure covered by Medicare item 16525 is already conducted in state and territory public hospitals, but we could assume that if this item were not available on the schedule, it could result in greater pressure being placed on those systems with potential demand from those systems for additional payment through the Commonwealth-state hospital cost-sharing agreements.

CHAIR—Thank you. Would anyone else like to make an opening comment?

Dr Cockburn—I am a registered medical practitioner in Victoria and a community health advocate. I was motivated to take part in this inquiry in the interests of clarifying this

information. My submission, which is No. 189, was written representing myself. I appear today for myself; I do not appear on behalf of or speak on behalf of any other organisation.

I believe that those who seek to disallow this item number do so with an honest desire to reduce abortion numbers. While removing or restricting MBS item number 16525 might take the issue of the second trimester abortion off the federal parliamentary agenda in the short term, it will not improve maternal health outcomes, it will not make gross foetal abnormalities go away and, more importantly, it will not reduce abortion numbers. Such a move would only add to the financial and emotional burden already facing people requiring these procedures that are currently covered by this item number. It is an item number that provides for procedures that are clinically relevant, safe and lawful. Removing it would not save the Commonwealth money as these procedures will still happen. They will simply be moved to the public sector, or people will have to find the money elsewhere to make up the shortfall that would have been covered by the Medicare benefit. The Commonwealth will still pay—possibly more than they do now—if this happens.

Disallowance of this MBS item number would be nothing more than a cost-shifting exercise that makes little sense other than to allow some people to turn a blind eye to a set of lawful and clinically relevant services that they find morally repugnant. Of course these people have the right to their moral objection for themselves, but, as evidenced in Victoria at least with the commencement of the Abortion Law Reform Act 2008 last week, their view is not reflected by law, clinical practice or community attitude and it should not be imposed on others who do not hold their view.

Medicare is about evidence based health outcomes. Proper processes and protocols are in place for clinical services to be assessed, included or excluded from the Medicare benefits schedule. In September 2003, the then minister for health told the parliament in response to a call from Senator Brian Harradine to remove this item number:

> The Commonwealth has no role in the policing of state and territory abortion laws. The Commonwealth, through the HIC, assumes without evidence to the contrary that terminations of pregnancy claimed against Medicare have been performed in accordance with state and territory laws … valid benefits would normally be paid for termination of pregnancy. Medicare benefits have always been payable for the termination of pregnancy.
>
> … … …
>
> It is a matter for a doctor's clinical judgment as to whether a patient's condition meets the second trimester requirements.

I believe her words are very relevant to this inquiry.

I have heard some claims during the course of this inquiry that there may be some practitioners who are performing procedures that either are not appropriate under this item number or may be illegal. Either way, if there is evidence that these practitioners exist, they should be referred to the appropriate authorities. I believe that isolated breaches of the law or the item number are not a justification to remove the benefits from all. Medicare benefits are not paid to doctors; they are paid to the women who have the procedures. I do not believe disallowance is the right solution.

If, however, this committee were to recommend that the motion of disallowance be put to the Senate, I believe it would set a dangerous precedent by bypassing the minister responsible for the Medicare Benefits Schedule and the Medicare Benefits Consultative Committee, which is set up for the purpose of evaluating these item numbers. If this committee feels that the validity or the efficacy of MBS item number 16525 is in question, I believe that the only appropriate conclusion that the committee can reach is to refer the matter to the Medicare Benefits Consultative Committee for proper assessment. With the greatest of respect, while it is obviously within the scope of a senator to put a disallowance motion to the parliament, to do so without first allowing the item number to go through the normal processes of the Medicare Benefits Consultative Committee, in my view, undermines the integrity of the Australian Medicare system.

Senator MOORE—My question is in terms of the processes you have just outlined, Dr Cockburn. Yesterday we had the department with us, and a number of senators asked them about processes and also whether there had been any complaint registered with them. They said no; I think the gentleman actually said that to the best of his knowledge there had not but that he would check it out. Can you give us some idea about the awareness of the processes that should be used, particularly in the medical profession, with people who have expressed concerns? You will have looked at the evidence and the submissions and seen that there are some doctors and other people in the community who have expressed concerns about processes that have gone on. Is it something that people within the profession know about? Is it widely publicised?

Dr Cockburn—It is certainly my understanding that doctors are aware of the processes of Medicare benefit item numbers. We receive a schedule every year in November. We all have to use it; we are aware of it. And I believe we certainly understand that there are expert committees that go through this process and decide which services are to be included in the Medicare Benefits Schedule. Yes, I believe it is widely known. I also believe that there are lots of medical practitioners who get involved in these committees and I think that there would questions asked by medical practitioners if this disallowance were to happen without using these evidence based protocols because we, of course, practise medicine in this country on an evidence base. That is why I believe that the Medicare Benefits Consultative Committee is the perfect place for this item number to be.

Senator MOORE—I have a general question to all or any of you about data collection. It has been put to the committee that it is impossible or difficult to obtain accurate data in Australia at the moment that reflects the need. You would also have seen in the submissions a wide range of figures that have been put forward, but there is generally some concern that it is not possible in the current situation to accurately reflect how the system is working. Do any or all of you have a comment on that?

Dr Mould—I am sure Dr Cockburn will probably have some comments to make as well. In respect of the question of health data—and not just that arising from Medicare data—and collecting data on health outcomes, disease status, morbidity and mortality in the Australian population, using claims through Medicare for that could only be described as a very blunt tool. That is because at various points in the process there is no capacity for quality control, quality assurance, from the point of what item the doctor chooses from the Medicare Benefits Schedule, how the claim is processed, correct entry of the item, correct processing of the item et cetera. So MSB data, while a very useful indicator, is not precise. There are of course a number of

morbidity and mortality data collections in hospitals but, unfortunately, to the best of my knowledge they do not involve private hospitals. So this country could really do with a national data collection on morbidity and procedures. Having said that, there are a number of collections, and Victoria stands out here as having a collection that you would be aware of in this area.

Senator MOORE—Are they mainly state based?

Dr Mould—Yes.

Senator JACINTA COLLINS—Can I follow up that question about the Victorian statistics. Do the Victorian statistics include stand-alone private clinics in their morbidity data or not?

Dr Mould—I am sorry; I do not know. I am not across the area, but I am sure the Department of Human Services in Victoria could clarify the matter for you.

Senator FIFIELD—Dr Cockburn, your second recommendation is that the committee recommend that the Medicare Benefits Consultative Committee take a look at the level of the rebate for the item number that we are looking at to see if it is adequate. Do you have a ballpark figure in mind as to what might be appropriate or it is just something that you think should be examined?

Dr Cockburn—As I said in the body of my submission, I came across this when I saw some of the figures being quoted for what women were paying for these procedures—up to, I believe, $4,000. As a doctor, obviously my patients get Medicare rebates. I think about the gap that they are up for in lots of things that I send them to a surgeon for, and they often tell me about the gap being enormously difficult. I just wondered when had been the last time that this item number had been looked at from the point of view of whether it reflected the complexity of the procedure. I spoke to one of my colleagues who perform these procedures, and they said it takes up a lot of their time and that is why they charge the amount they do—because it is a time-consuming procedure. I am no expert on that area and I would have absolutely no idea what it is worth, but it is something that I thought would be worth looking at. It sort of came out of this; I did not intend it.

Senator FIFIELD—It is kind of the antithesis of the intent of the disallowance—

Dr Cockburn—That is why I said I was not intending that.

Senator FIFIELD—Not at all; it is probably something that is worth looking at. This might be a question that is better directed to the college, but do you have an understanding of the history and origin of the item number?

Dr Cockburn—Sorry, I do not.

Senator FIFIELD—That is okay. Professor de Crespigny in his submission canvassed some of the item numbers which were previously used for different procedures. If that is better directed to the college, I will do that. Thank you.

Senator JACINTA COLLINS—The other question I had is probably for Ms Coleman. You referred to the policy position that has developed within your organisation over time. Would you have a concern about the reports out of Victoria—which we have been discussing here—of three terminations which appear to be related solely to babies with a cleft palate or harelip post 20 weeks?

Ms Coleman—I would have to take the view that a competent medical professional took the view that, within the terms of this item, there was a problem with the mother's health or a particularly severe condition with the baby. It is not for me to comment on that or on what might have been the relative severity or otherwise of particular issues, because I am not a medical practitioner on particular cases. We do expect that medical professionals will operate within the ethics arrangements of their profession and the organisations to which they are attached.

Senator JACINTA COLLINS—I suppose the question, though, is: do you believe it is ethical for our system to allow terminations of foetuses beyond 20 weeks solely for, as indications seem to be, issues such as a cleft palate or harelip?

Ms Coleman—I do not know the particular case to which you refer, Senator. I would be reluctant to make any remarks which suggested that I understood that that was the sole reason for the procedure having been carried out. I am sorry; I just do not want to comment on particular cases of which I have no knowledge whatsoever.

Senator JACINTA COLLINS—I agree with your concern that we have limited knowledge. It is more that I am challenging the assertion you made at the outset which is that as long as a matter has been discussed between a woman and competent medical practitioners, it is okay. I am trying to test that assertion.

Ms Coleman—It still has to meet the requirements of this item which I think refer to gross foetal abnormality or life-threatening maternal diseases. It is either meeting those criteria to be justified, to be claimed under this item, or it is not.

Senator FIERRAVANTI-WELLS—That is what Senator Collins is asking you. Do you think that cleft palate falls within that description? It is a simple question. With your experience—and you clearly have a lot of experience—it is a simple yes or no.

Ms Coleman—In my own personal situation I doubt that I would personally have sought to have a termination if I had known that an infant had a problem of that nature, but I do not wish to comment on the matters in Victoria.

Dr Cockburn—May I also add that cleft palate is an umbrella term. I think what Ms Coleman said is very true. I think it is very difficult for anybody to answer this question without knowing the clinical details, whether we are talking about a small divot in a lip as compared with a whole face that has not combined. That is why, I think, the statement that it is between a woman and her doctor—and the law in Victoria now says where all the circumstances are taken into account for over 24 weeks—means that it is a very difficult thing to make a black-and-white statement about an umbrella term like that.

Senator JACINTA COLLINS—There is an umbrella in two senses which we have discussed previously. One umbrella is that a foetus with a hare lip may be an indicator of other congenital abnormalities, it was suggested. But apparently that has been eliminated as a factor as to how these cases would have been reported in the Victorian statistics. In the other one you suggest there might be myriad other factors. We are yet to ascertain whether these three cases reported in Victoria were solely in relation to, as it appears, simply that condition, which is correctable.

Dr Cockburn—Did the women who had these procedures claim Medicare item numbers?

Senator JACINTA COLLINS—We do not know that. We do not have the data because we do not know where the procedure occurred, which is one of the other complications about having access to data.

Dr Cockburn—I refer back to Senator Patterson's statement in 2003 which was that Medicare works on the predication that the procedure claimed was lawful. It is clinically relevant if it is on the item number.

Senator JACINTA COLLINS—We heard from Professor de Crespigny that lawful is not the factor. It is whether it fits the definitions of the clinically relevant terms of gross foetal abnormality and the maternal factor. He actually suggested that we look at inserting 'lawful'.

Dr Cockburn—But the whole of Medicare works on the understanding that the procedure is lawful, and that was the statement made by Senator Patterson in 2003 in the parliament.

Senator JACINTA COLLINS—We will look at that.

Senator CAMERON—Thanks for coming along this afternoon. I indicate that nobody needs to answer yes or no to any question. If that were the case, we would have very short inquiries. People are entitled to answer in the way they feel they want to answer. I am interested in the psychosocial disorder question that has been raised in some of the submissions as if it is not a proper thing to be considered when payments are made in relation to terminations. Arising from that, there is this other issue of support for women who undertake a termination or abortion. Does anyone have any views on this question of psychosocial disorder? What is it? How do you deal with it? Is it an appropriate issue?

Dr Cockburn—Firstly, can I make the statement that this is exactly the sort of thing that the Medicare Benefits Consultative Committee would be able to work on and decide on. That is what they are there for. Having said that aside, I have covered it in my submission. Although I thought it was outside the terms of reference, I did cover it. Again, it is an umbrella term. The word 'psychosocial' can be many things but in order to make a claim under this item number the psychosocial condition would have to be life-threatening for the mother.

If you ask, 'What psychosocial conditions could be life-threatening?' some examples could be suicide, homicide—although you would hope you would be able to take her out of that sort of situation—or maybe a severe psychiatric condition that required medication that could be harmful to the foetus. But I think the term 'psychosocial' has been, if I may say so, bandied about as if it might be that I would like to buy a new pair of shoes to wear to the Cup. I have to say that in my experience in medicine I have never met a woman or seen a woman who would

ever decide to terminate her pregnancy for a reason of a trivial nature. I would really like to put that on the record, because these are real people we are talking about, people who are probably watching us right now, and I think that they would be insulted to think that we are saying that maybe they will do it because they do not fit into their dress for the Cup.

Senator CAMERON—So, in your experience, you have not seen any of what we were told was around—that is, deranged adults who go to doctors to have babies killed on demand?

Dr Cockburn—I have never in my entire career seen someone who wants to have a baby killed on demand. The 'on demand', in my view, is amazing to think about. Medical practitioners are registered in Victoria under the health registration act. We are trusted to open your chest and put your heart on bypass. Surely we can be trusted to sit in a clinical situation. We do not have to perform anything, we do not have to do anything, if it is not clinically indicated. We will not give an invoice for an item number—or we should not—if it is not under the recommendations that are there. For any practitioner that does so, we have the practitioners—I am not quite sure of the name, and Janet can probably help me here. It is not the practitioners board; there is a Medicare—

Dr Mould—Professional services review—

Dr Cockburn—Professional Services Review Committee which would deal with that. Again, to say that a woman comes in and demands an abortion I think is outside the ballpark. I do not believe any woman wants to have an abortion. I do not believe any doctor wants to do an abortion. It is something that is done because it is clinically relevant and it is requested and it is lawful and it fits in the item number.

Ms Coleman—Senator, if you want me to respond to that: I do have certain professional activities which are not part-covered by this submission. I deal with people, not only women but men and women, of varying ages, some of whom have extremely profound problems in managing their lives, whether it is because they have a personality disorder or they have associated substance abuse—all sorts of things. Much of that would be covered by the term 'psychosocial'. I deplore people thinking that this is a frivolous view. As Dr Cockburn says, these are serious decisions for anybody to make, and 'psychosocial' is the term which generally can be used and should be used to cover what are often very, very complex circumstances.

Dr Mould—I can only support the other two speakers and say that I think 'psychosocial' is not only an unfortunate term but also trivialises the whole issue.

Senator CAMERON—Arising from that, we have heard witnesses say that a woman who undergoes an abortion or termination then suffers problems and there is not enough support, so you should not create that problem; you should bring the baby to full gestation. What support are you aware of that is around?

Senator MOORE—Ms Coleman, Dr Cockburn and Dr Mould, we had reference to the Fergusson research. It has been quoted in a number of submissions and also to the committee.

Ms Coleman—I was just thinking that there is certainly research evidence around—which at this point I am totally unable to call to mind in terms of giving you a citation—which, at the very

best, does not suggest that all women suffer terrible distress. It acknowledges that some women do suffer distress. I would personally think that to have a situation where you had had a pregnancy that you had welcomed and where you had got as far as the second trimester and, for a set of complex reasons which were not of your making, you had discovered that you could not continue with the pregnancy would be deeply distressing, and it would be appropriate for various kinds of supports to be provided. I had the opportunity to watch yesterday afternoon in the closing stages of this committee's hearing when Professor Ellwood and Dr Pesce were talking, and I think they were discussing the kinds of social supports and counselling that their hospitals provided for very complex cases. It is highly desirable in very complex cases that there are supports.

Dr Cockburn—Could I also add that we have 17,000 practising general practitioners in this country, all of whom have access to a Medicare mental health item number, which now allows people to be referred to a psychologist for a rebate of up to $100 for six to 12 sessions during the year. We have community mental health centres—but a GP is the sort of place. We know the family; we deal with the family; we have dealt—possibly, hopefully—with this woman up until that time. It is a tragic and awful situation.

I need to say: it has come across through some speakers previously that both the doctor and the woman are almost rubbing their hands together with glee that they are having an abortion. No-one wants to do that, and I think it is very important that we care for these people and we want to help them. It is not necessarily the abortion but the circumstances around the abortion that may lead—and my reading of the Fergusson research was very much that he said he could not draw a causal relationship between abortion and mental illness. That is to do with the fact that there are so many compounding factors around it. This is something that I do not know that we will ever be able to resolve in this research—whether it is the cause.

Senator HANSON-YOUNG—This is a question to all three of you. Do you agree with previous witnesses who have suggested that disallowing this particular Medicare item would not necessarily stop people from going through the procedure but in some cases prolong the pregnancy and push those weeks even further out so that a woman would have a termination even later than perhaps she would have beforehand?

Dr Mould—It is a possibility. It is a hypothesis. I have seen no data to show that that is what happens. I am sorry, but I have no anecdotal evidence that I can call on to provide you with any assistance there.

Dr Cockburn—This came up in the Victorian debate, and I think it was around whether there should be a 24- or a 20-week cut-off in the Victorian law. I think that what was raised was—and, again, I have no evidence of this, but this was the theory—that often it is the 18-week ultrasound where they may get the first serious evidence of a foetal abnormality.

Senator HANSON-YOUNG—Some people do not have that until 20 weeks.

Dr Cockburn—That is right. And then they may need to go on and have an amniocentesis, which can sort of push it out. I think that is where that came from. I think there was some, again, anecdotal talk about whether women in Western Australia at that point might try to avoid going to the panel, if you will, and come to Victoria—or not even come to Victoria—and have the

termination before the 20-week mark to avoid having to go to the panel. As I say, that was the sort of discussion that was being had. I have no evidence of it.

Senator HANSON-YOUNG—Ms Coleman, do you have anything to add?

Ms Coleman—I was just going to say that the people who may hypothetically be having this procedure or who may hypothetically be travelling from Western Australia to Victoria are clearly not the people who are in the greatest financial need. That is just a by the bye.

Senator HANSON-YOUNG—What effect do you think that disallowing this particular Medicare item might have on women in rural or remote areas?

Ms Coleman—Women in rural and remote areas are already quite frequently disadvantaged in terms of their access to specialist services. The various state governments try all sorts of innovative ways to enhance women's access to consultants when they live in the bush, but I think anything that makes it more difficult for a resident woman, man or child in a remote area to get access to expert treatment is just an extra burden. There is a shortage of GPs in the bush. There is a shortage of specialists in the bush. I think removing this item as well is probably just going to be an extra burden, but that is a hypothetical statement.

Dr Cockburn—My concern—and I also used a hypothetical example in my submission—would be the woman who has a private obstetrician gynaecologist, let us say, in a rural centre and she only has access to a private hospital. Let us say that her finances are such that this is the tipping point. She may then have to travel to a public hospital in the city where she no longer has her choice of obstetrician, she no longer has her choice of hospital and she has to move away from her family. It is hypothetical, but $200 could be the tipping point for her. That is one thing that I think counts.

Senator HANSON-YOUNG—We have heard from a number of witnesses—and I must say that there have been those both advocating for the disallowance and those opposing the disallowance—and from people who have made submissions that this will mean women will use the public hospital services more. What kind of an impact do you think that is going to have on those services? A woman who has had a child in a public hospital is on a waiting list anyway.

Dr Mould—There are a number of issues there. The first is access in a geographical sense. Secondly, there is access in a timely sense and, regrettably, the pressure on the public hospital system is such that waiting times are very long despite the best efforts of the various state governments to improve them. So there are two issues. First of all they have to find or get a referral to a public hospital and, secondly, they then have to access what are at times rather meagre services at that public hospital and the resources that are at that public hospital

Dr Cockburn—It would be very important that that particular public hospital did provide the service, because there are places that are already serviced by public hospitals that may not provide that service. Adding to that, some people have said that the disallowance of this item number would send a message to the Australian people that second trimester termination under these circumstances was not appropriate. The thing is that the message would not get very far because, if these procedures are going to be shifted to the public hospital, I think that the state governments would realise that these are being underfunded and they would probably, through

the Commonwealth health services agreements, be applying to the Commonwealth to get more money to pay for these procedures. So it would end up that the Commonwealth potentially would be paying more and spending more taxpayers' money for these procedures if this item number were disallowed.

Senator HANSON-YOUNG—On another topic, there has been a lot of debate over the last day and a half about whether partial birth abortion is taking place in Australia or not and in particular practices or not. People who have said that they are taking place have not named any places. In your profession and in the work that you do, are you aware of this practice happening?

Dr Cockburn—My understanding is that it is not a recognised medical term. I was not taught this in medical school. I do not know anybody who does it. I have asked some of my colleagues and everybody I have spoken to has said that they do not know anybody who does this procedure. I have no evidence. I have not seen any evidence that it is being done in Australia. I find the description of the practice abhorrent in the sense that, if a baby were to be born partially and then murdered, that is terrible. I would assume that that is horrible and, to the best of my knowledge, I do not believe that it is being done.

Dr Mould—I have no knowledge at all. I am sorry, Senator.

Senator HANSON-YOUNG—From the National Foundation for Australian Women's perspective, if it were happening, do you think that you would be aware of it?

Ms Coleman—To the extent that I would assume that some of my colleagues who are in the medical profession might be aware of it and might draw it to my attention, yes, I guess we would probably hear of it in that way. But, as you can hear, we are not hearing about it. There are people who talk about it, but that is a separate issue. That is not the same as saying that we have heard that it is actually a practice. That we do not know about. I know that there are people who talk about it but I am not quite sure whether they have evidence.

Dr Cockburn—There have been people talking about practices that are clearly illegal or clearly not under this item number. I would say that if people are making these claims, why don't they refer those doctors to the relevant authorities? I do not understand, if these procedures are illegal and not under the item number, why the authorities are not dealing with them.

Senator HANSON-YOUNG—I must point out that the department clearly said yesterday that they had not received any complaints about these types of practices or practitioners using the item number liberally.

My final question is to clarify. A number of people who are supporting this particular disallowance are citing moral objections and I would say moral objections to abortion overall. Putting that aside, can you see any clinical evidence as to why this particular item should be disallowed?

Dr Mould—I think you have got to go back to the genesis of the item to start with and see that it is in the schedule because of clinical evidence. The genesis of the item is basically the department, the profession, Medicare Australia as it is now, or HIC as it was then, the AMA and the relevant learned colleges. There was clearly considered to be a need for an item to cover

circumstances such as this. That item was given the test of clinical relevance, and it was considered to be reasonable for inclusion in the schedule. As such, it is there because we have a universal Medicare system which provides reimbursement to patients for services which are considered clinically relevant and to provide universality, equity of access et cetera. To come at it from the back and say, 'Are there reasons why you would clinically say this item should not be here,' is to nay say the reasons it is in there in the first place. It is in there because it was considered to be clinically relevant and clinically necessary in the first place. That does not go to issues of morality, belief, choice, ethics, lawfulness et cetera. That is not what the Medicare benefits schedule is about. There are many items on the Medicare benefits schedule—well, not many, but there are items in the Medicare benefits schedule—that a person could object to on grounds that might be ethical or a waste of taxpayers' money et cetera. But that is not why they are there.

Dr Cockburn—If I may add to that, in my submission I put a graph of the claims over the years. This is an item number that is used. It is not used a lot but it is used consistently, which shows that it is not only clinically relevant but it is consistently clinically relevant.

Senator TROETH—Could I ask the medical practitioners are miscarriages common in the second trimester and how might that be reflected in the item number claims data?

Dr Cockburn—I am not a gynaecologist, I am just a general practitioner, but I believe the term 'miscarriage' carried applies up to 20 weeks and I believe over 20 weeks a different term is applied. But I am not an expert in that area.

Senator TROETH—Dr Mould?

Dr Mould—No, I am sorry, I do not have those figures. I am sure they are available through the college. But the terminology—

Senator TROETH—As with the earlier question asked, if we disaggregated some of the services provided in relation to this number, that might provide a clear indication of what could be called what.

Dr Mould—I think you then go to the question of the validity and the quality of collecting data.

Senator TROETH—Yes, that is right, and that goes further back.

Dr Mould—I think that is a very salient point.

Dr Cockburn—Also the terms are difficult. In medicine we often talk about a spontaneous abortion at the same time as a miscarriage. So we need to be sure that when we talk about terminology in lay terms it is the same terminology that we use in medicine.

Senator TROETH—That is correct.

Dr Cockburn—On that point about disaggregation of this item number, I realise that one of the problems has been very much around the notion of the gross foetal abnormality and the life-

threatening nature of an illness. Surely one of the simple ways around it for the Commonwealth would do to simply remove the descriptors and say 'as long as it is within the law of the state in which it is performed', which I think might be what you were getting at before, Senator Cameron, about the law. I would ask the committee to have a look at my recommendation 3.

Senator BARNETT—I was checking a page number and a reference to Dr Cockburn because on a number of occasions in your opening statement and in your submission you referred to your doubting or disbelief regarding babies being born alive and left to die.

Dr Cockburn—I said 'killed' actually.

Senator BARNETT—Well, you have previously raised doubt about the fact that they are born alive and left to die. I have got your submission in front of me and I thought I would just give you the reference to that and draw your attention to the transcript of yesterday from Dr Andrew Pesce and Professor David Ellwood. Professor Ellwood outlined to this committee in some graphic detail the descriptions for the two processes for late-term abortions post 20 weeks. I will not go into that, but I draw to your attention where he referred to the babies being born alive and left to die for up to two hours—and he specifically referred to up to two hours. I also draw your attention to page 13—

Dr Cockburn—Can I respond to the first bit before you move on to that?

Senator BARNETT—I will just finish this. On page 13 of the annual report for 2006 of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity are the Victorian figures showing 42 of the 298 abortions in Victoria post 20 weeks.

Dr Cockburn—I have covered this in my submission; I am sure you have read that bit. Again, I am not experienced in this area. And I was alarmed to see those figures as well. I understand that one explanation could be, let us say, where a family have discovered they have a pregnancy where the foetus has got a gross foetal abnormality that is consistent with the item number, consistent with the law, and that the baby has little or no chance of survival—the baby was maybe going to die within hours, days or weeks of birth. A woman may find that diagnosis is given to her at 18 or 22 weeks or whatever time. She still has up to 18 weeks of her pregnancy to go. During that whole time she has this pregnancy—and let us take the example of an anencephalic baby—she will know that when she delivers this baby at 40 weeks, if she goes to term, it will not have any chance of survival; it will die within minutes or hours—who knows?—of its birth. After consultation with her doctor and her family, she may find that the thought of carrying this baby to term for another 18 weeks, knowing it has no chance of survival, may be difficult for her. Therefore, she may opt to terminate that pregnancy.

Again, I come back to terminology. I rang the perinatal data people yesterday, but unfortunately they were not available, because I would like to know whether the term 'abortion' is correctly used there or whether it was a termination of the pregnancy. A lot of times during this inquiry, people have talked about babies being born and left to die as if that is the intention. There are times when the termination of the pregnancy will be done and the baby will try to survive. The trouble is that at 22 weeks and below there is no chance that that foetus will survive, that that baby will survive.

I go back to the scenario of the lady with an anencephalic baby who is having a termination, let us say at 22 weeks, because she feels she cannot go to term. I understand—and please ask my colleagues this—that sometimes these parents say: 'Please, rather than terminating my pregnancy and using KCl,' as they do, 'could I please hold my baby when it dies? Could I please have the privilege to let my baby at least feel its mother's arms?' I believe that that is what may account for some, if not all, of these. It would be a very hard-hearted world that would deny these parents the right to hold their baby as it dies.

Senator BARNETT—I can understand your last comment entirely and I think most Australians would. If you see the evidence from Professor Ellwood yesterday, he outlined in some graphic detail this process, that in and around the 24-week mark the potassium chloride is injected into the heart of the baby to kill the baby prior to the forced labour. But the other process is the forced labour, where the baby is born and dies shortly thereafter.

Dr Cockburn—Induced labour, which fits under the item number.

Senator BARNETT—Indeed, induced labour. I draw that to your attention because I hope it will dispel any doubts that you might have as you have set out in your submission. I just draw that to your attention.

Dr Cockburn—I am sorry, Senator Barnett, but I disagree with you on the intent of what I was saying. I am trying to say that I see the term 'being left to die' as very different from allowing a parent to hold their baby as it dies.

Senator BARNETT—Well, isn't that the purpose?

Dr Cockburn—What?

Senator BARNETT—Isn't that the purpose, in terms of the abortion—that the life of the baby is to be terminated?

Dr Cockburn—Yes.

Senator BARNETT—And that is exactly what is happening.

Dr Cockburn—But the termination of the pregnancy—

Senator BARNETT—So that is what you are describing.

Dr Cockburn—No, sorry—the termination of the pregnancy is to terminate the pregnancy.

Senator TROETH—Under this item number.

Dr Cockburn—Under this item number it is the termination of the pregnancy. This baby—the anencephalic baby—was going to die whether it was born at 40 weeks or whether it was born at 22 weeks. The baby was going to die.

Senator BARNETT—The example you are using is one example. There are many other examples, including a cleft palate and—

Dr Cockburn—I am afraid I am not sure about that. Can I say, on that point: if you have these examples, why don't you refer the people who have done this to the relevant authorities? You either have the examples or you don't.

Senator CAMERON—You have to put it in the proper context. It has not been put to you in the proper context.

Senator BARNETT—Okay.

CHAIR—Senator Barnett has the call.

Senator BARNETT—I do not have any further questions. I think we have come to a dead end in terms of our agreeing to disagree. What Dr Cockburn has in her submission which is in accord with my submission are the Medicare item numbers showing nearly $1.9 million for over 10,000 babies since 1994. So we agreed on that.

Dr Cockburn—No, we do not agree because in your submission you said they were for the 'abortions' performed in 10 years. You are actually incorrect. I cannot remember the figure—you just said it then—I can look it up. The figures that you quoted were for the services under this item number. They were not for 'abortions'. You also said they were performed by 'abortionists', which is not a recognised specialty under Medicare.

Senator BARNETT—It depends how you—

Dr Cockburn—No, it is not a recognised specialty under Medicare. It is just not.

Senator BARNETT—Okay.

CHAIR—Can we have questions asked and then answered. It is much better than talking across each other.

Dr Cockburn—Well, Chair, if I may respond to it please—

CHAIR—You have the call, Dr Cockburn.

Dr Cockburn—What I was trying to say and the point I made in my submission about your figures was that your figures were not correct, in that you said they applied to 'abortions' in the sense that they were done by 'abortionists'. They were benefits claimed under this item number, and this item number covers not only abortions in the common understanding but also for foetal death in utero and induction of labour. So that was my point.

Senator BARNETT—Sure. I appreciate your point. Doctors performing an abortion—many people in Australia, including me, call them 'abortionists'. That may be a colloquial term—

Dr Cockburn—We take offence at that.

Senator BARNETT—It may be a colloquial term—

Dr Cockburn—Sorry, Chair; could I please call it—

CHAIR—Sorry, are you raising a point of order? No? Can I just say that it is very hard for Hansard to record the proceedings if people talk across each other. Could we have one person at a time. People may want to take objection to either a witness's response or a question, but if we could do it in an orderly manner it would be most helpful. It is getting towards the end of the day and we have little time left.

Senator BARNETT—I have finished my questions, Chair.

CHAIR—Did you want to add anything, Dr Cockburn?

Dr Cockburn—Just that I would ask this committee to please respect medical practitioners and use recognised terms. 'Abortionist' is not a recognised medical term, nor is it a term, as far as I understand, for a recognised specialty under Medicare.

CHAIR—Thank you. Senator Fifield.

Senator FIFIELD—Dr Cockburn, you would not describe a medical practitioner who assisted a woman who had a stillborn child as an abortionist, would you?

Dr Cockburn—I would not describe anyone as an abortionist.

Senator FIFIELD—No. And I do not think, in common parlance in the community, anyone would consider the use of that pejorative term to be appropriate for someone who assisted a woman who had had the great tragedy of having their child die in their womb.

Dr Cockburn—I think it is a derogatory term and I think that we should be above that.

Senator FIFIELD—Thank you.

CHAIR—Senator Ryan—very quickly, one hopes.

Senator RYAN—This is a very sensitive issue. A lot of people have gone to a lot of trouble to keep it as unemotional as possible, and I do not think pejorative terms have a place when addressing witnesses in this regard.

CHAIR—Do you have a question for the witness?

Senator RYAN—No, I just wanted to bring that to your attention.

CHAIR—We started off so well yesterday! I do appreciate that it is a very emotional issue. We are not here to debate the pros and cons of abortion itself. We are here with very specific terms of reference. Before you go, I would be most interested to hear your comments on the fact that when we had the department before us they could not give us a definition of what 'gross

abnormalities' are in babies, and whether or not, from each of your perspectives, it would serve the community's interests to have more data available and proper definitions from the medical fraternity.

Dr Cockburn—I would like to answer by referring to my recommendation 3. Surely what is important is what is lawful, and, because the states all differ in their laws around these procedures, maybe the easiest thing for this item number would be to say 'induction of labour within the law of the state'. But could I then finally say that the most important thing to do would be to refer all of that, including definitions, to the Medicare Benefits Consultative Committee.

CHAIR—Does anyone else want to respond to that?

Ms Coleman—I think that is the sane position to take, Senator.

Dr Mould—If I could just say, for the benefit of the committee, that these items, as I said, come through the Medicare Benefits Consultative Committee, and it would be very useful for the department to go back and find out why this precise terminology was used in this particular item, because to try to further define it, I believe, will only increase the confusion and the discontent.

CHAIR—Thank you, each and every one of you, for your submissions and your participation in giving evidence today. Sorry that we were running a little behind. I call the next witnesses.

[2.27 pm]

BAARTZ, Dr David, Private capacity

KNIGHT, Dr David Charles, Private capacity

CHAIR—Good afternoon and welcome to you both. 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 and, at the conclusion of your remarks, I will invite members of the committee to put questions to you. Who would like to go first? Dr Knight.

Dr Knight—Thank you. In 1972 I commenced my specialist training in obstetrics and gynaecology in the United Kingdom. This was just after the abortion laws were changed to effectively permit abortion on demand. I saw first-hand the effect that this had on the gynaecology waiting lists. Many women with serious disorders, including cancer, had to wait much longer for treatment because the public operating lists had been taken over by abortions. However, at that time I also became aware of the small proportion of important cases in which there was a genuine threat to the life of the mother or where there was a lethal foetal deformity. During my first six months of training, I assisted in terminating a pregnancy to save the life of a young woman who had a form of heart disease called constrictive pericarditis. This woman would not have survived until foetal viability had the pregnancy not been terminated.

Since then I have worked in both the public and private sectors of medicine in Australia. I am currently employed at the Canberra Hospital, where one of my duties as a specialist obstetrician and gynaecologist is to chair the monthly perinatal maternal and gynaecology morbidity and mortality meeting. As one part of this process, all pregnancy terminations of 20 or more weeks gestation are reviewed by a panel of specialist obstetricians, neonatologists, pathologists, geneticists and midwives. In almost every case of lethal foetal deformity, the procedure will have been approved beforehand by an ethics committee. In cases where the woman's survival is at risk, such approval is of course not necessary. Such cases still occur with some frequency in the Australian Capital Territory every year. All women who have had such procedures are followed up in our Fetal Medicine Unit, where they receive a full debriefing which includes information regarding implications for future pregnancies.

I also belong to Women's Hospitals Australasia, which is an organisation made up of most of the major women's hospitals in Australia and New Zealand. We compare our figures in all areas of obstetrics and we meet annually to discuss important issues in patient care. I am well aware that the situation in Canberra is repeated in all major women's hospitals throughout Australia and New Zealand, so we are not unique.

I doubt that the processes of ethics committee approval, peer review, audit and ongoing patient support are present in those private abortion clinics where late termination of pregnancy is being performed, apparently for reasons other than those stipulated in item 16525. I am also aware that such facilities do not have intensive care units and other support facilities which are vital to the management of seriously ill patients. It is obviously absurd to expect that these clinics can

handle terminations of pregnancy in women who are so ill that they can no longer continue with the pregnancy.

I believe that Medicare funding for the late termination of pregnancy in the private sector should be restricted to cases of foetal death in utero. Private clinics are not equipped to treat genuine cases of life-threatening maternal disease. Nor, it appears, can they be trusted to properly diagnose lethal foetal deformities. All such cases should be restricted to major public hospitals. However, it is important to ensure that if Medicare item number 16525 is disallowed, that this will not stop funding of late-term pregnancy terminations in the public sector, because this could put some women's lives at risk.

CHAIR—Thank you very much, Dr Knight. Dr Baartz, would you like to make an opening statement?

Dr Baartz—I am also a full-time obstetrician and gynaecologist. I am currently the director of gynaecology at the Royal Brisbane and Women's Hospital, which is one of the largest teaching hospitals in Australia. I have been at that hospital since 1996, apart from three years of study leave in the UK and Sydney, and I have been at the coalface of problems from abortion. I have seen a lot of problems over many years at a big hospital, so I can tell you from my own personal experience, rather than from textbooks or talking to people, that there is no doubt that medical complications after abortions increase with the gestation of the pregnancy, and it is not just after 20 weeks that the medical risks rise. Even after 14 weeks I have seen major complications. I also see the psychological trauma that it brings about.

In 2005 the *Weekend Australian* quoted the AMA Queensland President at the time, Dr David Molloy, who is also a gynaecologist in Queensland. He is also the President of the National Association of Specialist Obstetricians and Gynaecologists, and he was reported as saying that late terminations should only be performed in public hospitals, on medical grounds, for the sake of women's safety. These procedures do represent a very significant danger for women. He said, 'These procedures do represent a very significant danger for women and should be performed with full hospital facilities.' Dr Molloy was responding to revelations by the present director of gynaecology at the Royal Brisbane and Women's Hospital—that is, me—about the series of major and life-threatening injuries sustained by women having late abortions in the surrounding clinics. Dr Molloy said, 'Abortions after 20 weeks are dangerous for women and should only ever be undertaken in a public hospital for medical reasons.'

Dr Molloy's position reflected that of the Queensland branch of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which said, 'There is absolutely no justification for termination of pregnancy after 20 weeks by anyone other than a recognised specialist.' The Senate and the federal government cannot control the registration of clinics, but what little they can do is to block subsidies for such unjustifiable and dangerous procedures and to urge the states to follow their lead by limiting any such late-term abortions to public hospitals.

CHAIR—Thank you very much.

Senator BARNETT—Chair, could I could get a clarification through you from Dr Baartz. He has made a confidential submission. His appearance today is obviously on the public record and alerting Dr Baartz to that point may be of merit.

CHAIR—I was just going to remind committee members that in fact Dr Baartz's submission is confidential and therefore there should be no reference to the information contained therein. I was going to ask whether or not you are happy to go ahead in the public forum or whether you want to go in camera to give any evidence or take any questioning.

Dr Baartz—I am sorry; I am not sure what—

CHAIR—You have asked for your submission to be kept confidential, which means that committee members cannot refer to your submission in the hearing because it is public, so I was seeking to clarify whether or not you want to go in camera for the evidence that you give or whether you are happy to go ahead in public as it is now. The hearing is being broadcast as we speak, and it will become public record. So I want to ensure that you are comfortable with that.

Dr Baartz—That is fine.

CHAIR—You are happy with that?

Senator BARNETT—And what about your submission?

CHAIR—You asked for your submission to be considered confidential, which means that committee members cannot raise or quote anything out of your submission. Do you still want it to remain confidential?

Dr Baartz—My only concern was that my experience with some abortion providers in Queensland, if I can use that term, has been very uncomfortable—that they are very litigious people. That has been a concern of mine.

Senator BARNETT—But can we—

CHAIR—You are covered by parliamentary privilege.

Senator BARNETT—Can we make your submission public? That is the question.

Dr Baartz—Yes.

Senator BARNETT—Then you need to tell—

Dr Baartz—Yes. It is fine to make that public.

Senator TROETH—It is too late, with respect, Madam Chair, in the sense that Dr Baartz has already given his name on the public record which is being broadcast.

CHAIR—But he can then choose to go in camera to give evidence—

Senator TROETH—He can.

CHAIR—as is the case in question.

Senator CAMERON—I have a point of order.

CHAIR—Can I just finish what I was saying, and then I will take your point of order. My understanding, having just been through this over the previous three days, is that somebody can identify themselves on the public record and then choose to give their evidence in camera. They can do that. So I am asking whether or not you want to go in camera.

Dr Baartz—What is the significance of in camera?

CHAIR—In camera means that it is not made a public record. It is a private session.

Dr Baartz—Yes. Well, that is how I would like it.

CHAIR—Okay.

Evidence was then taken in camera but later resumed in public—

CHAIR—Just so that people are fully aware of this, we have time restraints because not only some of the committee but also some witnesses have flights to catch. We are running a bit behind. I intend to finish promptly at 3.40 pm with Dr Knight—if we finish early, that is a bonus—before we go on to our final witness. Welcome back, Dr Knight.

Dr Knight—Thank you.

CHAIR—Could we go on to questions. Senator Barnett.

Senator BARNETT—Thank you, Dr Knight, and thank you for your submission to the committee and your opening statement. Focusing on the item number and, in particular, gross foetal abnormality, what is your understanding of 'gross foetal abnormality'? And, secondly, what do you think, in terms of how it is being administered by others: is it ambiguous, confusing, vague? Is it broadly understood? Or is it more particularly understood? So I would like a bit of a response to that particular part of item 16525.

Dr Knight—I think it is probably a bad term and I think it is capable of being misunderstood. My understanding of it is: it is a lethal foetal deformity or a deformity of such magnitude that it would prevent a human being from leading a normal life. That would be my understanding of the word 'gross'. I can see how it could be misinterpreted or misunderstood, and I would think that perhaps a better term should be found. But that is my understanding of it.

Senator BARNETT—I want to go now to your understanding of the process for a late-term abortion at 20 weeks plus. Can you describe the different processes—you are an expert in the field—as to how it is undertaken?

Dr Knight—It is really extremely dangerous to attempt to terminate a pregnancy after about 15 or 16 weeks by dilatation and curettage. That certainly is and has been done, but it is extraordinarily dangerous for the woman. There are risks of tearing the cervix, risks of perforating the uterus, risks of haemorrhage, risks of shock—these sorts of things unquestionably occur if you attempt this kind of procedure.

It is much safer for the woman, if you have to terminate a pregnancy after 14 weeks, to induce a labour of a sort and have the foetus expelled and then try to deliver the placenta afterwards. If the baby is expelled and you have to deliver the placenta separately then curettage is a lot safer because you are not dealing with large foetal parts.

The processes these days usually involve the administration of a hormone, and there are a variety of hormones that are used—misoprostol, cervagem and so on—the idea being to soften and dilate the cervix to induce uterine contractions and expel the baby. In the presence of a dead baby, that is something that pretty much all gynaecologists do and I certainly do myself. I have certainly performed lots of curettages on women who have had an intrauterine death up to about 14 weeks but I honestly would not be game to do it after about 14 weeks because of the enormous risks involved. Such terminations really need to be done in proper facilities, with intensive care units and blood transfusion services freely available, because they are so dangerous.

Senator BARNETT—Just on that point, in terms of 16525, of the total number there are about 700 or 800 every year. How many of that number would be intrauterine death?

Dr Knight—I would say probably not a great deal but I am speculating. The problem, to be honest with you, is that the vast majority of dilatation and curettages beyond 14 weeks are done in public as opposed to private hospitals because, when women are having a miscarriage or an intrauterine death, the vast majority present to, or are referred by their GPs to, accident and emergency departments, so these procedures are done in the public system. In the private system, which is what you are referring to, I would say it would be unusual.

Senator BARNETT—A very small number?

Dr Knight—A very small number, yes.

Senator BARNETT—Going back to my original question, what is the process for a late-term abortion of 20 weeks plus?

Dr Knight—If anyone is doing abortions beyond 20 weeks and not inducing labour as the method by which they are doing it then they are putting the women's lives very seriously at risk. They are certainly putting the women's lives at risk if they are doing them in a small clinic which does not have all the facilities of a major hospital.

Senator BARNETT—With the inducing labour approach, just to get clarity around that, we were advised yesterday by Professor Ellwood from Women's Hospitals Australasia that in and around 24 weeks there is the injection of potassium chloride into the heart to kill the baby and then there is an induction of labour. The other approach prior to that was simply to induce labour, and then the baby was born and subsequently died. He said that it sometimes took a very short time and sometimes took up to two hours or so. Is that your understanding—is that correct?

Dr Knight—Yes. When labour is induced between say 20 and 24 weeks many of the babies are born dead. Some of them are born alive, that is true, and they struggle for life. In most instances when that has happened, they are given some kind of palliative care to try and ease their suffering as they die. We are not totally inhuman when this happens. But, whether that is

done in abortion clinics, I have no earthly idea. Certainly, in the public hospital system where I work, we would attempt to ease the suffering of these babies as much as possible.

Senator BARNETT—How is that done?

Dr Knight—You might administer a drug like morphine or fentanyl, something that you would give to a terminal cancer patient.

Senator BARNETT—Is that distressing for the medical practitioners?

Dr Knight—I would think so; it certainly distresses me. More than once I have seen 16-, 18- or 20-week babies lying in a kidney dish struggling for life. I have seen that a number of times. What amazes me is that a lot of people who are in this debate, just talking off the top of their heads, have never actually seen or experienced what goes on. I have, and there is nothing more heartrending than seeing a little human being struggling for life and not being helped and knowing that there is no way this baby is going to survive. It is dreadful.

Senator BARNETT—So is it accurate to say that the babies are born and left to die?

Dr Knight—Yes.

Senator BARNETT—Thank you.

Senator MOORE—In terms of the process, particularly under the Medicare item, are you aware of the options that people have in terms of reporting knowledge of poor practice or concern about poor practice?

Dr Knight—Yes.

Senator MOORE—Have you ever had cause to do that?

Dr Knight—Yes.

Senator MOORE—In this area?

Dr Knight—Not in this area. I have in other areas.

Senator MOORE—What I am trying to find out is whether, if someone is troubled by something that goes on in the medical area, the knowledge of what to do about it is well known so that people know how to complain under the Medicare system. Also, if you had a concern as a practitioner about the behaviour of another practitioner, is there a process that you can follow?

Dr Knight—Absolutely, and we follow these processes all the time. One of the things that I am apart from a clinical practitioner is a teacher.

Senator MOORE—I thought you would know, but I thought to be fair I should ask.

Dr Knight—That is fair enough. I am assessing fellow practitioners, particularly trainees, all the time. Certainly there are stringent protocols in place for dealing with difficult issues. I deal with that all the time. If a specialist colleague is performing in a way such that there are serious concerns, there are processes for that. I have been involved in those processes as well, so I am well aware of them.

Senator MOORE—Thank you.

Senator CAMERON—You indicated that you are a teacher and trainer. Have pupils of yours graduated both into the public system and into the private system?

Dr Knight—As far as I am aware, yes. You tend to lose contact with people, but I believe so.

Senator CAMERON—Could some of your students be working in clinics?

Dr Knight—I suppose that is possible. I am just not aware of it.

Senator CAMERON—Hypothetically, if they were, would you consider that they have had a good training?

Dr Knight—The training that I do is in the specialty of obstetrics and gynaecology. I am well aware of the fact that those who graduate under the college program are well trained and, for the most part, very good practitioners.

Senator CAMERON—Even though you have not trained them, lots of these graduates could be in private clinics performing terminations.

Dr Knight—That is true, though I understand that many of the terminations are being done by general practitioners who are not actually trained as specialists.

Senator CAMERON—That is another question, isn't it?

Dr Knight—That is a totally different question.

Senator CAMERON—Thanks.

Senator TROETH—I want to ask you an extension of the answer that you gave to Senator Barnett when he asked you whether these babies were left to die. To be born or induced at the gestation period that you mentioned, they are going to die anyway, are they not?

Dr Knight—Yes.

Senator TROETH—That is correct—I just wanted to clear that up.

Dr Knight—That is true. They are going to die anyway.

Senator TROETH—In your submission, you say:

There is no evidence that any such safeguards—

as you have outlined in public hospitals—

exist in the private sector.

I do not want to put words in your mouth, but are you saying that some practitioners in the private sector are acting illegally or unsafely?

Dr Knight—The Medicare item number as I understand it means that to use that item number you would have to have a baby that has a significant lethal foetal deformity or the woman's life is genuinely at risk. If the woman's life is genuinely at risk, what on earth is she doing in a small clinic that does not have an intensive care unit and all the other facilities that are necessary to handle this? I have had to terminate pregnancies of around 24 weeks where the woman is so seriously ill that, had we not done so, she would have died within 24 hours. I cannot imagine that we could have done that without the facilities of a major institution. So it is patently absurd to suggest that the terminations that are being done in clinics for this reason could be done, because they do not have the facilities.

Senator TROETH—But there are large private hospitals in some capital cities which would be able to provide a similar service to the ones provided in public hospitals.

Dr Knight—A lot of the large private hospitals are actually run by religious institutions, as you are well aware.

Senator TROETH—I understand that.

Dr Knight—Of the others, I am not aware of them doing late-term terminations. My understanding is that the vast bulk of late-term terminations are done in the public system. The ones that are done in the private system, the ones that we have been talking about, are generally done in clinics not in hospitals.

Senator BARNETT—In terms of the late-term abortions, post 20 weeks, we were advised yesterday by Professor Ellwood that they would die within a short time—up to two hours. Is that your understanding? What is normal? Is it two hours? Could it be more than two hours? Can you answer that?

Dr Knight—I think that is a very arbitrary figure. The vast majority of babies that are born before 24 weeks will die within two hours. That is just what happens. They do not have the lung capacity to enable them to survive, and I would think it would be surprising if they lived beyond two hours. Of course, much later than that might be a totally different story.

Senator BARNETT—In and around that time—22 weeks, 23 weeks, 24 weeks—what if there was medical intervention following the birth? Could they live longer?

Dr Knight—Yes, they probably would, but that would require ventilation and I very strongly suspect that nobody in their right mind would attempt to ventilate a baby under 24 weeks.

Senator BARNETT—But, if attempts were made to keep the baby alive? We know from evidence that a baby can be kept alive and thrive and prosper—I think, with the baby from Florida, it was 21 weeks and six days. What is your response to that—if intervention was taking place?

Dr Knight—If you have a look at the very simple statistics: survival at 24 weeks is about 35-40 per cent, but the vast bulk of those babies end up with very serious problems. For babies under 24 weeks, survival could be regarded as a genuine miracle, I suspect. But the vast majority of those babies that do survive under that gestation have pretty serious lifelong problems.

Senator BARNETT—Sure. But what is the survival rate at 24 weeks—around about?

Dr Knight—About 40 per cent. But that is not 40 per cent without problems.

Senator BARNETT—Indeed. But 40 per cent, with intervention obviously, can survive.

Dr Knight—With intervention, yes.

Senator CAMERON—I think he may have answered it. Because, at 21 weeks, to use the description 'thrive and prosper' is not accurate.

Dr Knight—No.

Senator CAMERON—I just want to come back to the point 'left to die'. It is a very emotive phrase that has been bandied around quite extensively at this committee. As a doctor, a trainer and a teacher, you do not simply leave foetuses to die in that emotive manner. Are there processes and procedures that are undertaken? What is the process and procedure? Is 'left to die' an accurate description?

Dr Knight—Well, it is, simply because there is nothing else you can do. The only thing you could do is to provide some form of palliative care, and I certainly would want to do that if a baby appeared to be surviving longer than a few minutes, yes. But 'left to die' is probably reasonably accurate.

Senator MOORE—Is that the term you use in training?

Dr Knight—Probably not, no.

Senator MOORE—What term would you use in training?

Dr Knight—I would probably use the term 'palliative care'. That seems to be what most neonatologists use. In essence, palliative care means doing what you can to keep somebody comfortable, knowing the inevitable is going to happen. And that is what we attempt to do.

Senator MOORE—So, with the people who are learning, the practitioners and the nurses coming into the area, that is the terminology used in working with them.

Dr Knight—That is the terminology that we would use. But I emphasise that that is in our proper institutions.

Senator CAMERON—On this point: the baby is not left in a broom cupboard somewhere to die—

Dr Knight—No.

Senator CAMERON—with people walking away, turning their backs on that baby. What is the process?

Dr Knight—Generally speaking, the babies are wrapped up. It depends on the mother's wishes. Obviously, if pregnancies are being terminated because the women are seriously ill, many of the women are going to want to cuddle the babies and say goodbye to them. Quite clearly, we would wrap them up and give them to the mother and father to help that. There are very few terminations that we do that the mothers are happy with. We terminate pregnancies in the major public hospitals because the mother is seriously ill or the baby is already dead or has a deformity and, if it did not have the deformity, the mother would not want the termination. So in our setting it is a bit different to termination clinics where women go requesting a termination. For us, we are the ones suggesting it to them because of these serious problems. We would probably wrap these babies up, give them as much care as we can to avoid their suffering and let the parents say goodbye to them.

Senator FIFIELD—Just a point of clarification—

CHAIR—Can I just ask that this is the last point of clarification.

Senator FIFIELD—Sure. Further to Senator Barnett's questions which elicited the response that the baby is left there and that 30 per cent born at that time could survive, saying that gives the impression that this is an otherwise healthy baby. We are talking about circumstances here where the pregnancy is being terminated because the child has some serious problems already or because the mother's health is at risk.

Dr Knight—Yes.

Senator FIFIELD—If there were a chance of the baby surviving anyway, all steps would be taken to help them survive.

Dr Knight—That is my whole point. In the setting in which I work, that is what we do, but that is not what is done in the private abortion clinics. That is why I am arguing that this funding should be maintained in the public system but withdrawn from the private clinics where this kind of thing is not being done.

Senator FIFIELD—Sure. I just would not want there to be the impression left that in your institution you have children who are born who could otherwise be assisted in some way.

Dr Knight—No, that would never happen.

CHAIR—Thank you for your submission, for appearing before us today and also for your patience this afternoon.

[3.33 pm]

TIPPETT, Dr Christine, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists

CHAIR—I welcome Dr Tippett from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 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 ask questions.

Dr Tippett—Thank you for the opportunity to give evidence at this inquiry into item 16525 in part 3 of schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007. I am appearing on behalf of the fellows and members of my college and the women for whom we care. I would like to make it quite clear from the outset that we strongly oppose the removal of item 16523 from the Medicare Benefits Schedule. Given that the total cost of benefits paid under this item number in 2007 was $113,132 for 540 procedures, the cost savings if this item number were to be removed would be trivial and are clearly not the motivation for this proposal. Clearly the intention is to limit access to mid-trimester terminations of pregnancy in the private sector, presumably with the expectation that this would reduce the number of mid-trimester terminations undertaken.

If a motion to remove item 16523 from the Medicare Benefits Schedule were successful, it would make no difference to the number of abortions undertaken at later gestations but would be discriminatory and have a number of adverse impacts on the women for whom we care in the public health system. Making abortion difficult to access does not reduce the number of abortions undertaken. If the proponent of this measure wishes to reduce abortion then he should advocate strongly for better sexual health education in our schools and make contraception easily available. That is how one reduces abortion.

Parliament should be concerned primarily with maternal health outcomes associated with these services rather than purely economic or emotional moral issues. The proposed motion reflects a number of things: a lack of understanding of the procedures around this item number, a disregard for the health and emotional needs of women and their families and an attempt to override the well-established processes involved in determining the services included in the Medicare Benefits Schedule which are rigorous and evidence based.

If this proposal were to be successful, it would set a most disturbing precedent. It is using the federal parliament inappropriately to impose restrictions on access to financial support for a procedure which is both lawful and clinically relevant. The effects of disallowing this item would be several. Women would face higher costs for services if they wished to continue under the care of a private practitioner who was already very well known to them and had cared for them in previous pregnancies. If women could not afford to use the private system, they would seek late termination in the public system and place pressure on public hospitals which are already stressed and under-resourced. These women are very often already in great emotional stress, and I think this is quite inappropriate. Women are likely to experience delays negotiating

the system while seeking the public hospital services they require at a time when they are very distressed and vulnerable. Poor health outcomes both psychological and physical would result from the increased stress placed on women and this would add to the burden on other health services. Families would inevitably suffer due to loss of income as well as travel and child-care expenses. Delays could have adverse health outcomes, especially in the presence of infection, antepartum haemorrhage and pre-eclampsia.

Indigenous women and women living in rural and remote communities would be especially disadvantaged, with the problems already noted added to their acknowledged geographic and financial disadvantage in accessing termination of pregnancy services. Women would also experience added distress knowing that they had paid the Medicare levy from their own and partner's wages only to be denied benefits for a legal and medically indicated procedure.

The basis of payments made under the MBS schedule are, in accordance with the Health Insurance Act 1973, as a service rendered by a medical practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered. The law applicable to abortion is a state based jurisdiction and not the province of the federal parliament. Senator Barnett may disagree with state laws, but using federal parliament to try and prevent women accessing benefits for clinically relevant services in the management of mid-trimester pregnancy cannot be supported.

CHAIR—Thank you. Before I go to other committee members, I would just like to clarify some points out of your submission if I could. In relation to the reference in your submission and your opening statement, you refer to Indigenous women and women living in rural and remote communities that would be specifically or especially disadvantaged. Can you give me some figures about women from rural and regional Australia and Indigenous women that have accessed this service?

Dr Tippett—I cannot give you those figures. We do know that these women already have difficulty accessing terminations of pregnancy and they already have to travel long distances. If it is not available in the private facilities then some of these women will need to go to large centres. Unfortunately in Australia, as I am sure you know, we do not have very good figures on termination. The 35564 item number is often used for termination of pregnancy but we do not have good figures as to the distribution. South Australia is the only state that has good figures on that.

CHAIR—In relation to the evidence and submissions we have had before us, there has been reference to Victorian figures that suggest that three babies' lives were terminated due to cleft palate. Can you comment on that? There has also been differing evidence and lack of definition of the terminations that can proceed under this item. Can you comment on those three Victorian babies that supposedly were terminated for a cleft palate?

Dr Tippett—I clearly cannot comment specifically on those cases because I do not have the information available to me. One does not know, from just that bland description, how serious these problems were, whether or not they were associated with any other abnormalities. Also, of course, in the state of Victoria it is now lawful, as it is in many other states, to terminate a pregnancy up to 24 weeks if certain conditions are met. So I think, in picking out a single abnormality and saying, 'Is this right or is this wrong?' one could go on about that forever.

The reality is that currently in Australia 80 to 90 per cent of women have a mid-trimester ultrasound scan which is funded by Medicare. They do that on the expectation that, if there is a foetal abnormality, they will have a choice to terminate the pregnancy or not to continue the pregnancy. Over 85 per cent of women have Down syndrome screening. This is provided and supported by federal and state government funding on the understanding those women may choose to terminate a pregnancy afterwards. On the one hand we are providing women with access to diagnostic imaging and to different diagnostic tests on the expectation that they will have a choice whether or not to continue a pregnancy.

It seems to me to be somewhat contrary to then say, 'We have picked up an abnormality. You have decided that for you and for your family this is a major abnormality that will adversely impact on your child and your child's life and you have decided to terminate the pregnancy. Sorry but we do not think that is right. We have decided that these abnormalities are okay and these are not—so we will fund some and not the others.' I do not think that is very logical.

CHAIR—Do you consider that a cleft palate is a major abnormality in a baby?

Dr Tippett—I do not think you can put it in those terms because sometimes it is a very major abnormality. If you saw some of the babies who have gross facial deformities with clefts that go up both sides of their nose and who have virtually no palate—these children, despite numerous operations, often have great difficulty making themselves understood. Their speech is unclear. It affects their schooling. It has huge emotional impacts on them for the rest of their lives.

It is not just a cleft lip or a cleft palate where you can perform some plastic surgery and everything is fine. That is why I say it is very difficult to pick three out and say, 'These shouldn't have been done.' I am saying to you that you cannot comment without further detail.

At the end of the day if we provide diagnostic imaging services to identify problems so that women and families can expect to have a choice to continue or not continue with the pregnancy, then we cannot put value judgements on them.

CHAIR—Thank you very much. I will now hand over to the deputy chair. My apologies for having to leave.

ACTING CHAIR (Senator Fifield)—Thank you, Chair.

Senator CAMERON—Dr Tippett, we have had a range of witness statements to the inquiry. How many members do you have?

Dr Tippett—We have 1,700 specialist members and with diplomates and specialists we have over 5,000.

Senator CAMERON—You would be the pulse of your specialisation across the country.

Dr Tippett—I would like to think so. We have our vision. Our purpose in life is to provide the best standard of health care for the women of Australia and New Zealand.

Senator CAMERON—Given that you have this widespread membership, have any of your members reported to you that there is cruel and gratuitous child destruction within the hospital or clinical system across the country?

Dr Tippett—I have had no such comments come to me. As you are aware in Victoria there has been a lot of discussion with regards to the Abortion Law Reform Bill and there has been no communication with me to that effect.

Senator CAMERON—Would you have any idea why we would have received evidence on that issue?

Dr Tippett—I am not sure about that. My fellows and members are working in this area all the time. They deal with it compassionately and well. I think some of the comments that are sometimes made are made by people who really do not understand or may not wish to understand exactly what happens in a clinical setting.

Senator CAMERON—We have also received witness statements to say that there are deranged adults simply coming up and getting an abortion.

Dr Tippett—I find that really quite dismissive.

Senator CAMERON—Can I get the proper call—

Senator BARNETT—I did not hear you, sorry, did you say 'deranged'?

Senator CAMERON—What was put to us was, 'Why should the public be forced to contribute money through Medicare for deranged adults to go to doctors to have such babies killed on demand by a method so cruel that you could not apply it to animals without prosecution'. That is before us. Would you like to comment on that?

Dr Tippett—Yes, I would like to comment. On the first part, it is almost as if people get pregnant just so they can have an abortion. Women go through a great deal of distress deciding whether or not to terminate a pregnancy. If a woman is 20 weeks, or 21 weeks, and her baby is kicking she makes a decision to have a termination with a great deal of distress and after a great deal of consideration. The idea that women do these things on a whim is, in fact, very dismissive of women and does not really understand the problems that they face.

I think there is a great deal of misunderstanding, too, about how pregnancy terminations and late pregnancy terminations are undertaken. There has been comment made and pictures shown—once again referring to Victoria—of procedures that I, in 30 years of practice, have never heard of being done. I had to inquire as to what they were because I was unfamiliar with them. I have worked for a long time in the public system. My practice is in the area of high-risk pregnancy, so I look after a lot of women who are extremely unwell themselves and who may need to terminate their pregnancies before the foetus is viable. I also look after a number of women whose foetuses are diagnosed as being abnormal and also parents who carry genetic abnormalities and who have antenatal testing to determine whether the child has a significant abnormality.

Senator CAMERON—Do you have any comment on the issue of psychosocial reasons for termination? Should that be removed as a reason for termination?

Dr Tippett—I think 'psychosocial' is a term that is obviously interpreted very badly. The women that we see, and the women I am aware of, who access late terminations for psychosocial reasons are women who are very deprived, socially and economically. They are often young women who are drug addicts, who have no permanent place of residence and who find out they are pregnant very late. They are not either physically or emotionally able to look after their pregnancy. We see young women who are in families where sex outside marriage is a religious taboo but who have become pregnant, and if the pregnancy continues they will be ostracised from their community. These psychosocial reasons are often very sad, very distressing and very real. They are not trivial reasons and they are not because somebody just wants to be unpregnant. Women do not do that and I think it is very dismissive, in fact, to actually consider that women would do that. I cannot say that never happens. Of course I cannot. No matter what procedure you use and whatever you are doing there will always be outliers and you cannot legislate or have laws to ensure they do not happen. But I think the vast majority of terminations done are done for very good reasons, and I think they are done compassionately and well.

Senator CAMERON—Thank you.

Senator MOORE—There has been significant evidence, both in the submissions and evidence to the committee, that draws comparisons between the circumstances in public hospitals and those in stand-alone private clinics. As you know, the Medicare item will mostly refer to people who are taking this option in a private clinic or a private hospital. Do concerns about different practices, different levels of professionalism and different processes in a private clinic, as opposed to those in a hospital setting, come before your college at times?

Dr Tippett—With regard to the hospital setting first, the women whose late pregnancies I terminate are my private patients but they are looked after in the public hospital because we share a public hospital labour ward. They are looked after by the same staff, but I am their doctor who cares for them. In some cases I have looked after those families and known them for several years or will see them again and continue their care. That is a model that I think provides women with a great deal of very good care.

I know a very large number of the practitioners around Australia. The private hospitals have their own processes and their own scrutiny, and private hospitals do not let inappropriate things go on. We have staff in private hospitals, just like in public hospitals. Things that are done in private hospitals have to be acceptable to the staff at that hospital and to the administration. It is not as if private hospitals perform medical procedures without any constraints—of course they do not.

In respect of the private clinics people talk about, the one that is probably very pertinent to these discussions is one in Victoria where, I am sure you know, there are a significant number of late terminations being undertaken.

Senator MOORE—We have heard of it.

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

Senator MOORE—We have heard concerns raised about the degree of preparation in private clinics and that counselling for the women involved and also offers of counselling later are not generally offered in private clinics. Have you heard that? I know you do not work in one, but in your role as a doctor and also in your college have you heard complaints that processes in the private clinics are not as professional as in a hospital setting or are too focused on getting the task done? That was raised in one of the submissions.

Dr Tippett—I would probably have to concede that. It can be the case. I know the clinic in Victoria has been asked to address those issues sometime in the past, but not recently. I am very aware of their activities. I sit on the Victorian Stillbirth Committee. All stillbirths come to that committee, including those cases that come from Croydon. It may be that the counselling is not as rigorous as it may be in a public setting, but I am not sure if that is really the question that is before this inquiry. We all like to think that, whatever the medical procedure being done, it is of the highest quality for a woman. We know not only with abortion services but with any other medical procedure that there will be procedures that are done in some circumstances in some settings by some practitioners that are done to a much better standard than others. That is the reality. In answer to your question, I think that there probably is some difference. But I think in fact the services provided in the Victorian clinic are of a very high standard. Why do I say that? I have very good connections within Victoria and I am unaware in the last seven years of any woman being transferred from that clinic with a problem related to her termination of pregnancy.

Senator MOORE—And that is the kind of thing you would know?

Dr Tippett—Absolutely. I can assure you that we have a very good grapevine.

Senator MOORE—If there are concerns about process, behaviour or doctors performing professionally, do doctors know the process of how to make a complaint? Also, is there knowledge within the profession of how the Medicare process operates? If there is any concern about what is happening in Medicare, do doctors know the process to make a complaint or to ask questions about that through the system?

Dr Tippett—First, in regard to whether doctors know how to make a complaint or make an authority or a body aware of processes that one of their colleagues is doing inappropriately, I think we all do. We all know that, first of all, there is always the hospital administration. That is sometimes the first port of call. It is clearly important that hospitals themselves have good governance processes in place so they take such complaints seriously and do not dismiss them. That happens sometimes. But we are not talking about terminations here; we are talking generally about how medicine is practised. Clearly there are medical boards which have a great deal of input in this area. As a college, we do not investigate complaints. That is not in our remit and we do not have the indemnity to do that. There are some areas we do look at with standard complaints but not complaints about somebody's professional behaviour. With regard to the Medicare process and how people do that, I suspect we do not know how a lot of doctors go

about doing that. They will find out if in fact Medicare sends them a letter saying that they have been billing inappropriately.

Senator MOORE—If they are the subject of the complaint they will find out.

Dr Tippett—That is right. Basically, we have the MBS item number book, and most of us know the numbers that we use very well. I suspect most of us do not actually know the descriptors that go with the item numbers. But the best item number that fits is the one that is used. That is the reality.

Senator MOORE—Although Senator Cameron has finished his questions, he has asked me to raise with you the issue of evidence you may have heard earlier that used the term 'left to die'. That has come up a couple of times during the last couple of days and in some of the submissions. From your position as a professional in the area, would you care to make some comment on the term 'left to die' and the circumstances around it?

Dr Tippett—I think it is a very unfortunate term, and I feel some disquiet that it has been used so generally here. If a pregnancy is terminated and the baby has the capacity to be born alive, and that can happen any time after 14 or 15 weeks, those babies will die if they are not given supportive care. As you get closer to 24 weeks they will take longer to die than if the pregnancy is terminated sooner.

Those babies will die from hypoxia because they cannot breathe, they cannot get oxygen to their brain and although we think there is no difference in the way foetuses or babies of this gestation experience pain, in fact those babies are hypoxic just like an adult who becomes hypoxic and effectively unconscious and unaware of what is going on around them. I think one can be confident that these babies do not suffer.

Secondly, where those babies are cared for will depend on the parents. Usually we tell parents that the baby may be born alive and if the parents say they do not want that to happen, the baby will be given an injection prior to or during the termination so that the baby is not born alive.

Senator MOORE—Is that the injection into the heart that we have heard about.

Dr Tippett—Yes.

Senator MOORE—That is that process, nothing different.

Dr Tippett—No. Parents are often given that option but a lot of parents, if they have gone through the process of an abnormality being detected, they have gone through a lot of counselling usually over several weeks and decided to terminate the pregnancy, quite often actually want to have some time with that baby be it alive or not. The babies are delivered; they are wrapped up. They are given to the parents if the parents want that if not they are put in a cot and we put them very safely in a room sometimes by themselves but that is probably not an unreasonable thing to do. I think it has to be acknowledged that this is a very difficult time for parents and for staff and these babies are looked after very gently. They are fragile little things and we all feel a great deal of compassion for all the people involved.

Senator CAMERON—They are treated with dignity.

Dr Tippett—Absolutely. In fact the midwives at my hospital go to great lengths to make the parents a small memorial book. Often they will take handprints and footprints, they write the name of the baby and they give them a beautiful memorial to take home. This is something that a great deal of time, effort, thought and care is put into and the concept that these babies are left to die is so far from the truth. I think that it is a great pity that it is a term that is used.

Senator MOORE—This is discussed with the parent.

Dr Tippett—Absolutely. These babies are desperately wanted by these families. I have had families who have been trying for a long time with IVF for instance to have a baby. Then they have a baby with an abnormality after 10 years of trying. This is an extremely difficult time for everybody. We do discuss it with the parents—if the baby is going to born alive it is essential that parents know that. I do not know whether or not what I am saying is applicable to other hospitals—I cannot see why it should not be, my hospital is no different from other hospitals. I think in Australia we are very fortunate in that we have a very high standard of health care and there has been a lot of effort since the early eighties by a number of not-for-profit organisations to raise the awareness of how to look after babies that are terminated. It is actually translated from stillborn babies that used to be whisked away and nobody saw them. There was a huge change in how that was managed and that has now translated to how these babies who are born very early for whatever reason are looked after.

Senator EGGLESTON—Addressing the terms of reference (c) the basis upon which payments of benefits are made under this item, we have heard evidence that mid-term terminations may be authorised by ethics committees or groups of doctors on the basis of fairly minor abnormalities such as extra digits or missing digits and cleft palates all the way through to very serious abnormalities such as anencephaly, severe spina bifida and conditions such as that. There seems to be, at times, a divergence of opinion or variation of opinion about what constitutes an abnormality gross enough to justify mid-term termination. I wondered what your college's view would be if we had national legislation providing for the rights of the unborn child. Would that provide a legal framework which might assist ethics committees and doctors responsible for drawing up reasons for the performance of mid-term terminations a sense of acting within the law and a sense of security about what they were doing in the sense of consistency across the whole country?

Dr Tippett—First of all, I do doubt very much that such legislation would achieve what you are hoping it would achieve. Secondly, I think the proposal to put in place legislation for the rights of the unborn child is extremely difficult. The main reason for that is that in many ways then puts the woman in a very difficult situation. There are some countries that are looking at this—and I know that Canada has some proposal on the table. The college in Canada are strongly opposing it, and we would strongly oppose it also. Basically it means that the mother loses her autonomy. So people outside the mother are telling that mother what she should do with her pregnancy. I find that an extremely difficult moral and ethical proposal that you are putting forward. I think that many people would agree with me with those comments.

The question you asked was: how do you decide what is a gross foetal abnormality? I cannot see how putting legislation in to look at the rights of the unborn child can translate to that—

obviously, that is something you have thought about—and cannot see how those two could be juxtaposed. The whole issue of how you define gross foetal abnormality is extremely difficult. It is not a good term. I think you could argue that the termination itself has to be lawful, and in fact it would be much more appropriate if this Medicare item number were available when a mid-trimester termination of pregnancy was done lawfully.

Foetal abnormality was discussed at length by the Victorian Law Reform Commission with regards to the new abortion bill in Victoria. It was so difficult to define what are gross foetal abnormalities or list the abnormalities that would be appropriate that it was decided it was not something to be included in that bill. That was for the reason I think people have struggled with here: what is a gross foetal abnormality? I cannot see how one would facilitate the other.

Senator EGGLESTON—I would like to pick up on one point you made and that is that the mother would lose her autonomy. That is exactly the point. It is not just the mother; it is also a child. We have heard plenty of evidence that post-24-week foetuses are capable of independent life. The whole point of legislation for the rights of the unborn child is to establish the autonomy and the separate rights of the foetus. I think that is a point which perhaps your college should think about.

Dr Tippett—We have thought about it. The foetus is not autonomous until it is born. The thought of bringing that in without a huge amount of consideration from the point of view of a women's rights issue is extremely problematic. Does that mean that the foetus that comes out whose growth is restricted because of hypertension can sue the mother when it is 30 because she smoked? The implications of such a thing are enormous. There is much written about this but I would not like to see the discussion go down that pathway.

Senator EGGLESTON—I think the foetus is alive whether its life support system is the mother or an incubator in a neonatal intensive care unit.

Senator RYAN—Can I clarify what you said then. You do not think there is a state interest in protecting the rights—for lack of a better term—of the foetus at any stage of pregnancy?

Dr Tippett—No, I do not. This is not an area that I have studied. Maybe I should have looked at it more before I came here today, but there have been problems where in fact the mother's rights have been overridden in law in both America and the UK. It is extremely concerning when the mother's wishes are overridden by a court of law. How do you then quantify when the baby's rights are greater than the mother's? Who decides that?

Senator RYAN—I appreciate the difficulty, it is just that I have not heard that over the last few days. I put to you and seek your response on the fact that that is a more radical position that I have heard in my study of this area and probably one that is not as widely supported throughout the community as a procedure might be at the 10-week mark.

Dr Tippett—I am sorry, I do not know what you are referring to when you say 'more radical position'.

Senator RYAN—The position that there is no state interest at any point throughout the pregnancy, the consequence of that being there could be a termination presumably at 37 weeks.

Dr Tippett—The question put to me was about foetal autonomy, and I was saying that I do not agree with the premise that that would be a good way to go. We have laws in our country that make termination of pregnancy lawful or unlawful, and I guess you could argue that when the termination is unlawful the woman's rights have been superseded by the law but not by foetal rights.

ACTING CHAIR—We are straying a little bit from the terms of reference here. Senator Barnett—and we will be finishing on the dot of 4.15.

Senator BARNETT—Yes, we are very tight, so I will try and whip through it. I would like to clarify one point on Senator Ryan's question. You do not believe that unborn children have any rights?

Dr Tippett—Within our system, no, they do not.

Senator BARNETT—In terms of the Victorian clinic you are referring to which you are familiar with, do they undertake partial birth abortions as far as you are aware?

Dr Tippett—I know they do not. This whole term 'partial birth abortion' is not a medical term. When I heard it being bandied around some months ago I had to ask somebody what it was.

Senator BARNETT—You were not aware of it?

Dr Tippett—I was not. Why would I be aware of it, because I have never seen it done, I have never heard it talked about and I have never been aware of it having been done. I think it is something that has got some space, but I am not sure. And I know that in the Croydon Health Clinic—and I can give you the figures—all the terminations done there for social reasons were all stillbirths. They do some terminations for foetal abnormalities. They were stillbirths. Partial birth—

Senator BARNETT—Okay, that is fine. I am just whipping through it. Now that you are familiar with it, are you aware of it being done anywhere else in Victoria or elsewhere?

Dr Tippett—No, I am not, and I have never been aware of it ever being done in the 30 years that I have been practising.

Senator BARNETT—In terms of the item number, I am getting a feeling that you think Medicare should pay for second trimester and even late-term abortions without having item number 16525 so long as it is lawful in that state or territory. You would prefer to do away with the item number? Is that correct?

Dr Tippett—No. I think the item number should be written so it is the same as the state law. So if a woman can have an abortion lawfully in a state, she should be entitled to get a rebate through the Medicare schedule.

Senator BARNETT—Exactly—that is my point. So you support paying for it so long as it is lawful within that state or territory?

Dr Tippett—Medicare paying for it?

Senator BARNETT—Yes.

Dr Tippett—Yes.

Senator BARNETT—Okay, good; thank you. How many private clinics are there in Australia?

Dr Tippett—I do not know how many private clinics there are in Australia. I know that the one in Victoria does a large proportion of late terminations of pregnancy and I think at last count something like 50 to 60 per cent of those were from interstate.

Senator BARNETT—Do you know then how many there are in Victoria?

Dr Tippett—There is one that does late-term abortions.

Senator BARNETT—Do you know how many there are in Victoria or could you take it on notice?

Dr Tippett—How many terminations there are?

Senator BARNETT—No, how many private clinics that undertake procedures under item 16525?

Dr Tippett—No, I do not know that.

Senator BARNETT—Is that something you might be able to take on notice and advise the committee of?

Dr Tippett—I could.

Senator BARNETT—The second part of that question is where are they? We are interested in locations. Are they in capital cities or outside capital cities.

Dr Tippett—I am not aware of any outside capital cities because I recently had reason to ring around all my colleagues in rural centres in Victoria to find out how easy or difficult it was for women to access termination of pregnancy services in rural Victoria and, firstly, it is difficult and, secondly, nobody told me of any private clinics. There is one and there are possibly two other ones in Melbourne, but we, the Victorian stillbirth committee, do not get any notifications for those for over 20 weeks and by law any foetus delivered after 20 weeks must have a birth certificate. So I think over 20 weeks Croydon is probably the only private facility where they are being done.

ACTING CHAIR—Senator Barnett, in terms of location, that is something we could put on notice with the Department of Health.

Senator BARNETT—That would be good, yes; no problem. I have two more questions, if I could. The definition of gross foetal abnormalities, which you referred to in your comments earlier: would they include, as far as you are concerned, dwarfism and Down syndrome?

Dr Tippett—Yes, they would.

Senator BARNETT—Thank you. Finally, do you support Medicare funding for third trimester abortions?

Dr Tippett—Third trimester abortions are extremely rarely done and people tend not to refer to them as third trimester abortions. They tend to refer to them as late abortions. So I said currently they are probably put in the same basket as 'late', although I know they are not mid-trimester. I think this is probably something that should be addressed with Medicare, that you have this disconnect between what is lawful and what is done and what Medicare pays for. You could argue yes, but you are probably talking about very, very few.

Senator BARNETT—I know. That is what I am asking. If it is lawful, you would say yes. Is that your response?

Dr Tippett—Yes, I think I would.

Senator BARNETT—Thank you.

ACTING CHAIR—Thank you very much, Dr Tippett. That concludes this public hearing of the Senate Finance and Public Administration Committee. Thank you to the witnesses who are in the gallery and thank you to the committee staff and officers of the Department of Parliamentary Services.

Committee adjourned at 4.10 pm