

Scientific Advice, Traditional Practices and the Politics of Health-Care

The Australian Debate over Public Funding of Non-Therapeutic Circumcision, 1985

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Australia is unusual among comparable developed nations in providing automatic coverage for non-therapeutic circumcision of male infants and boys through a nationally funded health insurance system. This is despite at least one attempt to drop circumcision from the schedule of benefits payable under the scheme (now known as Medicare), and it is surprising given that relevant health authorities have repeatedly stated (1971, 1983, 1996, 2002, 2004 and 2010) that ‘routine’ circumcision has no valid medical indication and should not generally be performed. Since public hospitals in most states do not provide the surgery, it has become the province of private hospitals, general practitioners and, in recent years, specialist clinics, whose activities are subsidised through Medicare.

Australian practice is thus very different from that in comparable countries. In New Zealand the government health service has never funded circumcision; and in Canada it is funded only in the province of Manitoba.¹ Even in the United States, where policy on Medicaid coverage is also the responsibility of the states, 17 out of the 50 have dropped circumcision from the list of free procedures, and more are likely to do so as fiscal constraints intensify.² The British National Health Service has traditionally not covered non-therapeutic circumcision, though in recent times has come under pressure from Muslim and some African immigrant groups, who argue that publicly funded circumcision of their male children is essential to prevent parents from resorting to the services of incompetent operators. In some areas local authorities do perform the operation as a free service, but the question is unsettled and the focus of controversy.³ In predominantly Muslim countries, where circumcision is performed as a customary or religious ritual, the state does not fund

1 And even there most doctors refuse to charge the state and insist that parents pay: see Manitoba Medical Association 2001, p. 6.

2 Craig and Bollinger 2006; Craig et al. 2001; Iglehart 2011.

3 Shah et al. 1999, Paranthaman et al. 2010.

the procedure through the public health system or any other government agency. A partial exception to this rule may be the mass circumcisions carried out by the Turkish army in Afghanistan and the former Soviet republics of central Asia, where the operation seems to have had neither medical nor religious significance, and was only a temporary measure following the dissolution of the Soviet Union.⁴ The traditional practice in Muslim communities is for boys to be circumcised between the ages of 6 and 10 in the course of a celebration organised by the parents; these events have no health significance, and the costs are met by the family.⁵ A similar policy prevails in Israel, where the government would no more think of paying for the Jewish rite of circumcision on the eighth day than it would subsidise the celebration of the boy's Bar-Mitzvah or the Feast of the Passover.⁶

In line with recent studies,⁷ I take the view that circumcision is a primarily a cultural phenomenon, to be understood in sociological terms, such as parental values and group expectations, not a simple 'precaution' to be explained in terms of its contribution to 'hygiene' or a child's future health. Although medically rationalised circumcision of male infants and boys arose in late Victorian Britain and enjoyed a limited vogue in English speaking countries, including Australia, for several generations,⁸ the practice has been rejected as medically unwarranted and ethically problematic by all the medical bodies that have issued a policy on the subject.⁹ This attitude may change as a result of the efforts of some health authorities to promote circumcision in certain African nations as a tactic against heterosexually transmitted HIV infection, but such considerations are irrelevant to the Australian situation in the 1980s.

One of the major objectives of the reforming Labor government which came to power in 1972 was to introduce a universal insurance scheme that would ensure affordable health care for all. The plan was strenuously resisted by the medical profession, the private health insurance companies and the Liberal (conservative) Opposition in the Australian parliament; they used their numbers in the second

4 Ozdemir 1997.

5 Abu-Salieh 1994, 2001.

6 Ben-Yami and Zoossmann-Diskin, personal communications; Zoossmann-Diskin adds that the Israeli Absorption Ministry used to have a policy of meeting the costs of circumcision in the case of Jewish immigrants who had not been circumcised but wished to have it done after arrival.

7 For example, Wallerstein 1985; Brown and Brown 1987; Gollaher 2000; Miller 2002; Waldeck 2003.

8 Darby 2001; Darby 2005.

9 These include the American Academy of Pediatrics, 1971, 1975, 1989 and 1999; British Medical Association, 2003 and 2006; Canadian Pediatric Society, 1982, 1989, 1996; Finland Central Union for Child Welfare, 2003; Royal Australasian College of Physicians, 2002, 2004 and 2010; Royal Dutch Medical Association 2010. Most of these statements are collected at <http://www.cirp.org/library/statements/> or <http://www.circinfo.org/doctors.html>. On ethics, see Svoboda et al. 2000; Hodges et al. 2002; Hellsten 2004; Fox and Thomson 2005.

chamber (the Senate) to block the legislation twice, thus creating the conditions for a double dissolution, fresh elections, and the holding of a joint sitting of both houses, where the bill was passed in 1974.¹⁰ The scheme, known as Medibank, reimbursed patients obtaining medical treatment (including circumcision) from doctors at 85 per cent of the scheduled fee, and provided free treatment in standard wards at public hospitals. Hardly had the system been set up when the government changed (in the bitterly fought election of December 1975), and the Liberals took office. Although they had promised to maintain Medibank, the new administration gradually reduced the scope and generosity of the scheme, and by the early 1980s the Labor Opposition had identified the revival of Medibank as a likely election winner. Labor returned to power in 1983, and one of its first moves was to establish a health insurance system along similar lines. Again there was furious opposition from the medical profession and the private health funds,¹¹ but this time their political allies were weaker, and the measure was carried. Under this scheme, known as Medicare, the Commonwealth medical benefit was set at 85 per cent of the scheduled fee, with a maximum gap of \$10 for any one service. Patients could either obtain a cheque and pass it on to the doctor along with their 'co-payment', or pay the doctor up-front and collect the refund from Medicare. Doctors had the options of charging patients more than the scheduled fee at the time of consultation, or of 'bulk-billing', in which case they received only the scheduled fee back from the government. Although the latter option has been discouraged in recent times, it remains popular among both clients and doctors, especially those with practices in low-income areas. The scheme is funded by a 1.5 per cent levy on taxable income.¹² Unlike the U.S. and Canadian schemes, the whole system is funded and regulated by the central (Commonwealth) government, and there is no direct financial contribution made or policy control exercised by the states. Although there has been endless tinkering with the details, the basic structure of this system remains operative today. In relation to the controversy over the funding of routine circumcision that broke out in 1985, the context to bear in mind is that the new system had only just been established after a bitter fight with the private health

10 The use of the double dissolution (calling new elections for both the House of Representatives and the Senate) and the holding of a joint sitting to resolve legislative deadlocks (as provided by Section 57 of the Australian Constitution) had occurred only twice before 1974 (in 1914 and 1951). See Reid and Forrest 1989, pp. 204–6.

11 As Gillespie (1991) shows, Australian medical practitioners have a long history of opposition to government regulation and other 'interference'.

12 There is a considerable literature on the Hawke government generally and the establishment and operation of Medicare specifically. I have been particularly guided by Sax 1984; Scotton and Macdonald 1993; Maskell 1988; Parliament of Australia 2003, esp. chap. 2; and submissions to this inquiry by Professor J.S. Deeble, 26 June 2003, and Royal Australian College of General Practitioners, 18 June 2003.

funds, the Opposition and the doctors, who were still far from happy with it;¹³ the last thing the government wanted was a row with the Jewish community. The fact that it got one helps to explain some of the features of the Australian situation today.

Although its own guidelines state that benefits are payable only for services that are clinically necessary, and although it is prohibited from funding circumcision-like operations on girls, Medicare continues to pay for non-therapeutic circumcision of male infants and boys.¹⁴ The Medical Benefits Schedule includes Item 30653 covering circumcision of a male infant under six months; in the 2009–10 financial year 20,246 claims were made on this item, at a cost of \$770,360.¹⁵ The policy of making these payments is all the more surprising given that paediatric authorities have repeatedly stated that there is no medical indication for routine (non-therapeutic) circumcision. The most recent policy statement (October 2010) by the Royal Australasian College of Physicians states: ‘After reviewing the currently available evidence, the RACP believes that the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand’.¹⁶ At the same time, Australia has reported a steadily declining incidence of neonatal circumcision (under 6 months) from about 25–30 per cent at the time of Medicare’s establishment to 10 per cent in the mid-1990s, suggesting that the continued availability of the rebate has not had as much effect on the popularity of the practice as might have been expected in the light of U.S. experience.¹⁷ These anomalies have prompted calls for the rebate to be dropped, on medical, financial and equity grounds,¹⁸ but the suggestions have not met with enthusiasm in government circles. One reason for this surprising indifference to a proposal with potential cost savings of up to \$24 million per year¹⁹ may be the memory of what happened

13 Daniel 1990, chs 7–9.

14 The Medicare website states that does not cover ‘medical services which are not clinically necessary’ or ‘surgery solely for cosmetic reasons’ <http://www.medicareaustralia.gov.au/public/claims/what-cover.jsp>

15 Calculated from data on Medicare website: https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml. It should be noted that this figure is the cost of the rebate alone, and that the real costs to the government will be considerably higher, given that there is likely to have been more than one consultation, anaesthesia is usually charged separately, and parents may be entitled to additional tax deductions for medical expenses associated with childbirth. The issue is too complex to be pursued here.

16 RACP 2010, pp. 5–6.

17 Wirth 1986; Cozjin 2004; Darby 2011. The incidence has increased to about 12 per cent nationally since then, though it also appears that nearly as many boys are circumcised between the ages of 6 months and 10 years, often on the basis of a questionable diagnosis of phimosis. See Spilsbury et al. 2003A and 2003B.

18 Rouse 2003; Phillips 2003.

19 Spilsbury 2003A, p. 613.

when, on the advice of the National Health and Medical Research Council, the rebate was withdrawn by the Hawke government in 1985; within a week, protests by Jewish and Muslim religious leaders forced the government into a humiliating backdown, and the decision was reversed.²⁰

The suggestion that routine infant circumcision offered no significant health advantages and should not, therefore, be funded by taxpayers through the public health system was not a new idea. Indeed, given the state of medical opinion in 1975 it is perhaps surprising that circumcision was originally included in the schedule of Medibank benefits. The *British Medical Journal* had repudiated the practice over 25 years before,²¹ and in 1970 a study at Adelaide Children's Hospital had found that most parents sought circumcision for social or spurious health reasons, that complications ran at 15 per cent and that 9.5 per cent of cases required a second operation to correct the faults of the first. The author recommended that 'hospital waiting lists be unburdened of unnecessary routine circumcisions, and that if parents request the operation as a social ritual, it should be done in private, not public beds'.²² Leitch's recommendation was supported by R.G. Birrell, who argued that 'the potentially lethal risks of neonatal circumcision surely make "social custom" as the indication quite unjustified', and that if the operation had to be performed it was better to wait until the child was 12 or 15 months old.²³ Another paediatrician backed up these proposals and added that it was the medical profession's duty to 'encourage a basic mood in the community that to be uncircumcised is to be normal'.²⁴ A decisive moment came in 1971, when the Australian Paediatric Association recommended that male infants should not 'as a routine' be circumcised,²⁵ and this viewpoint gained strength over the following decades. The context in 1985 was a rapidly falling rate of routine circumcision in Australia; concern at escalating health costs, prompting the idea that unnecessary surgeries like circumcision could be minimised; and a strengthening consensus that the operation was undesirable and that medical authorities should make more effort to discourage parents from requesting and doctors from performing it. Figures compiled by J.L. Wirth show that the incidence of neonatal circumcision had declined from 49 per cent of male births in 1973–74 to 39 per cent in 1979–80, and declined further to

20 In preparing this account I have been vitally assisted by the recollections of both the then Minister for Health, Dr Neal Blewett, and his principal advisor, William Bowtell, to both of whom I offer warm thanks. Although both Mr Bowtell and Dr Blewett kindly consented to be interviewed and spoke frankly, they bear no responsibility for the interpretations I have placed on the information they so generously provided.

21 BMJ 1949, p. 1458; 1979, p. 1163.

22 Leitch 1970.

23 Birrell 1970, 67.

24 Durham Smith 1970, 69.

25 Belmaine 1971, p. 1148.

24 per cent in 1982–83.²⁶ In 1978 a paper on the financing of health services suggested that, among other measures to contain costs, benefits for ‘least medically necessary’ services such as routine circumcision could be reduced or eliminated.²⁷ The last of the three factors was probably the most important: visiting Australia in 1982, Edward Wallerstein was told that a national campaign to reduce unnecessary surgery was planned, and that circumcision was high on the list.²⁸ In an official circular issued that year the NSW Health Commission pointed out that there was ‘no valid medical indication for circumcision in the neonatal period’, mentioned risks such as infection, meatal ulcers and haemorrhage, directed that hospitals not permit the circumcision of hospitalised infants, and stressed that parents seeking to have a boy circumcised must be given advice on ‘the nature, effects, advantages, disadvantages and risks’ of the operation.²⁹ Shortly after this, in 1983, the Australian College of Paediatrics reaffirmed its policy of discouraging circumcision in the male infant,³⁰ and it was these two statements which prompted the National Health and Medical Research Council (NHMRC) to take action.

Around the same time articles in medical journals revealed the direction in which the tide of professional opinion was running. In a critical review published in 1984, Geoffrey Hirst pointed out that although routine circumcision had once been common in English-speaking countries, it had nearly disappeared in Britain and was a rare procedure on a world scale: ‘The mere fact that this procedure has not gained universal acceptance ... is a telling count against its necessity’. Hirst argued that neonatal circumcision was inappropriate care and that doctors should try to dissuade parents from having it done, but he noted that controversy would continue until medical bodies took a more proactive role in educating the public:

Only when people have been educated to believe there is no medical justification for routine circumcision ... will the controversy subside. Until the campaign is directed through the lay press rather than solely in the consulting room, it is doubtful that rapid advances will be made.³¹

These words were prescient: the failure of professional and government bodies to communicate this message was a major factor in the debacle of July 1985. Hirst, a

26 Wirth 1982; Wirth 1986. Since these figures exclude mothers in private hospitals, private patients in public hospitals, parents who arranged the operation informally and any procedure where a rebate was not claimed, they are almost certainly an underestimate, though Wirth is correct to say that the rapid decline is evidence that Australia was abandoning routine circumcision. At its peak in the 1950s the incidence is thought to be somewhere above 80 per cent. On the rise of circumcision in Australia see Darby 2001.

27 Sax 1981, p. 23.

28 Wallerstein 1985, p. 124.

29 NSW Health Commission 1982.

30 Australian College of Paediatrics, 1983.

31 Hirst 1984, p. 20.

consultant urologist, was supported by two general practitioners, who commented that although there was continuing controversy over some aspects of circumcision, there was consensus on one point: there was no medical indication for its performance on infants. Although the authors noted that the incidence of routine neonatal circumcision (RNC) in Australia was falling rapidly, they found a disturbing level of ignorance and misinformation among family GPs as to normal male anatomy and the correct management of the immature penis, and a surprising degree of apathy on circumcision itself: of 101 doctors surveyed, only 39 were firmly opposed to the practice, 33 were in favour and 28 were indifferent.³² In 1985 Dr Brian Learoyd included routine circumcision in a list of unnecessary and over-performed surgeries. Citing the 1975 statement of the American Academy of Paediatrics that there was 'no medical indication for routine circumcision of the newborn' rather than the similar policy of Australian paediatricians, Learoyd deplored the high incidence of the practice in New South Wales and laid much of the blame at the door of the medical profession, which had not made adequate efforts to inform the public: 'It is highly improbable that such a large number of operations would be done if parents were put in full command of the facts, viz., that no medical benefit is to be gained'.³³ The increasingly anti-circumcision mood may be judged from the fact that in 1984 a radio talk on the history of circumcision in which the author referred to it as 'a great piece of nonsense' was printed in expanded form in the *Medical Journal of Australia*.³⁴ One may thus conclude that the assessment of routine infant circumcision as a procedure without medical value and which ought to be discouraged was not the opinion of a radical minority, but the consensus view of the Australian medical establishment.

It was thus entirely proper for the NHMRC to recommend that routine circumcision be dropped from the Medical Benefits Schedule. At a meeting in Adelaide in June 1983 the Council considered a report on RNC from its Medicine Advisory Committee and recommended that the Department of Health draw the attention of the Medical Benefits Schedule Revision Committee (MBSRC) to the Council's statement, namely:

The Council having considered the opinion of the Australian College of Paediatrics and the Health Commission of New South Wales was of the opinion that there is no medical indication for undertaking routine circumcision on newborn male infants, and that the hazards of the operation at this age outweigh any possible advantages.

32 Broadhurst and Davey 1984, p. 731.

33 Learoyd 1985, pp. 17–18.

34 Hackett 1984, 189.

The Council therefore asked the MBSRC to consider whether the rebate for RNC should be dropped from the MBS.³⁵ The Committee duly considered the proposal, and some time in the first half of 1985 the Department of Health sent a submission to the Minister for Health (Neal Blewett) containing a number of revisions to the schedule, including the deletion of circumcision, which he approved without much thought. As a spokesman explained later, circumcision of boys under six months had been under investigation by the College of Paediatrics for over two years, and its recommendation against the procedure had been made to the NHMRC in 1983, 'well before Medicare came in'. The NHMRC concluded that the hazards of circumcision at that age outweighed any possible advantage. With a certain rueful hindsight, the spokesman continued: 'The new ruling may prove a little controversial, but when the majority of the medical profession are against it, the ministry must act on their advice'.³⁶ According to Blewett's principal advisor, Bill Bowtell, there was little in the way of background papers accompanying the submission and no warning that the dropping of the subsidy might pose political risks and prove a hard decision to sell in certain quarters; the government was thus unprepared for the narrowly-based but vigorous opposition which arose.

The decision was to come into force on 1 July, and ten days later both the *Age* and *Sydney Morning Herald* ran small, but front-page, articles giving sympathetic coverage to the disapproving reaction of Jewish community leaders. The president of the Victorian Jewish Board of Deputies, Robert Zablud, 'denounced' the decision as 'an attack on the Jewish people' and warned that his community would 'do everything to fight this discrimination'. He said that the removal of the rebate might seem a small thing, but that it showed 'an attitude to the religious practices of the Jewish people. There is no way that circumcision can be forgone, irrespective of whether the Minister wants to save some money'. In Sydney the reaction was more moderate, the president of the NSW Board merely expressing disappointment that the government had not consulted the Jewish community, but adding that, although he did not consider the intent of the decision to be discriminatory, it had this effect because 'it discriminates against all Jews'.³⁷ The *Australian Jewish Times* (Sydney) did no more than report the decision, giving considerable space to the government's justification for it, and making no mention of Jewish objections at all.³⁸ It was hardly a thunderous outcry, but it was exactly the sort of reaction that might have been expected and against which the Health Department should have warned and prepared the Minister. Its failure to communicate clearly, its distortion of the NHMRC recommendation, and a series of coincidences, determined what happened next.

35 NHMRC 1984, p. 13.

36 Anon 1985A.

37 Carbines 1985A, p. 1.

38 Anon 1985A.

The first coincidence was that Dr Blewett was away and, in those distant days before mobile phones, could not be contacted. Responsibility for handling the issue thus fell to his principal advisor, Bill Bowtell, whose concern was to defuse the political fall-out as quickly as possible.³⁹ Although he was well informed on many public health issues, he had not been briefed on the circumcision proposal and was unaware of current medical policy in the area; he thus regarded the matter as trivial and sought not to defend the government's decision but to placate its opponents. The second coincidence was that the office next door to Blewett's was that of Barry Cohen, from whom Bowtell sought urgent advice. Cohen, a celebrated parliamentary wit and Minister for Home Affairs and Environment, was one of the most prominent Jewish members of the Labor Party, described by W.D. Rubenstein as 'deeply and consciously affected by his Jewish heritage'.⁴⁰ He pointed out that religious emotions on the issue would be strong, asked why it was necessary to disturb the status quo and advised that the decision be reversed. The third coincidence was the character and presence, in that old, cramped Parliament House, of the Prime Minister, Bob Hawke, whose close links with the Jewish community and sympathies with Israel were well known.⁴¹ Bowtell did not speak to him personally, but outlined the situation to a member of his staff and asked for direction; word came back in the form of a personal reference and folksy aphorism typical of Hawke's style: 'If it's good enough for me it's good enough for the MBS'. The fourth coincidence was the deadline for getting media releases out in time for the morning newspapers – about 5 pm. To mollify the critics Bowtell had to release a statement by then, and in Blewett's name he announced that the decision would be reconsidered by the MBSRC. Although there was no promise of reversal, everybody seem to have assumed that this is what would happen. Next morning Mr Zablud was delighted, a rabbi in St Kilda praised Dr Blewett's judgement and criticised the original decision as 'ill considered and too expeditious', and a lecturer in Islamic studies commented that he was 'heartened' by the review because 'Moslems believed circumcision was essential for religious and health reasons'.⁴² The following week the government announced that the rebate would indeed be restored, 'after an outcry from the Jewish community and intervention by the Health Minister', as the *Age* reported. According to the press release, the government had reversed its decision 'because of the possibility that circumcision might be performed by untrained people if removal of the medical benefit proved an economic hardship'. Dr Blewett added that he still believed that circumcision of young boys should be discouraged

39 For the details in this account I am indebted to the recollections of Bill Bowtell: personal interview, Sydney, 14 November 2003.

40 Rubenstein 1991, p. 301.

41 Rubenstein 1991, pp. 547–50.

42 Carbines 1985B, p. 3.

but that restriction of the rebate was not the appropriate way to do it.⁴³ What the right way might be was not revealed, and although letters on the matter from health ministers continue to state that the government believes that circumcision should be discouraged through education of parents and doctors, it has never launched or funded any programs with this objective.⁴⁴

Dr Blewett's absence was the decisive factor in these developments. When he returned to Canberra he was annoyed at the action taken in his name, and particularly upset that Bowtell's press release had pre-empted the possibility of other responses. Had Blewett been on the spot it is likely that he would have sought advice on how to defend the original decision and Bowtell would probably not have asked the opinion of Barry Cohen and the PM's office. Hawke's intervention was also crucial. He generally took a strongly collegiate approach to government, left policy decisions to the responsible minister and rarely interfered with the management of their portfolios,⁴⁵ and even in this case, where his emotional allegiances and personal experience were involved, he would have been open to argument. Had Blewett been able to discuss the issue with him it would probably have died down as soon as it was realised that the intent of the decision was not to place restrictions on Jewish or Muslim religious observances, but to discourage unnecessary surgery (with its costs and risks) in the wider community. The order and pace of events, however, conspired against such an approach, and by the time Blewett returned to Canberra he had received a phone call from the PM in which Hawke had told him that the decision must be reversed because it was arousing too much opposition from forces normally antagonistic to one another: 'You've united Jews and Moslems for the first time in a thousand years, and against us', Blewett recalls him saying (expletives deleted).⁴⁶ Looking back at the incident, Bowtell considers that his own reaction was precipitate and acknowledges that the Minister's absence was unfortunate. Although all the government players regarded the issue as trivial and the cost saving as not worth the political flak, he blames the Health Department for failing to warn the Minister that the decision would be controversial and neglecting to devise a strategy to manage the likely opposition. The upshot was the government made no attempt to defend the dropping of the rebate and reversed its decision with hardly a murmur: 'We ran up the white flag and capitulated without a firing a shot', Bowtell comments. The fact that the government did not investigate the policy in comparable countries overseas is in itself telling. The medical bodies which had made the original recommendation on the basis of the best available scientific evidence were themselves not consulted in the backtracking and had every right to feel betrayed by the government's haste.

43 Anon 1985C, p. 5.

44 Information from Mr Michael Glass, Ashbury, NSW; further details below.

45 Blewett 2000, pp. 391–2.

46 Blewett 2003.

It is thus wrong to see the reversal of the decision as a gracious response to widespread public indignation. The opposition was in fact quite limited: although Bowtell recalls some activity on talkback radio, the only newspapers to give space to the opponents of the measure and to report its rescission were the *Age* and the *SMH*, though the *Australian* and *Canberra Times* also picked up the statement that the decision would be reconsidered. There were no editorials on the issue, and the only comments in letters to the editor (four in the *Age*) or by columnists all supported the government's original action. The most significant letter was from the Professor of Paediatrics at Melbourne University, Dr P.D. Phelan, who congratulated the Minister for accepting the recommendations of the NHMRC and drew attention to the professional consensus that there was no medical justification for neonatal circumcision. He expressed concern that some groups were lobbying to have the decision reversed and commented that if parents wished to have infants circumcised out of religious conviction they should pay for it themselves; there was no reason why such procedures should be a charge on the national health budget.⁴⁷ A similar viewpoint was put more vehemently by a columnist in the *Sunday Times* (Perth) who roundly criticised those who expected the taxpayer 'to fund the religious practice of circumcision', even though it had been given 'a universal thumbs down by today's paediatricians'. He described circumcision as 'a cruel and unnecessary assault on the vital male organ', pointed out that the incidence of the procedure was now less than 30 per cent nationally and that many doctors refused to perform it, and he berated the Minister for caving in to sectarian pressure. From a surgical point of view, he claimed that circumcision should be classified with 'nose jobs, facelifts and breast implants', and urged the government to stick to its original decision.⁴⁸ These points were indeed relevant, but the fact that they never became central to such public discussion as occurred is another indication of the government's failure to set the terms of or even influence the debate.

The government's ability to defend its decision was compromised not only by the ineptitude of the Health Department, but also by a distortion to the NHMRC's recommendation which entered the process at some point. At first sight the complaints of discrimination seem rhetorical, for surely everybody who wanted to circumcise their boys was equally affected by the decision, not just Jewish parents. But in fact the objection of Dr William Wise that it was 'unfair to remove the benefit because they have allowed it for children over six months'⁴⁹ was perfectly justified. In the 1980s the MBS was technically a schedule to the Health Insurance (Variation of fees and medical service) (No. 37) Regulations; frequently updated, it gave the details of Medicare rebates, including the definition of the service and the amount payable. By the crucial amendment withdrawing the rebate for circumci-

47 Phelan 1985, p. 12.

48 Sattler 1985.

49 Harris 1985, p. 1.

sion – amendment 1985 No. 149, to come into effect on 1 July – the benefits payable for circumcision were defined as follows: ‘4319 – circumcision of a person under six months of age, where medically indicated; 4327 – circumcision of a person under ten years of age but not less than six months of age; 4338, 4345 – circumcision of a person ten years of age or over.’ It may thus be seen that there *was* discrimination against Jews, since the wording of the schedule maintained coverage for circumcision without medical indication in boys older than six months. The reversal of the decision was simply accomplished by amendment 1985 No. 207, to come into effect on 1 September, which deleted ‘where medically indicated’ from item 4319.⁵⁰

The path by which the MBSRC or the Health Department got this ‘under six months’ qualification is unclear. There was nothing authorising such a condition in the NHMRC recommendation, the advice in the NSW Health Commission circular of 1982, or the 1983 policy of the Australian College of Paediatrics. The circular warned against performing the operation earlier than four weeks and recommended that it not be done until the boy was at least a year old, while the ACP policy merely stated that if parents insisted on circumcision, it was ‘the responsibility of the medical attendant’ to recommend that the operation be performed ‘at an age and under medical circumstances that reduce the hazards to a minimum’. It is true that paediatric surgeons now recommend that circumcision should not be performed on boys of less than six months because of the pain and trauma involved and the impossibility of safe anaesthesia.⁵¹ But these guidelines were not issued until 1996, and there was no basis in the advice available to the Health Department in 1983–85 for providing a rebate for circumcision without medical indications in boys older than six months, nor for confining protection to those younger than six months. It is thus impossible to disagree with Rabbi Lubofski’s comment that it was ‘illogical to distinguish between a child under six months or over’;⁵² indeed, one wonders why the ‘where medically indicated’ tag was not simply applied to all age groups. It is true that the paediatricians leading the opposition to circumcision were particularly concerned at the risk of complications and other harm when the operation was performed neonatally or within the first 15 months. This message would appear to have been picked up by the Health Department officials, who then interpreted the NHMRC’s advice that there was ‘no medical indication for undertaking routine circumcision on newborn male infants’ as a recommendation to withdraw the subsidy from the existing code for infants under 6 months, but to make no change to the codes for other age groups.

50 Details can be searched at <http://www.comlaw.gov.au/Browse/ByTitle/LegislativeInstruments/Current#top>, but because the information is generated from a database it is not possible to give a specific URL.

51 Australasian Association of Paediatric Surgeons 1996.

52 Anon 1985E, p. 11.

However the six-month qualification came to be introduced it was an ill-judged refinement to the NHMRC recommendation that bears much of the blame for upsetting the Jewish community and sinking the whole proposal. Judging from the outcome and reports of the meeting between Health Department officials and Jewish community leaders in Sydney on 11 July, it was this particular means of limiting applicability of the rebate which caused offence. As Graham de Vahl Davis, President of the Jewish Board of Deputies (NSW) explained, the six month rule meant that if circumcision was performed under that age, no benefit was payable; 'since most Jewish males have the operation performed at the age of eight days, this presents a problem'. It appeared that in reaching the original decision the Minister 'did not fully appreciate the position of the Jewish community', and he was concerned 'at the apparent discrimination'. The decision of the meeting was that the Health Department would delete the words 'where medically indicated' from the schedule, and Professor Davis pronounced himself 'very pleased'. Whether it was the optimum outcome from a public policy perspective is not so clear. As reported in the *Australian Jewish Times*, the Health Department explained the reversal of its decision in a convoluted paragraph which betrays its awareness that other options were possible:

This was an inconsistency in that if no benefit was to be paid under the age of six months if there was medical indication, we realised there would have to be similar medical grounds over this age, so we decided to reinstate the rebate.⁵³

It was indeed true that if circumcision was to be performed on boys older than six months there should be a genuine medical indication, and it is not at all clear why the discrimination was not eliminated simply by requiring a genuine medical indication at all ages to qualify for the rebate. Another option would have been to make an exception for parents with conscientious religious beliefs, though there is little doubt that that the other approach would have been both simpler and more equitable. As it was, the government got the worst of all worlds: it enshrined the principle that it was acceptable for the health budget to fund both medically unnecessary procedures and the ritual practices of selected religions; it showed that it was prepared to ignore the advice of specifically charged professional bodies when faced with some minor political flak; and it ensured that an unknown number of boys whose parents were neither Jewish nor Muslim would continue to be circumcised for no valid reason.

The decision has cast a long shadow and limited the government's freedom of action on subsequent occasions. In 1996 it was reported that the Health Minister in the new Liberal administration, then in a cost-cutting mood, intended to include the circumcision rebate among a number of services to be dropped from the MBS,

⁵³ Anon 1985D, p. 1.

but that the plan was abandoned because other government figures feared that the move ‘would upset the wealthy Jewish community and the conservative Christian churches’.⁵⁴ The idea that there was a ‘backlash’ against Dr Blewett’s decision now seems to be embedded so deeply in the files and corporate memory of the Health Department that when a member of the public writes in to suggest a simple means by which money could be saved and boys spared a surgical alteration they may not want, they receive a reply like this:

The question of the continued payment of Medicare benefits for male circumcision has been considered on a number of occasions. In fact, a restriction was introduced in 1985 to limit benefits in respect of persons under six months of age to those cases where there was a medical indication. However, implementation of this decision caused a strong reaction from the community at large and the restriction was subsequently withdrawn. It was considered that ... male circumcision should be discouraged through better education and informed discussion rather than through ... the Medicare Benefits Schedule’.⁵⁵

Just about every statement in this letter is untrue: there was no ‘strong reaction from the community at large’; the intent of deleting the rebate was not to discourage circumcision, but to reduce unnecessary surgery and save money; and, as stated earlier, the Australian government has never funded any educational programs with the aim of discouraging circumcision.

Another puzzling feature of the episode, again suggesting failure of communication on the part of the government, was that both supporters and opponents of the original decision responded to it as though it was primarily, by intention or in effect, as an attempt to restrict the power of parents to circumcise their children, not as a measure aimed at reducing unnecessary surgery and containing the cost of the new and expensive Medicare system that had just been established after such a bitter fight. Dr Blewett himself seems to have seen it at least partly in these terms,⁵⁶ and a writer to the *Age* commented, ‘At last someone is doing something about surgical attacks on children. The sooner this horrible practice is outlawed the better’.⁵⁷ A Melbourne doctor criticised the *Age* for presenting the policy change as an anti-Jewish measure, pointing out that ‘the vast majority of unnecessary circumcisions are performed on the sons of gentiles of Anglo-Saxon origin’, and suggesting

54 Middleton 1996, p. 3.

55 Senator Kay Patterson, Minister for Health and Ageing, letter to Anthony Albanese, member for Grayndler (Sydney), 30 October 2002. Mr Albanese had inquired on behalf of a constituent, Michael Glass. I am grateful to Mr Glass, of Ashbury, NSW, for this information. Letters with almost identical wording were sent by the Department of Health to John Shanahan on 14 April 1993 and 11 April 1997; copies provided by Mr Shanahan and held by the author.

56 Blewett quoted in Anon 1985D.

57 Anon 1985B.

that restoring the rebate would mean that many boys other than Jewish or Muslim babies would continue to be circumcised.⁵⁸ And as we have seen, Jewish community leaders interpreted the loss of the rebate as an attack on their religious practices and implied that if it was not available they would be unable to perform their most time-honoured and sacred rite. As Rabbi Lubofski stated, 'circumcision is not an operation by choice. It is absolutely indispensable. ... Removal of the foreskin for a Jew is as essential surgery as the removal of an inflamed appendix'. Although one aim of the decision was indeed to reduce the incidence of circumcision by sending a hip pocket message to parents, such protestations seem either misinformed or disingenuous: there had been no suggestion that parents' right to circumcise boys would be restricted, merely that they would not receive a public subsidy for doing so. Jewish spokesmen who criticised the loss of the rebate did not claim that circumcision offered any health advantages, only that it was a religious obligation placed on parents. Denying that the removal of the benefit should be interpreted as an expression of anti-Semitism, Rabbi Lubofski said that because circumcision 'was carried out as a religious and not medical requirement, they presumably felt it did not warrant a medical rebate'. Despite this recognition, he believed that 'restoring the benefit was the right thing to do even though for the Jewish community the operation is not carried out for surgical but religious reasons'.⁵⁹ Lubofski's feelings are understandable, and evidence of the truth of Barry Cohen's warning, but he made no attempt to explain why a religious practice should be subsidised through the health budget. It is more likely that the question of religiously-motivated circumcision simply never occurred to the health department officials who drafted the original recommendations. If it had they might have handled the matter more tactfully.

Would the withdrawal of the rebate really have made any difference to ritual practices? The sum involved (\$24.50) does not seem so great that its loss would have deterred anybody who sincerely regarded the procedure as essential – as several Jewish leaders pointed out. Rabbi Apple, chief minister of the Great Synagogue in Sydney, said that although the new arrangements would disadvantage Jews, he did not think they were being singled out, nor that they would be deterred from having the operation performed:

Irrespective of changing fashion, Jews will continue to have their male children circumcised. Medical points of view vary from for, neutral and against. But none of these particular fashions affect Jewish practice. Jews will continue regardless of medical benefits.⁶⁰

If that was the case, one wonders what all the fuss was about.

58 Smibert 1985.

59 Anon 1985E.

60 Harris 1985, p. 1.

The fuss was related to touchiness about status and fears of discrimination – social, not religious, and certainly not health concerns. Despite the misleading reference to an inflamed appendix (Christian baptism would have been a more accurate analogy), Jewish spokesmen were generally in agreement with the twelfth century philosopher and physician, Moses ben Maimon (Maimonides), that circumcision should be performed strictly for faith, not for any material benefit. An article by a Jewish paediatrician published at the same moment as the Medicare controversy made the point that among Jews circumcision should be performed only for ritual reasons: there were insufficient ‘health benefits’ to justify it on any other basis.⁶¹ An article in the *Australian Family Physician* some six months later similarly stated that ‘Circumcision in Jewish life is a religious ceremony and should ... be performed by a Jewish doctor who has been trained to do it and will read the appropriate religious service and name the child’.⁶² It was not just a matter of getting rid of the foreskin as expeditiously as possible. Even Muslim doctors concurred on this point. Dr S.N. Khan, expressing ‘the official viewpoint of the Australian Federation of Islamic Councils’, explained that circumcision was ‘encouraged in Islam and widely practised by Muslims ... a tradition of the Prophet and an important ritual’. There was no mention of any parental duty to circumcise children, nor of the timing, nor of health benefits, and Dr Khan’s cool assessment of circumcision as no more than ‘encouraged’ contrasts sharply with his advice that ‘lesbianism, homosexuality, premarital sex and adultery are prohibited in Islam; they are a sin and a crime. Masturbation is generally prohibited’.⁶³ According to Khan, these errors were more strongly condemned than circumcision was approved, yet he is not on record as urging the government to outlaw or discourage such practices. Another point to consider is that Jewish sensitivities would have been particularly acute at this time because there were strong murmurings within their own community against the continuation of circumcision; the same issue of the *Australian Jewish Times* which hailed the restoration of the rebate reprinted a letter from the *Jerusalem Post* in which Israel Berkovitch complained of his persecution by co-religionists in England for having suggested ‘that we should stop cutting the flesh of Jewish babies in the circumcision ceremony without an anaesthetic’.⁶⁴ The anxiety of Jewish leaders in Australia over the Medicare issue might well have been related to fears that it would encourage sentiments such as these within their own commu-

61 Leiter 1985.

62 Levi 1986, p. 19; these comments were in accordance with the recommendations of Weiss 1962.

63 Khan 1986, p. 179.

64 Berkovitch 1985, p. 23; his article was published in the *Observer* (London), and became the subject of a complaint to the Press Council on the ground that it was ‘a racist attack on Jews’.

nity, not just that it signalled an unsympathetic attitude on the part of the wider society.

Conclusion

Recent arguments that the rebate for non-therapeutic circumcision of males should be dropped from the Medical Benefits Schedule in Australia are unlikely to be successful because the Commonwealth Government remains haunted by the memory of the public outcry which is supposed to have broken out when this was attempted in 1985. The purpose of this article has been to review the episode and assess whether such apprehension is warranted. My conclusions are that the original decision to drop routine neonatal circumcision from the schedule was justified on medical and public policy grounds; that there was no wide public outcry and, indeed, that the decision was widely approved; and that the rapid reversal of the decision was the result of inept implementation, failure to consult, and a fortuitous combination of subsequent factors, including, vigorous lobbying, by the groups who felt most deeply affected, the pressures of day to day politics and unnecessary haste on the part of the principal advisor to the Minister for Health. The adverse reaction of the Jewish community (and to a lesser extent the smaller Muslim community) was related to concern about their social status, possibly exacerbated by (unvoiced) fears that the dropping of the circumcision rebate would encourage liberal and reforming Jews to abandon the practice, or even that it represented the thin end of a broader wedge, foreshadowing the possibility that parental rights to circumcise their children would be restricted in the future. The strong reaction was certainly the effect of justified touchiness about discrimination and deep concern that the means by which the amendment to the MBS was executed meant that Jewish practice was singled out and thus treated unfairly. The government's failure to anticipate these reactions meant that it neglected to consult; and, in its haste to defuse minor political fallout, it was then unable to resolve the issue on an optimum basis that paid due regard to financial prudence, medical advice, the rights of ethnic/religious minorities, and the well-being and human rights of children. It is to be hoped that the negative lessons of this episode will be taken into account in any future policy reforms in this sensitive area.

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