Women's Health VICTORIA

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Religious Discrimination Bill – Exposure Draft

Submission by Women's Health Victoria, October 2019

Women's Health Victoria (WHV) welcomes the opportunity to provide a submission on the exposure draft of the *Religious Discrimination Bill 2019* (Cth) (the Bill).

WHV is an independent Victorian statewide health promotion, support and advocacy service. We advocate and build system capacity for a gendered approach to health that reduces inequalities and improves health outcomes for women. WHV is committed to a social model of health which focuses on addressing the social and economic determinants of health, including as freedom from discrimination and harassment, and equitable access to economic power and resources. Women's equality and women's sexual and reproductive health are key priorities for WHV.

Summary

While WHV supports reform to improve protections against religious discrimination for all people in Australia, we are extremely concerned that the Bill, as currently drafted, privileges the right to religious freedom over the rights of women and marginalised groups to be free from discrimination and to access health, employment, education and other services.

In particular, we are concerned that the provisions relating to conscientious objection by health practitioners have the potential to further restrict access to essential health services for women, including abortion. Safe access to abortion is good public health practice and plays an important role in supporting women's health, wellbeing and gender equality.

Our submission raises the following key concerns:

1. The Bill does not strike an appropriate balance between protection of religious freedom and protection against other forms of discrimination
2. Clause 8(5) and (6) would further restrict access to abortion in Victoria and across Australia
    a. There is already a significant level of non-compliance with the conscientious objection requirements under the Abortion Law Reform Act 2008 (Vic)
    b. The right to conscientious objection to abortion is already adequately protected in state law and policy
3. Clause 8(5) and (6) creates a general right to religious conscientious objection for health professionals that could have serious implications for patients
4. The Bill may pave the way for institutional conscientious objection to abortion
5. The Bill would limit the ability of employers to foster safe and inclusive workplaces and services

While the focus of our submission is conscientious objection, we also endorse the submissions of the Australian Human Rights Commission (AHRC), the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) and the Human Rights Law Centre (HRLC).

We note that the consultation period on the exposure draft was extremely short and has not enabled community members to make informed comment on the Bill, which has potentially far-reaching implications for anti-discrimination law. We recommend that further consultation be undertaken and include a range of materials in accessible language(s) and formats.

WHV's submission is endorsed by:

- Gender Equity Victoria
- Gippsland Women's Health
- Multicultural Centre for Women's Health
- Women's Health & Wellbeing Barwon South West
- Women's Health Grampians
- Women's Health in the North
- Women's Health in the South East
- Women's Health West

Key issues

1. WHV supports the intent of the Bill to improve protections against discrimination on the basis of religion

The Bill enacts federal protection against discrimination on the ground of religion. This brings federal discrimination laws into line with most state and territory laws that have provided this protection for many years.

In principle, WHV supports protections against discrimination on the basis of religion, including the prohibition on direct and indirect discrimination on the ground of religious belief or activity. For example, the *Report of the Religious Freedom Review* (the Ruddock Review) cited examples of discrimination against and abuse of women on the basis of religion, particularly Muslim women, demonstrating the compounding impact of gender-based and religion-based discrimination:

"The Panel was told that some women have been subjected to verbal and physical abuse on the basis of their religion, due to the fact they were easily identified by their religious dress. These incidents have often occurred in public areas, such as on public transport or in shopping centres. Similar incidents targeting adherents were reported with respect to a number of minority religions.

The Panel heard examples of the impact that such hostility has on people in the community. For example, some women from minority faiths reported that they do not feel comfortable being in public places for fear of being subject to abuse. Some individuals are reluctant to deal with government, non-government and commercial services, and avoid accessing particular public places and transport, and curtail their social activities and those of their children." (Report of the Religious Freedom Review, page 90)

It is critical to ensure that all women, of any (or no) faith, are protected from discrimination and abuse, and feel safe in their communities.

2. The Bill does not strike an appropriate balance between protection of religious freedom and protection against other forms of discrimination

Rights are not absolute and may be limited in some circumstances, including when they need to be balanced to protect and promote other rights, including to protect other groups from

discrimination.[1] While WHV supports protection for religious freedom in principle, the Bill does not strike an appropriate balance between the right to religious expression and the right to be free from discrimination.

The Bill elevates protection of religious freedom above other rights, including protection against sex- and gender-based discrimination and the right to access health services. Under clause 41, the expression of people's religious views would potentially override all existing protections against discrimination under federal, state and territory discrimination laws.

For example, as noted in the submission from the Australian Human Rights Commission (AHRC), *'discriminatory statements of belief, of the kind described in clause 41 of the Bill, whether they amount to racial discrimination, sex discrimination or discrimination on any other ground prohibited by law, would no longer be unlawful. The Commission considers that this overriding of all other Australian discrimination laws is not warranted, sets a concerning precedent, and is inconsistent with the stated objects of the Bill... [t]his provision seeks to favour one right over all others.'*

As further elaborated by the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) in its submission, *'in practice, this can mean religious people making statements of belief may be exempt from complying with other laws that non-religious people must comply with. This provision is likely to give licence to harmful and offensive statements in areas of public life.'*

WHV strongly urges the Commonwealth Government to amend the Bill to avoid limiting other human rights and overriding existing anti-discrimination laws. This includes removing clause 41. Whether or not religious statements of belief constitute discrimination on the basis of attributes such as sex, sexual orientation or gender identity, should be determined under existing anti-discrimination laws.

3. WHV has strong concerns that clause 8(5) and (6) would further restrict access to abortion in Victoria and across Australia

WHV is particularly concerned that clause 8(5) and (6) would further restrict access to essential health services for women, including abortion. This clause privileges the rights of health professionals with religious beliefs over the rights of women to make informed decisions about their reproductive health and options.

The duty to disclose a conscientious objection and to refer patients to another health professional who can provide the health service is vital in ensuring timely, unbiased access to healthcare and information. The UN's Committee on the Elimination of Discrimination against Women states that governments must introduce measures which ensure that women are referred to alternative health services if a health provider conscientiously objects to providing a service.[2]

Clauses 8(5) and 8(6) of the Bill would, in many circumstances, undermine the important duty for health practitioners to refer their patients to another health practitioner who can provide the service.

Clause 8(5) appears to preserve existing state and territory laws that allow a health practitioner to conscientiously object to providing a health service because of a religious belief or activity. WHV assumes this would include Victoria's *Abortion Law Reform Act 2008*, which provides for a clear

[1] See, for example, *Charter of Human Rights and Responsibilities Act 2006* (Vic), section 7.

[2] This is consistent with Committee on the Elimination of Discrimination against Women, General Recommendation 24: Women and Health, UN Doc A/54/38/Rev 1 (1999) [11].

statutory duty for health practitioners with a conscientious objection to abortion to refer or transfer care, and to perform an abortion in the event of an emergency.[3] However, the interplay between this clause and existing state and territory laws is unclear and is likely to cause confusion.

Concerningly, under clause 8(5) and (6), a 'health practitioner conduct rule' (that is, a condition, requirement or practice imposed on health practitioner that would restrict or prevent conscientious objection) which are not 'consistent' with the state or territory law, is deemed not reasonable and therefore constitutes unlawful indirect discrimination, unless the rule is 'necessary to avoid an unjustifiable adverse impact' on the ability of the person imposing the rule to provide the health service or on the health of the patient. What constitutes an 'unjustifiable adverse impact' is not defined.[4]

In the Victorian context, this means that if a government department, a health service or a professional body attempted to set standards or clarify the duties of conscientious objectors, and the policy or guidance were seen to be restricting the right to conscientious objection in a manner that is not 'consistent' with Victorian law, these 'health practitioner conduct rules' would be deemed unreasonable under clause 8(5). This would limit the ability of health services to put in place any policies or guidance that specifies how conscientious objection is to be managed within their health service to ensure adequate service provision. For example, the very useful guidance and checklist recently issued by Queensland Health would potentially be deemed unreasonable and unlawful. The Bill may also place constraints on future legislative reform in Victoria, for example if were considered necessary to amend the *Abortion Law Reform Act 2008* in the future.

In jurisdictions where the relevant abortion legislation allows conscientious objection but is silent on referral (as in Western Australia),[5] there is a real risk that a government policy directive requiring referral, in the interests of patient health, would be deemed unreasonable and unlawful because it is 'not consistent' with the legislation.

In jurisdictions where the right to conscientious objection is not defined in law, any policy-based directives regarding the right to conscientious objection – including existing codes of conduct for health practitioners (see section 5 below) – would be presumed to be unreasonable (and therefore amount to unlawful discrimination) under the Bill.

As noted by the HRLC, the presumption that a health practitioner conduct rule is not reasonable would only be displaced by an individualised assessment of each situation where compliance with the rule is sought. Accordingly, whether or not a health service can require its staff to comply with the obligation to refer would require an individualised assessment of the impact of enforcing the rule on the particular health service and on the health of the patient.

'This will create enormous complexity and uncertainty for health systems and health services in relation to the enforcement of rules and policies that require disclosure of an objection and referral.

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[3] The HRLC notes that 'it is not clear whether clause 8(5) would apply to conscientious objection to abortion in Victoria. Victorian abortion legislation does not specifically allow or create a right to conscientiously object, but it does require doctors to make a referral if they conscientiously object to providing an abortion.'

[4] Alarmingly, the Explanatory Notes say that death or serious injury would 'generally' amount to an unjustifiable adverse impact. As noted by the AHRC, 'the only conclusions that can be drawn from this are that not all adverse impacts on patients will justify rules that limit conscientious objections, and sometimes even the death of a patient may be insufficient… The Commission is concerned that this appears to countenance a wide range of possible adverse health impacts in the name of protecting the freedom of religion of health practitioners.'

[5] See *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(2).

It would essentially replace a consistent, reasonable state-wide policy with a case by case analysis. It would harm the ability of health providers to adopt and enforce referral policies that seek to ensure safe and timely access to health services for patients.'

The lack of clarity about the operation of rules and policies on conscientious objection would create uncertainty for both patients and health practitioners and may lead patients – particularly those who may have experienced stigma – to avoid or delay accessing essential health services. The impacts of delayed access to contraception and abortion are outlined in section 4 below.

WHV echoes the recommendation of the AHRC, VEOHRC and HRLC that clause 8(5) and (6), together with related clause 31(7), be removed from the Bill. Clause 8(5) and (6) undermines access to safe and inclusive health services, creates a risk of confusion among health providers seeking to comply with existing laws and policy directives and, where no state and territory conscientious objection laws exist, it introduces broad conscientious objection provisions without appropriate safeguards or regulation.

4. There is already a significant level of non-compliance with the conscientious objection requirements under the *Abortion Law Reform Act 2008* (Vic)

Section 8 of the *Abortion Law Reform Act 2008* (Vic) requires a health practitioner with a conscientious objection to abortion to inform the woman that they have a conscientious objection and to refer her to another health practitioner who they know does not have a conscientious objection. It also requires a registered medical practitioner to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman (and requires a registered nurse to assist).

Despite these clear legislative provisions, qualitative research shows that there is a significant level of non-compliance. Non-compliance occurs due to a mix of health practitioners not understanding the law and deliberate non-compliance or obstruction. A study conducted in 2015 involving interviews with abortion experts found that doctors had: directly contravened the law by not referring; attempted to make women feel guilty; attempted to delay women's access; or claimed an objection for reasons other than conscience. Use or misuse of conscientious objection by Government telephone staff, pharmacists, institutions and political groups was also reported.[6]

CASE STUDY: Women's experiences attempting to access sexual and reproductive health services in Victoria

WHV operates a statewide phone and information service for sexual and reproductive health called *1800 My Options*. *1800 My Options* has reported the following examples of women's experiences accessing sexual and reproductive health services:

- A GP in metropolitan Melbourne telling a woman seeking an abortion that the only assistance they would provide would be a referral. The referral was to an IVF clinic that does not provide termination of pregnancy (TOP).
- A woman in rural Victoria whose GP told her they would not assist her, and would not refer her on. The woman was then scared to approach another local GP, in case of similar treatment. The

[6] Keogh et al (2019) *Conscientious objection to abortion, the law and its implementation in Victoria: perspectives of abortion service providers*, BMC Medical Ethics 20:11. Available at: URL

woman could only find services 4+ hours away when using Google. She was provided with numerous local services by *1800 My Options*.

- A rural GP who advised a woman to wait at least two months before seeking abortion, stating that there is a 'high rate of miscarriage'. When the woman returned to the GP for follow-up as she had not miscarried, she was 12+ weeks pregnant and the GP informed her that they would not assist her. The woman was unable to access local services as she was beyond their gestational limit, and needed to travel 3+ hours for Melbourne services.
- A woman seeking medical termination of pregnancy (MTOP) early in pregnancy was told by her GP that they do not provide these services. The GP said that the only services available are private, and that they cost several thousands of dollars. The GP did not provide a referral for TOP.
- A rural GP who told a woman they would not assist her outside of ordering pathology and ultrasound, but ordered inappropriate tests that caused delays in accessing services. The woman was then scared to approach another local GP, in case of similar treatment.
- A GP in metropolitan Melbourne who told a patient 'we only help women who keep their babies', then showed her the door.
- A woman who had contacted nine clinics looking for an MTOP and then finally found *1800 My Options*. By this time she had exceeded the gestational limit for MTOP and the only option was a surgical termination which had financial implications.

Some general themes arising from calls with women asking GPs about access sexual and reproductive health services include:

- Women being told that abortion is unavailable in Victoria after 12 weeks' gestation.
- Women being given misinformation about MTOP – that it is dangerous, experimental or ineffective.
- Women encountering hostility, obstruction, misinformation and/or judgment from GPs, and this preventing them from seeking services elsewhere as they are scared of encountering this treatment again. This creates particular barriers for women who are young, located in a rural area, from a non-English speaking background, etc.

During visits to primary care providers, *1800 My Options* staff have found some clinics unwilling to provide MTOP, unwilling to refer and unwilling to promote the *1800 My Options* phone service even in the waiting room, despite this being another way for women to find the services they need.

Rates of conscientious objection are particularly high in some rural and regional areas. A 2017 survey of GPs and Practice Nurses in the Grampians Pyrenees and Wimmera regions in western Victoria showed that 38% of GPs 'sometimes' or 'always' referred women to a colleague because they hold a conscientious objection, with the proportion increasing to 62% for GPs trained overseas.[7]

In the context of high rates of conscientious objection in some regional areas, and the misuse of conscientious objection by some practitioners, it is critical that the Bill does not increase barriers for

[7] Keogh et al (2017), *Rural GPs and unintended pregnancy in the Grampians Pyrenees and Wimmera Regions*, Women's Health Grampians and University of Melbourne. Available from: URL.

women seeking to access sexual and reproductive health services. Delays in access to contraception can lead to unwanted pregnancies. Delays in access to abortion can lead to more complex and expensive terminations at later gestations,[8] being forced to carry an unwanted pregnancy to term, financial loss due to time away from work and costs associated with travel and medical expenses, and negative impacts on mental health. Further, if more practitioners claim a conscientious objection or do not comply with conscientious objection requirements, this also places additional pressure on providers who do provide these services within an already stretched workforce.

Rather than expanding the scope of conscientious objection for health practitioners, there is instead a need to enforce compliance with existing laws and policies on conscientious objection, to ensure that all women have timely access to essential, legal health services, particularly in rural and regional areas where there are fewer services available. As suggested by the HRLC, the Commonwealth Government should consider including a provision in the Bill that provides that stipulates that the obligation to refer in cases of conscientious objection is reasonable.

5. The right to conscientious objection to abortion is already adequately protected in state law and policy

There is no evidence as to the problem that clause 8(5) and (6) of the Bill seeks to rectify. Restrictions on the right to conscientiously object to providing health services were not raised as a significant issue in the Ruddock Review. There is only one mention of conscientious objection in the report.

There is no need for the inclusion of clause 8(5) and (6) as the right to health professional conscientious objection by health practitioners is already in operation across Australia in current clinical practice, and in some States in legislation.

As noted above, the right to conscientious objection is set out in section 8 of the *Abortion Law Reform Act 2008* (Vic).

Section 2.3 of the Australian Medical Association's position statement on conscientious objection states that:

> *A doctor with a conscientious objection should:*
>
> - *inform the patient of their objection, preferably in advance or as soon as practicable;*
> - *inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;*
> - *take whatever steps are necessary to ensure the patient's access to care is not impeded;*
> - *continue to treat the patient with dignity and respect, even if the doctor objects to the treatment or procedure the patient is seeking;*
> - *continue to provide other care to the patient, if they wish;*

[8] Medical termination of pregnancy is generally only available up to 9 weeks' gestation: see https://www.betterhealth.vic.gov.au/health/HealthyLiving/abortion-procedures-medication. There are a very limited number of services in Victoria that provide abortions after 12 weeks: https://www.1800myoptions.org.au/information/considering-abortion

- *refrain from expressing their own personal beliefs to the patient in a way that may cause them distress;*
- *inform their employer, or prospective employer, of their conscientious objection and discuss with their employer how they can practice in accordance with their beliefs without compromising patient care or placing a burden on their colleagues.*

Similarly, section 2.4 of the Medical Board of Australia's *Good medical practice: A code of conduct for Australian doctors* (2014) ('Decisions about access to medical care') makes clear that:

> *Your decisions about patients' access to medical care need to be free from bias and discrimination. Good medical practice involves:*
>
> *2.4.3 Upholding your duty to your patient and not discriminating on medically irrelevant grounds, including race, religion, sex, disability or other grounds, as described in anti-discrimination legislation.*
>
> *…*
>
> *2.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.*
>
> *2.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.*

These and other policies and codes issued by professional bodies already adequately manage health practitioners' right to conscientious objection, yet they would likely be deemed unlawful under the Bill.

The issue with conscientious objection is that it is inadequately regulated and enforced to ensure timely access to appropriate health services, not that the requirement to refer impinges on religious freedoms.

6. Clause 8(5) and (6) creates a general right to religious conscientious objection for health professionals that could have serious implications for patients

The Bill creates a dangerous general right to religious conscientious objection for health practitioners that could have very serious implications for patients.

The provision authorises conscientious objections across a broad range of health services and disciplines (e.g. optometrists and dentists) and doesn't require a nexus between the religious belief or activity and the health service in question. As noted by the VEOHRC in its submission,

'it is not clear what treatments can or cannot be conscientiously objected to, and whether this authorises objections based on the presenting patient's attributes – such as sexual orientation or gender identity – rather than the health service they are requesting… [W]e are concerned the absence of clarity affords too much discretion to practitioners about when they can conscientiously object, which will likely impede access to health services.'

Under this clause, for example, it would be possible for a doctor to refuse to provide contraception to an unmarried woman or provide IVF treatment to a LGBTQI person.

As with other professions, health practitioners often provide care and treatment to patients who have attitudes, beliefs and behaviour that are in conflict with those of the practitioner. Nevertheless,

practitioners have a duty to provide lawful, safe and necessary care and treatment, regardless of their personal beliefs and values. As the Australian Medical Association's position statement on conscientious objection states: 'Doctors have an ethical obligation to minimise disruption to patient care and must never use a conscientious objection to intentionally impede patients' access to care.'

In practice, except in very limited circumstances, conscientious objection by health practitioners is generally not permitted, regardless of the practitioner's beliefs. Nevertheless, as explored above, in some limited circumstances (such as abortion and voluntary assisted dying), current practice has allowed codified and regulated conscientious objections. Professional guidelines require practitioners to make arrangements to protect the patients' interests and to ensure they have access to treatment when a practitioner has a conscientious objection.

Patients' rights to accessible and safe care should always come before the religious beliefs of health professionals. There is a very real danger that a general right to conscientious objection on religious grounds will lead to a significant expansion of discrimination and harm to patients.

7. The Bill may pave the way for institutional conscientious objection to abortion

Conscientious objection by an institution (as opposed to an individual) is not currently provided for under Australian law and policy. However, research indicates that some health services are 'opting out' of providing abortion services.[9]

Institutional conscientious objection is likely to intensify barriers to abortion, including exacerbating inequalities in rural and regional areas where there are a more limited number of providers. It can also limit the ability of primary care providers to provide abortion if they are not able to refer to a local hospital in cases where complications arise.

Institutional conscientious objection perpetuates stigma and discrimination in relation to abortion and perpetuates a cultural belief that support for women's right to reproductive autonomy is optional or negotiable.

WHV is very concerned that the inclusion of 'religious bodies' and 'religious institutions' within the definition of a 'person' who would be protected from discrimination in clause 5, combined with the exemption of 'religious bodies' from engaging in discrimination in clause 10, may pave the way for institutional conscientious objection. Clause 5, for example, could have the effect of enabling a religious health service to bring a claim of discrimination against a government department that sought to regulate the provision of health services or set standards relating to conscientious objection. Clause 10 could mean that religious hospitals and health services would be exempt from engaging in religious discrimination if they refused to provide particular health services. Similarly, religious educational institutions could omit aspects of sexual and reproductive health from their training or discourage placements within hospitals that perform abortions, exacerbating already significant workforce shortages. Together, these clauses give rise to a very real risk that institutions, such as Catholic hospitals, could claim a conscientious objection to abortion and defend any attempt to set standards around conscientious objection on the basis of religious discrimination.

Consistent with the recommendations of the AHRC and the VEOHRC, WHV recommends that clause 5 be amended to limit the right to bring a complaint of religious discrimination to natural persons, and clause 10 be amended to limit the definition of 'religious body' to 'bodies established for

[9] Keogh et al (2019) *Conscientious objection to abortion, the law and its implementation in Victoria: perspectives of abortion service providers*, BMC Medical Ethics 20:11. Available at: URL

religious purposes'.

8. The Bill would limit the ability of employers to foster safe and inclusive workplaces and services

Clause 8(3) and (4) would prevent employers from imposing reasonable conduct rules on employees' religious expression outside of work hours, even where those views are contrary to the employer's values or mission and are harmful to the employer's reputation or to other employees, customers or members of the public.

By restricting the ability of employers to set codes of conduct, workplaces will find it more difficult to foster inclusive, safe and respectful work cultures and services. Evidence shows that women are much more likely than men to become targets of workplace harassment, sex-based harassment, gender-based discrimination, and negative gender-based attitudes.[10] LGBTQI people also experience high rates of gender- and sexuality-based discrimination and violence.[11] Evidence further shows that gender inequality and other forms of discrimination and inequality drive violence against women and LGBTQI people.[12] In order to prevent violence against women and LGBTQI people, we must combat the attitudes, behaviours, systems and structures that promote perpetuate inequality and discrimination. This includes enabling and supporting workplaces – as key sites of influence over social norms and practices – to create safe, respectful and inclusive cultures.

WHV echoes the recommendation of the AHRC and the VEOHRC that clause 8(3) and (4) be removed from the Bill.

Recommendations

WHV makes the following recommendations:

1. Given the very short time period allowed for consultation on the exposure draft of the Bill, further consultation should be undertaken to ensure a more appropriate balancing of rights. This could include a referral to the Australian Law Reform Commission. This should include a range of materials in accessible language(s) and formats
2. Clauses 8(3)-8(6), 31(7) and 41 should be removed from the Bill. The indirect discrimination test in clause 8(1) and 8(2), which assesses rules or conditions in all the relevant circumstances, including the need to protect others from harm, is sufficient.
3. Clause 5 should be amended to limit the right to bring a complaint of religious discrimination to natural persons.
4. Clause 10 should be amended to limit the definition of 'religious body' to 'bodies established for religious purposes'.

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[10] Sojo et al (2015). Harmful workplace experiences and women's occupational wellbeing : a meta-analysis. *Psychology of Women Quarterly* 23. Available at URL.

[11] Australian Human Rights Commission (2014), *Face the facts: Lesbian, Gay, Bisexual, Trans and Intersex People*. Available at: https://www.humanrights.gov.au/our-work/education/face-facts-lesbian-gay-bisexual-trans-and-intersex-people

[12] Our Watch et al (2017), Summary report: Primary prevention of family violence against people from LGBTI communities. Available at URL.