Women's Health VICTORIA

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Religious Discrimination Bill – Second Exposure Draft

Submission by Women's Health Victoria, January 2020

Women's Health Victoria (WHV) welcomes the opportunity to provide a submission on the second 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.

WHV also operates **1800 My Options**, Victoria's statewide phone and information service for sexual and reproductive health. WHV's submission draws on the experiences of women attempting to access sexual and reproductive health services in Victoria, which have been reported to **1800 My Options**.

WHV's submission is endorsed by:

- Australian Women's Health Network
- Gender Equity Victoria
- Gippsland Women's Health
- Women's Health East
- Women's Health Goulburn North East
- Women's Health Grampians
- Women's Health in the North
- Women's Health in the South East
- Women's Health Loddon Mallee
- Women's Health and Wellbeing Barwon South West
- Women's Health West

Overview

WHV opposes this Bill on the grounds that it:

- harms women's health and winds back women's reproductive rights in Australia
- privileges health practitioners' religious views over women's health needs
- will delay women's access to contraception and abortion leading to unwanted pregnancies, more complex and expensive abortions, financial loss and negative mental health impacts
- will increase stigma and discrimination against women who are asserting their reproductive health rights and perpetuate a cultural belief that support for women's reproductive autonomy is optional or negotiable.

More broadly, the Bill compromises existing anti-discrimination law and elevates protection of religious

freedom above other rights, including the rights of women and marginalised groups to be free from discrimination and to access health, employment, education and other services.

The Bill creates a double standard whereby religious views and practices are protected from discrimination, but discrimination against other groups on the grounds of religion is authorised, even in cases where a religious institution is providing publicly funded services.

Our submission focuses on the risks posed by the Bill to women's access to essential health services. In particular, we are concerned that the provisions relating to conscientious objection by health practitioners have the potential to further restrict women's access to sexual and reproductive health services, including contraception and abortion.

The Bill restricts the ability of health services to limit the extent to which health professionals can refuse treatment to people on religious grounds, meaning that women, LGBTIQ people and people with disabilities will find it harder to access non-judgmental health care.

The Bill also creates uncertainty about the operation of existing state-based laws which allow for conscientious objection – in particular, the obligation to refer patients to alternative health professionals who do not have a conscientious objection.

The Bill harms women's health and winds back women's reproductive rights in Australia

By extending protections for health practitioners who conscientiously object to the provision of these and other services, the Bill will harm women's health.

Safe access to contraception and abortion is good public health practice and plays an important role in supporting women's health, wellbeing and gender equality. It is also a matter of human rights. As the Beijing Platform for Action on women's empowerment states: 'the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence'.[1]

Inability to access sexual and reproductive health services can contribute to social and economic disadvantage for women and increase health inequalities. For example, 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,[2] 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. This is likely to have a disproportionate impact on certain groups of women,

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[1] UN Women (1995), *Beijing Declaration and Platform for Action*, para 96. The Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women (CEDAW) have both clearly indicated that women's right to health includes their sexual and reproductive health. This means that States have obligations to respect, protect and fulfil rights related to women's sexual and reproductive health. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health maintains that women are entitled to reproductive health care services, goods and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality. CEDAW (article 16) guarantees women equal rights in deciding 'freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights': United Nations Office of the High Commissioner on Human Rights, *Sexual and reproductive health and rights*. https://www.ohchr.org/en/issues/women/wrgs/pages/healthrights.aspx, accessed 30 January 2020.

[2] 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

including women in rural areas who have access to fewer services, and young LBTIQ women, who are more likely to have been pregnant than their peers.[3]

Further, if more practitioners claim a conscientious objection or do not comply with conscientious objection requirements, this places additional pressure on providers who do provide these services within an already stretched workforce.

It is critical for women's health and gender equality that the Bill not compromise women's access to essential sexual and reproductive health services.

High levels of conscientious objection and non-compliance with existing laws and policies are already limiting women's access to reproductive health services

In Victoria, section 8 of the *Abortion Law Reform Act 2008* 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.

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.[4]

Qualitative research also shows that there is a significant level of non-compliance with these provisions. 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.[5]

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 women seeking to access sexual and reproductive health services.

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.

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[3] Both Australian and international research indicates that adolescent girls and young women who are same sex attracted or identify as lesbian or bisexual are significantly more likely to have been pregnant than their opposite attracted peers. The Sex in Australia study found that, of the women in Australia aged 16 to 59 who had ever been pregnant, those who identify as lesbians or bisexual had two to three times the rate of terminations compared to heterosexual women, while bisexual women had used emergency contraception at twice the rate of lesbian and heterosexual women: Smith, A., Rissel, C., Richters, J., Grulich, A., & de Visser, R. (2003). *Sex in Australia: Reproductive experiences and reproductive health among a representative sample of women*. Australian & New Zealand Journal of Public Health, 27(2), 201-209.

[4] 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.

[5] 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

Summary of WHV's concerns with the Bill

WHV opposes the Bill on the following grounds:

1. The Bill elevates the right to religious freedom above all other rights. It removes protections against discrimination for women, LGBTIQ people and other marginalised groups when discriminatory statements are made on the basis of religion.
    a. Religious 'statements of belief' would override existing protections against discrimination
    b. Religious 'statements of belief' made by health professionals outside the course of their employment could not be restricted by employers or professional bodies
    c. Qualifying bodies' ability to uphold service quality and patient safety would be restricted
    d. Anti-choice campaigners would be permitted to intimidate women and health service staff
2. The Bill continues to privilege health practitioners' religious views over patient health needs. Specifically:
    a. The Bill undermines the ethical and professional obligation of health professionals who have a conscientious objection to make a referral
    b. The Bill expands protections for health practitioners who refuse to provide treatment
3. The Bill paves the way for institutional conscientious objection to contraception and abortion
4. The Bill would allow providers of government-funded services to discriminate against people with different or no religious beliefs.
5. The Bill would limit the ability of employers to foster safe and inclusive workplaces and services.

While WHV opposes the Bill for the above reasons, our submission also includes some specific recommended amendments that would limit the negative impacts of the Bill were it to proceed.

Key issues

1. The Bill removes protections against discrimination for women, LGBTIQ people and other marginalised groups when discriminatory statements are made on the grounds of religion

1(a) Religious 'statements of belief' would override existing protections against discrimination

Under clause 42, the expression of people's religious views would override all existing protections against discrimination under federal, state and territory discrimination laws, and there is a power to prescribe additional laws that would also be overridden by this provision.

Beliefs regarded as stemming from religion would have higher protection than political beliefs that do not stem from religious belief or lack of belief, such as support for women's reproductive rights.

This means the Bill would protect offensive, derogatory or harmful statements of belief based on religion, even if they would amount to racial discrimination, sex discrimination or discrimination on any other ground prohibited by law under existing anti-discrimination laws. In effect, religious people making 'statements of belief' would be exempt from complying with laws that non-religious people must comply with.

1(b) Religious 'statements of belief' made by health professionals outside the course of their employment could not be restricted by employers or professional bodies

The Bill places restrictions on the rules that employers, qualifying bodies and health services can place on the behaviour of health professionals; these rules are known respectively as 'employer conduct rules', 'qualifying body conduct rules', and 'health practitioner conduct rules'.[6] The interaction between the restrictions on these three types of rules is complex and confusing. Restrictions relating to health practitioner conduct rules are dealt with in section 2(a).

Clause 8(3) provides that large private employers (which would include some large private hospitals)[7] cannot impose a rule restricting or preventing an employee from making a 'statement of belief' outside the course of their employment (for example, in their 'spare time', on social media or in non-work contexts) unless compliance is necessary to avoid 'unjustifiable financial hardship' to the employer. This ignores other harms to the employer, such as reputational harm, as well as harm to other employees and patients. This provision would permit, for example, a doctor at a large private hospital making a statement on social media that pregnant single women are sinners or that abortion is murder.

Clause 8(4) provides that qualifying bodies (such as medical boards) cannot impose a rule restricting or preventing a person from making a 'statement of belief' outside the course of their employment unless compliance with the rule is an 'essential requirement' of the profession.[8] This means that, while qualifying bodies would be able to impose restrictions on conduct that takes place 'in the course of employment', they may not be able to respond appropriately if a health practitioner makes statements based on religion outside the course of their employment, even if this conduct compromises patient care for example by eroding public trust in the profession or limiting access to health services by increasing stigma.

For example, in a small rural town where there is only one GP or pharmacist, statements made in a social context relating to the GP's or pharmacist's religious views about contraception or abortion are likely to have a significant impact on women's access to sexual and reproductive health services. Women who call WHV's **1800 My Options** service regularly report that encountering hostility, obstruction, misinformation and/or judgment from their local GP has prevented them from seeking services elsewhere as they have feared encountering this treatment again. This kind of hostility and obstruction creates particular barriers for women who are young, located in a rural area or from a non-English speaking background.

If the Bill proceeds, clauses 8(3-5) and 32(6) should be removed. At a minimum, it should be clarified that employers and qualifying bodies can impose restrictions on the expression of 'statements of belief' that would compromise patient care.

1(c) Qualifying bodies' ability to uphold service quality and patient safety would be restricted

Under clause 16, qualifying bodies would also be prevented from refusing to register or renew the registration of a health practitioner and from revoking the practitioner's registration based on their

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[6] Employer conduct rules and qualifying body conduct rules apply more broadly than to health professionals, but this submission focuses on the Bill's impacts on access to health care.

[7] Under clause 8(3), the restrictions on employer conduct rules apply to employers with a revenue of at least $50 million.

[8] What would constitute an 'essential requirement' of the profession is not defined. However, in the context of the rest of the Bill, it seems unlikely that it would be considered an 'essential requirement' of the health care profession to refrain from making statements on religious grounds related to a health practitioner's views on contraception or abortion outside the course of the practitioner's employment, for example in a social setting or on social media.

religious belief or activity, unless the practitioner is unable to carry out the inherent requirements of the profession due to their religious belief or activity (clause 32(4)). This could prevent, for example, disciplinary action being taken against a health practitioner who told a woman who had an abortion due to foetal abnormality to 'ask for God's forgiveness for her son's death', as occurred in a case in NSW in 2013.[9] It would also compromise regulatory bodies' capacity to ensure that health practitioners maintain their duty of care; for example, if a woman with medical complications were delayed in accessing an abortion due to a practitioner' conscientious objection, this may put her health at serious risk and require more intrusive and expensive health care.

If the Bill proceeds, clauses 16 and 32(4) should be amended to clarify that disciplinary action can be taken by a qualifying body against a health practitioner where the health practitioner's conduct compromises patient care.

1(d) Anti-choice campaigners would be permitted to intimidate women and health service staff

The Bill enables 'street preachers', religious protestors and religious organisations that are denied permits by local government authorities to sue for religious discrimination, even if their religious activities would contravene local by-laws that everyone else must comply with (clause 5(2)).

In jurisdictions without legislated safe access zones around abortion providers, this would enable anti-choice activists to insult and intimidate women seeking abortions as well as clinic staff irrespective of any local by-laws prohibiting this. This could limit the ability of health services to provide a safe workplace for staff and lead to further erosion of the sexual and reproductive health service system.

If the Bill proceeds, clause 5(2) should be removed.

2. The Bill continues to privilege health practitioners' religious views over patient health needs and may further restrict access to contraception and abortion in Victoria and across Australia

2(a) The Bill undermines the ethical and professional obligation of health professionals who have a conscientious objection to make a referral

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, they have a duty to provide lawful, safe and necessary care and treatment, regardless of their personal beliefs and values.

The duty to disclose a conscientious objection and to refer patients to another health professional who can provide the health service is vital to ensuring timely, unbiased access to health care 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.[10]

In practice, except in very limited circumstances, conscientious objection by health practitioners is generally not permitted, regardless of the practitioner's beliefs. Nevertheless, in some limited

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[9] Health Care Complaints Commission v Sharah [2015] NSWCATOD 99: https://www.caselaw.nsw.gov.au/decision/5600a0e8e4b01392a2cd0f88 In the context of the rest of the Bill, it seems unlikely that it would be considered an 'inherent requirement' of the health care profession to refrain from making statements on religious grounds related to a health practitioner's views on abortion outside the course of the practitioner's employment, for example in a social setting or on social media.

[10] 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].

circumstances (such as abortion and voluntary assisted dying), current practice has allowed codified and regulated conscientious objections.

In Victoria, section 8 of the *Abortion Law Reform Act 2008* 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).

The obligation to make a referral is also reflected in relevant professional codes of practice. 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. Examples of these professional obligations are set out below:

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;*
> - *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.

Clauses 8(6) and (7) of the revised Bill set out restrictions on 'health practitioner conduct rules' that purport to regulate conscientious objection by health practitioners. Clause 8(6) of the Bill provides that, where state or territory laws allow conscientious objection in health care (for example, in relation to abortion or voluntary assisted dying), health sector employers and professional bodies must not impose rules that are 'inconsistent' with these laws.

While this clause ostensibly preserves existing state and territory laws that provide for conscientious objection,[11] it is silent on the validity of any state legislative provisions that impose an obligation to refer. This clause would also likely limit the ability of health services in Victoria (or elsewhere) 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),[12] there is a real risk that a government or professional policy directive requiring referral, in the interests of patient health, would be deemed unreasonable and unlawful because it is 'not consistent' with the legislation, unless compliance were necessary to avoid an 'unjustifiable adverse impact' (clause 8(7)).[13] What constitutes an 'unjustifiable adverse impact' is not defined.

In the Bill's explanatory notes, the Government gives an example of a small rural town whose only doctor conscientiously objects to prescribing contraception. In this example, the Government suggests that this 'may' amount to an 'unjustifiable adverse impact' because the woman in that town 'may be unable to access alternative health care promptly without significant travel and costs'.

We know scenarios like this already occur (even though they are in breach of the current Victorian law on conscientious objection to abortion). The following examples reported to **1800 My Options** demonstrate the impact of conscientious objection in communities where there are low levels of service provision:

- 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.

[11] In its submission on the first exposure draft, the HRLC noted 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.'

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

[13] Examples of a health practitioner conduct rule provided in the Explanatory Notes explicitly include rules that require health practitioners to provide information or referrals (para 171).

- A woman who had contacted nine clinics looking for a medical termination of pregnancy (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.

In the example provided in the Bill's Explanatory Notes, it is unclear how significant the travel and costs would need to be before the doctor would be obliged to help. An individualised assessment would be required for each situation where compliance with the health practitioner conduct 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.

As argued by the HRLC in its submission on the first exposure draft: *'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. 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. 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,[14] 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.

Patients' rights to accessible and safe care should always come before the religious beliefs of health professionals. By limiting longstanding ethical obligations on health practitioners to make referrals, the Bill represents a very significant departure from existing professional standards and practice in the health sector.

2(b) The Bill expands protections for health practitioners who refuse to provide treatment

A number of amendments made to the Bill expand the protection given to health practitioners to refuse treatment to patients based on conscientious objection:

First, the revised Bill extends protections for conscientious objection to **health services that relevant health professionals *participate* in**, not only services that they provide themselves. This means that a doctor, nurse, pharmacist or psychologist could refuse to refer a patient to another practitioner who will provide an abortion or give them information about a procedure which is available, such as abortion, that they object to.

We know this already occurs in Victoria, despite the legal obligation to refer in the *Abortion Law Reform Act 2008*. During visits to primary care providers, **1800 My Options** staff have found some clinics 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. Other examples from **1800 My Options** of health practitioners failing to comply with the obligation to refer include:

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[14] 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

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

Secondly, under the revised Bill, a health professional could refuse to provide or participate in ***any* given health service or procedure**, provided that the refusal is based on a religious belief (see below)[15] and they refuse to provide that procedure or service to any person at all and do not deny the service only to a particular category of persons.[16]

Thirdly, for the conscientious objection to be validly based on a religious belief, it need only be shown that a person of the same religion as the health practitioner could reasonably consider the refusal as being in accordance with the doctrines, tenets, beliefs or teachings of that religion. Equality Australia notes that this test is extremely broad, uncertain and highly subjective, **requiring only one other person to establish a religious requirement exists and deserves protection**. In effect, 'a person who believes what you believe is the arbiter of whether you are correct in what you say your particular beliefs entail.'[17] This would give protection to potentially extreme and unorthodox views.

The second and third revisions would almost certainly be relied upon by some health practitioners to conscientiously object to providing contraception. Given conscientious objection to contraception is not currently provided for in legislation, any policy or guidelines restricting conscientious objection to contraception (for example, requiring a health practitioner with a conscientious objection to refer the patient) would most likely be unlawful under clause 8(6) of the Bill (see discussion above in section 2(a) of this submission).

If the Bill proceeds, clauses 8(6) and (7) (and related clause 32(7)) should be removed. These clauses undermine access to safe and inclusive health services, create 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, introduce broad conscientious objection provisions without appropriate safeguards or regulation. Conventional discrimination protections would protect the ability for health practitioners to practise in accordance with their faith, but without prioritising religious views over a patient's right to access health care.

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[15] See clause 5 – definition of 'conscientiously objects'

[16] See Note 2 on clause 8(6). Equality Australia notes that this requirement means a health practitioner could simply refuse to provide health services (such as contraception) to everyone. This would create significant issues in rural areas in particular, where there is very limited provision of sexual and reproductive health services and there are already high rates of conscientious objection to abortion. It may also be difficult to prove that the health practitioner is denying a service only to a particular group of people. Equality Australia also notes that some health services are indistinguishable from the kind of person who needs them, such as gender affirming health care, so refusing to provide particular types of services is simply another way to refusing to provide services to a particular group of people. Further, it is not clear what a 'particular type of service' means. As noted by Equality Australia, if a pharmacist refuses to dispense a prescription for hormones to a trans patient, must the pharmacist also refuse to dispense a prescription for hormones to a woman post-menopause? If a doctor refuses to prescribe the contraceptive pill to a woman, must the doctor refuse to prescribe any and all medications to any person?

[17] Equality Australia (2020). *Religious Discrimination Bill Submission Toolkit*, page 10. Available at: https://equalityaustralia.org.au/resources/submission-toolkit/

As suggested by the HRLC in its submission on the first exposure draft, if the Government retains these clauses, it should also consider include a provision in the Bill that stipulates that the obligation to refer in cases of conscientious objection is reasonable. WHV also recommends that health practitioners who hold a conscientious objection to any procedure be required to publish a public notice to this effect.

3. The Bill paves the way for institutional conscientious objection to contraception and 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.[18] This appears to be the case even where these health services are publicly funded.

Clause 32(10) of the Bill explicitly provides scope for religious hospitals as institutions to refuse to provide certain health services, such as abortion or contraception, by permitting them to discriminate against a prospective employee who does not share their faith.

Institutional conscientious objection intensifies 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 also 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.

Under clause 11 of the Bill, which provides that educational institutions do not discriminate when they engage in conduct in accordance with their faith, religious schools would be authorised to refuse to provide sex education and religious tertiary institutions would be authorised to omit aspects of sexual and reproductive health from their training or discourage placements within hospitals that perform abortions, exacerbating already significant workforce shortages.

The Bill should be amended to better protect the rights of individuals seeking to access health services, particularly in areas where there are fewer providers.

4. The Bill would allow providers of government-funded services to discriminate against people with different or no religious beliefs

This submission does not explore concerns with clauses 11, 32(8)-(11) and 33(2)-(5) (which permit discrimination by faith-based schools, charities and other organisations) in detail.

However, we echo concerns raised by Equality Australia that the Bill would permit faith-based organisations that provide government-funded services, such as family violence response services or mental health services, to discriminate against individuals with different or no religious beliefs who are receiving those services.

Given the significant role played by faith-based organisations in the delivery of government-funded health and social services, this raises a very serious concern that the Bill could seriously limit the provision of essential community services. Individuals who rely on government-funded services delivered

[18] 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

by religious organisations must be protected from discrimination.

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

As noted in section 1(b) of this submission, clauses 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 and prohibit offensive speech, 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.[19] LGBTIQ people also experience high rates of gender- and sexuality-based discrimination and violence.[20] Evidence further shows that gender inequality and other forms of discrimination and inequality drive violence against women and LGBTIQ people.[21] In order to prevent violence against women and LGBTIQ 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 notes that the report of the Australian Human Rights Commission's national inquiry into sexual harassment in Australian workplaces is due to be tabled in the Commonwealth Parliament in early 2020. The report is likely to recommend increasing protections against sexual harassment at work. By contrast, the provisions in this Bill would limit employers' capacity to protect their employees from offensive speech that constitutes sexual harassment. For example, under the Bill, a manager could tell an employee that women must submit to their husbands. Proceeding with this Bill would be out of step with the likely findings of the national inquiry into sexual harassment.

As noted above, clauses 8(3) and (4) and clause 42 should be removed from the Bill if it proceeds.

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

[20] 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

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