

Inquiry into Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013



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Introduction

Women's Health West is the women's health service for the western metropolitan region of Melbourne. Our services include research, health promotion, community development, training and advocacy around women's health, safety and wellbeing. Since 1994, Women's Health West has managed the region's largest family violence crisis support and prevention program. These two main arms of the service place Women's Health West in a unique position to incorporate women's experiences directly into our research, health promotion and project work, ensuring that we clarify the connections between structural oppression and individual experience.

As a feminist organisation we focus on redressing the gender and structural inequities that limit the lives of women and girls. Women's Health West's work is underpinned by a social model of health that recognises the important influence of, and aims to improve the social, economic and political factors that determine the health, safety and wellbeing of women and their children in our region. By incorporating a gendered approach to health promotion work that focuses on women, interventions to reduce inequity and improve health outcomes will be more effective and equitable.

Informed by our vision of equity and justice for women in the west, our work is guided by the following five strategic goals:

- Delivering and advocating for accessible and culturally appropriate services and resources for women and their children
- Improving the conditions in which women live, work and play in the western region of Melbourne
- Putting women's health, safety and wellbeing on the political agenda to improve the status of women
- Recognising that good health, safety and wellbeing begins in our workplace
- Working with others to achieve our goals.

Women's Health West has specific expertise in sexual and reproductive health, including leading the development and implementation of a strategy for sexual and reproductive health promotion for Melbourne's west. Along with other key projects, Women's Health West contributes to social policy discussions regarding sexual and reproductive health, including over a decade of lobbying to ensure that abortion was decriminalised in Victoria and that women have access to appropriate, safe and affordable abortion service provision.

General comments

In keeping with the submission made by our sister service, Women's Health Victoria, Women's Health West welcomes the opportunity to respond to this inquiry. Women's Health West does not support sex selective abortion, as it reflects deeply entrenched gender inequality. However, we believe that restrictions on sex selective abortion are not an appropriate way of addressing such inequality. Restrictions of this sort have proved ineffective in other countries.^{1,2} They could also discriminate against certain groups of women if implemented in Australia, where there is no comprehensive evidence to suggest that sex selective abortion is occurring, or that Medicare is being used to fund such procedures. Restrictions on sex selective abortion may also compromise access to abortion, which is a vital health service for women in Australia, and an important sexual and reproductive health right.

Women's Health West is concerned that the terms of reference assume that sex selective abortion using Medicare is prevalent, when there is little evidence to suggest this. Such assumptions may impact on women's access to abortion in Australia. All women should be able to access safe, legal and affordable abortion services. The decision to continue or terminate a pregnancy can be difficult for many women and they should not be made to feel guilty or judged for their decision.³ It is a decision that should be made by those most closely involved with the situation. Research indicates that the best outcome is achieved when women are in control of their own decisions about pregnancy termination.⁴ A woman's ability to control reproductive decision-making is crucial to maintenance of her health.⁵

In this submission, Women's Health West uses the term 'sex selective abortion' rather than 'gender selective abortion'. The use of the word 'sex', which refers to the biology of male or female, is a more accurate description of the procedure.

1. The unacceptability to Australians of the use of Medicare funding for the purpose of gender selection abortions

There is no comprehensive or reliable evidence to suggest that Medicare is being used for the purpose of sex selective abortion. Australia has an entirely normal ratio of male to female births, which would suggest that sex selective abortion is rare, if not non-existent. Just over half (51%) of all births registered in 2011 were male babies, resulting in a sex ratio at birth of 105.7 male births per 100 female births.⁶ The biologically normal sex ratio at birth ranges from 102 to 106 males per 100 females.⁷ It

is also worth noting that most abortions occur early on in pregnancy, before the sex of the foetus is known.⁸

There is also no comprehensive or reliable evidence to suggest that Australians find the use of Medicare funding for sex selective abortions unacceptable. Extensive surveys or studies asking this question simply do not exist in Australia. However, the attitudes of Australians towards abortion more generally are known. According to the Australian Survey of Social Attitudes in 2003, 81% of Australians agree that women should have the right to choose an abortion. This was independent of their gender or religious affiliation. Only 9% of the 5000 adults questioned disagreed with a woman's right to choose, and the remaining 10% were undecided.⁹

2. The prevalence of gender selection - with preference for a male child - amongst some ethnic groups present in Australia and the recourse to Medicare funded abortions to terminate female children

Sex selective abortion, with a preference for a male child, is known to take place in some countries.¹⁰ It is based on entrenched gender inequality and a low regard for the status of women. There is no comprehensive evidence to show whether this practice occurs in Australia. There is also no way of showing that Medicare is being used for this purpose. The Medicare item numbers that are used by health professionals to cover abortion include a range of procedures other than 'induced abortion', and Medicare is therefore not an accurate way of ascertaining how many abortions are taking place.

It is worth considering how a restriction on the use of Medicare to fund sex selective abortion would be implemented. Restrictions of this nature would be untenable because of the practical difficulties they impose on both health professionals and women. For example:

- How would health professionals ascertain whether the abortion being sought was based on the sex of the foetus?
- How would this be done without discriminating against and stigmatising certain groups of women, thereby jeopardising the health services that they receive?

Restrictions on sex selective abortion in countries such as China and India have not proved successful:

because enforcement is extremely difficult, affordable ultrasound services are widely available and fetal sex information can be relayed to potential parents without even saying a word. Moreover, an ultrasound may be performed in one location and an abortion obtained in another, where a woman can provide alternative reasons for the procedure.¹¹

Restrictions on sex selective abortions alone are ineffective at altering skewed population ratios. This is because they do not deal with the root cause of gender

inequality. Restrictions, if introduced in Australia, have the potential to perpetuate racial and sexual discrimination by 'stereotyping and racial profiling of Asian women whose motivations for an abortion would be under suspicion.'¹² An outcome of this sort is unacceptable and represents an important reason for ensuring that restrictions on sex selective abortion are not implemented.

3. The use of Medicare funded gender-selection abortions for the purpose of 'family-balancing'

There is no comprehensive or reliable evidence to suggest that Medicare funding is being used to fund sex selective abortion for 'family balancing' or indeed, any other reason. The National Health and Medical Research Council's Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research advise against sex selection for non-medical purposes (section 11).¹³ Sex selection is not possible through the use of assisted reproductive treatment in states with legislation on this matter.

Few (if any) Australian studies on the reasons women provide for undergoing abortion indicate sex selection. Instead, reasons usually relate to:

the woman herself, the potential child, existing children, and the woman's partner and other significant relationships, most of which contribute to what it means to a woman to be a good mother.¹⁴

Other studies have found that the decision to terminate a pregnancy for many women centres on concerns about 'wanting to be a good mother and provide a good home'.^{15,16} The reasons that women give for terminating a pregnancy are varied and complex and it is vital that women should be able to 'make their own reproductive decisions with dignity and freedom from stereotypes and stigma'.¹⁷

4. Support for campaigns by United Nations agencies to end the discriminatory practice of gender-selection through implementing disincentives for gender-selection abortions

As noted above, sex selective abortion is known to take place in countries in which gender inequality is deeply entrenched and male children are more highly valued.¹⁸ Women's Health West supports UN efforts to end the discriminatory practice of sex selection. Sex selection occurs within a complex social and cultural context – restricting sex selective abortion is ineffective in addressing the broader social and cultural issues that lead it. It is through widespread societal change in attitudes towards women that lasting improvements to the lives of women will be achieved.¹⁹ The World Health Organization has stated:

Some (governments in affected countries) have passed laws to restrict the use of technology for sex-selection purposes and in some cases for sex-selective abortion.

These laws have largely had little effect in isolation from broader measures to address underlying social and gender inequalities.²⁰

Comprehensive, well-resourced and whole-of-government approaches are needed to reduce gender inequality and promote the status of women. Such measures go well beyond restrictions on sex selective abortion.

5. Concern from medical associations in first world countries about the practice of gender-selection abortion, viz. Canada, USA, UK

Medical associations such as the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), the Royal College of Obstetricians and Gynaecologists (RCOG), the American College of Obstetrics and Gynaecologists (ACOG) regard abortion as an important health service for women. Some medical associations have made specific statements about sex selective abortion, supporting sex selective abortion because of sex-linked genetic diseases, but not for personal or cultural reasons. Women's Health West supports these statements and recommends that the most effective way to address sex selective abortion is through broad interventions to promote gender equality and the status of women. Restricting access to abortion risks curtailing women's right to choose if, when and how many children she will have.

Comments on the Bill's *Statement of Compatibility with Human Rights*

Restrictions on sex selective abortion threaten the human rights of the women it seeks to protect because it can restrict access to abortion. The Beijing Declaration, which stemmed from the Fourth UN Conference on Women in 1995, unequivocally affirms that 'the right of all women to control all aspects of their health, including their own fertility, is basic to their empowerment'.²¹ This is not referred to in the *Statement of Compatibility with Human Rights* that applies to the Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013. A number of other UN human rights instruments are also omitted. For example, The UN Factsheet on the Right to Health asserts that:

States should enable women to have control over and decide freely and responsibly on matters related to their sexuality, including their sexual and reproductive health, free from coercion, lack of information, discrimination and violence.²²

Australia also has an obligation to implement the principles of the Convention on the Elimination of All Forms of Discrimination Against Women. Article 12 requires that measures be taken to ensure 'on a basis of equality of men and women, access to health care services, including those related to family planning'.²³ Restrictions on abortions restrict this access. In addition, a woman's right to be treated equally and with dignity and respect must not be infringed by placing restrictions on abortion services.

The *Statement of Compatibility with Human Rights* refers to the child's right to life. There is much jurisprudence demonstrating that life begins at the moment of birth. The *Law of Abortion: Final Report* published by the Victorian Law Reform Commission in 2008 provides an exploration of the key issues.²⁴ In international law there is no precedent for interpreting the word 'human being' as including the foetus.^{25,26} The Universal Declaration of Human Rights states that 'everyone' has a right to life and, following debate during the drafting process, chose not to include specific reference to the foetus.²⁷ In the International Covenant on Civil and Political Rights, the right to life has been consistently interpreted as beginning at birth. The Committee on the Convention on the Rights of the Child has referred to the need for States to take measures against unsafe abortion practices.²⁸ The UN Human Rights Committee has also made consistent calls for states to decriminalise abortion laws.²⁹ The right to life is not specifically conferred by Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), however the CEDAW Committee has framed the issue of maternal mortality as a result of unsafe abortions as a violation of a woman's right to life.³⁰ In addition to these conventions, the Victorian Law Reform Commission also cited examples of case law in Australia, as well as the UK, Canada, South Africa and France, in which the foetus does not have legally enforceable rights until they are born.³¹

This extensive body of law should be acknowledged in any discussion of the right to life in the *Statement of Compatibility with Human Rights*.

Summary:

- 1. Restrictions on abortion jeopardise a woman's right to choose if, when and how many children she will have.**
- 2. Measures to reduce sex selection by addressing gender inequality are strongly supported.**
- 3. There is no comprehensive evidence to suggest that sex selective abortion for cultural or family balancing reasons is taking place in Australia, or that Medicare is being used for this purpose.**
- 4. There is no comprehensive evidence to suggest that Australians find sex selective abortion unacceptable – this evidence simply does not exist.**
- 5. Medicare item numbers relating to abortion cover a range of other procedures and are therefore not an accurate indication of rates of abortion.**
- 6. Restrictions on sex selective abortion in other countries have not been successful and risk discriminating against women from certain ethnic groups.**

- 7. Sex selective abortion for non-medical purposes is already banned in the NHMRC's Ethical Guidelines on the use of Assisted Reproductive Technology in Clinical Practice.**
- 8. International human rights instruments support women's right to control their own fertility.**

Recommendation:

The Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill should not be passed into law.

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