Thank you for providing the opportunity for make a submission on the Exposure Draft of the proposed *Religious Discrimination Bill 2019* (Cth).

**This submission**

Our submission draws on our collective experience in law, health administration, clinical research, and ethics. While noting the draft Bill provides ample scope for public debate, this submission focuses on our particular area of expertise, specifically the **provisions dealing with conscientious objection by health practitioners outlined in s8 (5) & (6)**, and related provisions.

The submission does not involve what would be reasonably construed as a conflict of interest.

Overall the proposed legislation fails to address substantive concerns regarding health services. If the Bill is enacted it will result in regulatory incoherence, with

- uncertainty about conflicts between Commonwealth and state/territory law
- disagreement rather than certainty about the rights and responsibilities of health practitioners and other health service providers, including institutions
- litigation to resolve uncertainties beyond the scope of anti-discrimination agencies and practitioner regulation bodies
- perceptions that practitioners with particular belief systems have a social licence to discriminate at the expense of the body of Australian human rights law and the nation’s commitment to international human rights frameworks.

Our concerns regarding the Bill in its current form are detailed below.

**Is there a need for specific mention of Conscientious Objection in this Bill?**

As an initial comment, we question whether it has been demonstrated that a need for specific provisions considering conscientious objection in healthcare within the *Religious Discrimination Bill* exists.

Conscientious objection over provision of certain forms of medical treatment is a longstanding and deeply divisive issue. Many practitioners and community members have deeply held views on the matter. Those views range from concerns about requiring practitioners to provide services which are inconsistent with their right to freedom of religion, through to concerns about the potential infringement of rights of patients to access healthcare services, not experience judgement or discrimination at the hands of healthcare providers, and not to have the religious views of others imposed on them. These views are particularly significant with regards to the impact
they may potentially have on accessibility of specific healthcare services for
Australians living in remote or regional areas where the objecting practitioner operates
in a geographical monopoly or is otherwise restricted or isolated as a result of social
barriers. Those views have, in most cases extensively, been canvassed by state and
territory parliaments during legislative debate and related consultation processes
associated with issues likely to raise conscientious objection arguments, including
provisions of assisted dying, pregnancy termination, contraception, and assisted
reproduction services. In most relevant current Australian legislative instruments,
there has been extensive debate about conscientious objection protections, and some
legislation includes clear exemptions permitting practitioners to withhold those
services on the basis of conscientious objections (See e.g. s9 of the recently passed
Reproductive Health Care Reform Bill NSW, and s7 Voluntary Assisted Dying Act
2017 Vic). In other cases where conscientious objection provisions have not been
included, it is as a result of careful consideration and debate, rather than omission.

While acceptance of the justice or validity of those exemptions is not universal, the
states have nonetheless attempted to achieve a workable solution through legislation.

The Exposure Bill, particularly s8(5), does not add anything useful to the existing
legislative framework.

Instead, it potentially undermines it by creating further confusion and division and
undermining the outcomes of deliberative democratic processes engaged in by the
states. Indeed, it entrenches discrimination on the basis of holding religious beliefs, or
not holding religious beliefs, in a way that is inconsistent with the stated objectives of
the Bill. That entrenchment is also inconsistent with the ‘neutrality’ expected in
Australia’s engagement with the international human rights frameworks, including
the Universal Declaration of Human Rights and conventions such as the International
Covenant on Civil & Political Rights.

Subsection 8(5), in effect, states that if there is law of a state or territory which ‘allows’
conscientious objection by a health practitioner with respect to providing a health
service because of a religious belief or activity held or engaged in by that practitioner,
any ‘health practitioner conduct rule’ that is inconsistent with that law will be
‘unreasonable’.

This provision is problematic for a number of reasons.

First – and perhaps foremost – it is not clear why the provision is required. Generally
legislative provisions recognising conscientious objection operate to provide an
immunity to practitioners from being compelled to provide a particular health service.
That immunity may be limited in the event certain circumstances exist (for example
an emergency requiring provision of the service), or it may contain a requirement that
the practitioner, in exercising the conscientious objection, provide referrals to
alternative practitioners who may be able to provide the service.

Those provisions exist in law. They establish, at the level of law, that a practitioner who
holds a conscientious objection cannot be compelled to provide those services unless
the relevant circumstances apply. ‘Health practitioner conduct rules’ – defined as
‘conditions, requirements, or practices’ – lack the weight of law. Any health
practitioner conduct rule that is inconsistent with the conscientious objection provisions in the legislation is likely, therefore, to be unlawful, because it fetters an express or implied right to refuse to provide certain services. As the Health practitioner conduct rules are unlawful, they are both unreasonable and – more importantly – unenforceable. It does not require reference to an instrument of the Commonwealth, such as the Exposure Bill, to establish the inherent unreasonableness of a conduct rule which on its face is unlawful under state or territory law. In this respect, the provision contained in subsection 8(5) serves no beneficial purpose in clarifying or elucidating the existing law. Instead, it is likely to cause additional confusion through unclear wording and imprecision.

Problematically the Bill’s provisions do not address the arguably more challenging issue of the right of institutions to assert a conscientious objection to the provision of certain services. That issue, currently unaddressed, is potentially an example of where a tension between a health practitioner conduct rule (the policy or standards imposed by an employer) may arise, as institutions who are unable to rely on legal protection to assert a conscientious objection under the legislation may instead coerce individuals to claim a lawfully protected conscientious objection not otherwise available to them directly. Recognition of institutional conscientious objection in its current form relies on policy and goodwill, rather than legal protection. It is conceivable that in future lack of legislative certainty, or changes in the policy environment governing the conscientious objection status of institutions, as distinct from individual practitioners, may result in practitioners being pressured to exercise conscientious objections on behalf of their employers. Institutional conscientious objection is an especially fraught issue, noting the potential for monopoly service provision governing access to all health providers and services within a particular healthcare context. The significant role of religiously-affiliated institutions in provision of end of life care services in particular has evident potential to restrict access to otherwise lawful services, even in metropolitan areas, in a way that is inconsistent with the rights of patients.

In addition, the conscientious objection rule here is discriminatory on its face, since it only permits these violations of rule for those with designated religious beliefs- a flawed concept in the context of this Bill for reasons which will be discussed further shortly. Anyone else with a conscience is excluded and required to conform to rules, while the conscientious objector whose objections are attributable to religion is empowered to do otherwise. Religious believers are not the only people with consciences. Consistency - and indeed the rule of law – demands that the rule apply to all or none. This problem gets even more complicated when healthcare institutions that count as religious bodies under the Act assert a conscientious objection, since they employ non-religious staff. In doing so, they deny to these staff the same right to object that they reserve to themselves. Thus the non-religious healthcare provider is required to submit to religious rules of conduct with which they disagree and are liable to be fired in the event that they object. Yet they are not protected by this bill. This is a particular problem in 8.5.(2) and 8.5.(3)

The situation is further complicated by the lack of certainty under the Exposure draft about the need for causality, rather than mere coincidence, of the religious beliefs or activities as the basis of the conscientious objection. Not all Catholic doctors, for
example, attribute their opposition to euthanasia or abortion to religious doctrine. Some Catholic opposition is based, either partially or wholly, on ethical beliefs and values of alternate origin, similar to those of conscientious objectors whose objections are not based on religious beliefs. Without clarification about the causal importance of religion to the conscientious objection in question, this Bill potentially privileges the conscientious objections of a healthcare practitioner whose behaviours are identifiable as religious in nature over a healthcare practitioner with the same objections, held for the same reasons, who does not participate in religiously-identifiable behaviours.

**Regulatory incoherence and confusion attributable to defective drafting**

That potential for ambiguity is demonstrated when the wording of the clause in the Bill itself, and the description of the clause provided in the Explanatory Memorandum, are compared.

Subsection 8(5) makes it clear that the conscientious objection being claimed by the practitioner must be one created by a law of a state or territory. In the Explanatory Memorandum, that specificity is lost. Paragraph 134 of the Explanatory Memorandum makes no mention of the requirement for the conscientious objection to be formally recognised under law. It instead implies that *any* conscientious objection raised by a practitioner, regardless of whether it is recognised in legislation or not, will render unreasonable *any* health practitioner conduct rule which is inconsistent with it.

Further, in paragraph 137, an example is provided of a rule which may require practitioners to provide referrals, or provide information, about the services to which they conscientiously object to providing. That paragraph conflates requirements to engage in those activities which are contained within health practitioner conduct rules, with legislative obligations contained in some of the legislative provisions recognising conscientious objection. Indeed, in some instances the compromise achieved by the state or territory legislature is that in not compelling practitioners to provide certain services, practitioners relying on the conscientious objection provisions will provide patients with appropriate referrals and information. That provision of information and/or referrals balances recognition of the rights of the practitioner not to be compelled to provide services which compromise their moral values, against the rights of the patient to access lawfully-permitted medical services and exercise their autonomy through facilitation of informed decision-making about their own healthcare needs.

The existing history of effective referral requirements is unpromising. A substantial number of religious believers refuse to refer even when willing and professionally competent colleagues are available, on the grounds that referral itself is inconsistent with their religious beliefs. This creates inequities for a range of populations, but above all women in particular. As written the *Religious Discrimination Bill* promotes gender and sexual orientation discrimination, and is thereby inconsistent with Commonwealth anti-discrimination legislation, including the *Sex Discrimination Act* 1984(Cth).

If the intention of s8(5) is more closely reflected by the explanatory memorandum rather than the existing Bill, the Government should be aware that the provisions directly undermine the legislative provisions of state and territory governments, and
raise the spectre of lengthy and highly contested debates about the supremacy of the legislative competence of the respective levels of government, noting the strong human rights implications associated with the issue, regardless of how it is ultimately resolved. That interpretation is, moreover, inconsistent with the explanation of s8(5) contained within para 140 of the Explanatory Memorandum.

**Definitional inadequacy**

The definition of religious belief or activity, as provided in the Definitions section, is inconsistent with the drafting of the conscientious objection provisions, and indeed is fundamentally - even fatally - flawed as a matter of logic.

The Bill defines ‘religious belief or activity’ as:

(a) holding a religious belief; or
(b) engaging in lawful religious activity; or
(c) not holding a religious belief; or
(d) not engaging in, or refusing to engage in, lawful religious activity.

On this definition, a religious belief exists when a person either holds a religious belief or does not hold a religious belief; similarly a religious belief or activity includes engaging in a lawful religious activity or not engaging in, or refusing to engage in, a lawful religious activity. If this is correct, then any and all beliefs are religious, which is incoherent, as it reduces everything to be a matter of religion. This then distorts the conscientious objection discussion. For if the definition of ‘religious belief’ is already incoherent, then by any standard rule of logical inference every and all healthcare rule of conduct is a legitimate subject of objection. Everything follows from a false proposition, as logicians say.

This problem is exacerbated by the later explanation of discrimination, as (a) holding a religious belief and (b) engaging in lawful religious activity are mentioned, but there is no role for definitions (c) not holding a religious belief or (d) not engaging in, or refusing to engage in, lawful religious activity. Also, and just as importantly, even if (c) and (d) are eliminated, the definitions (a) and (b) are both circular. Religious belief is defined in terms of religious belief and we are none the wiser about what is actually meant. The result is that there is no logical way to determine who is entitled to a conscientious objection, and who is not.

This reductive definition of religion, whereby everything is religious, is inconsistent with the idea of a secular state, as outlined under s116 of the Constitution, which provides: *The Commonwealth shall not make any law for establishing any religion, or for imposing any religious observance, or for prohibiting the free exercise of any religion, and no religious test shall be required as a qualification for any office or public trust under the Commonwealth.*

Through the drafting of the definitions in their current form, the Bill seeks to reduce everything to a matter of religion, thereby circumventing the Constitutional protections expressly outlined.

An additional concern about the wording of the existing Bill is that its definition of health practitioner, while consistent with other legislative instruments, is too broad to be contextually relevant.
Further, many of the principles underpinning conscientious objection simply do not apply to certain of the health professions identified within the Bill. It is questionable, for example, whether the intention of the Bill is to extend conscientious objection principles to an optometrist, a podiatrist, or a dentist, the right to conscientiously object to providing services they are not authorised to provide in the first instance, such as abortion or assisted dying. The definitional framework used in this context has retained consistency with other legislation in preference to rationality.

**A disproportionate response**

The most critical flaw of the provision, however, is that it further divides the already-contestable issue of conscientious objection in a way that the states and territories have consistently avoided doing through legislation.

By including reference to religious beliefs and activities as a justification for a conscientious objection, the Bill privileges the conscience of those whose values are formed by religion over the conscience of those whose beliefs may be as deeply, or even more deeply held, but are attributable to personal experience, reflection and their own moral acculturation, rather than religious dogma.

This entrenches discrimination against practitioners who do not hold or practice particular religious views, in a way that is inconsistent with the objectives of the Bill, as outlined in s5, where the definition of religious belief or activity is defined to include both holding and not holding religious beliefs and practicing or not practicing religious beliefs.

Read in conjunction with s8(5), the cumulative effect of the Bill is to prohibit discrimination against people who do not hold religious beliefs, while simultaneously telling them that their conscience is not worthy of protection because it is not informed by religious beliefs. This is fundamentally inconsistent and discriminatory in a way that is not justified by any of the evidence presented in support of the Bill to date.

It is also inconsistent with the Australian law’s assimilation of the international human rights framework, which does not place a sincerely held religious belief ahead of a sincerely held non-religious belief. As noted above, Australian human rights law at the Commonwealth, state and territory levels has not privileged a specific faith or religious faith generally over any other belief system.

**Conclusion**

We urge those reviewing the Bill to consider firstly whether the inclusion of the provisions in s8(5) is warranted, and, if it is determined that they are appropriate, to redraft them in order to better reflect consistency with the objectives of the Bill, and coherence with existing law.

We are happy to provide further information regarding this submission on request.

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