HSU NATIONAL

Submission of the Health Services Union

The Religious Discrimination Bill 2021 (from the 'religious discrimination legislative package')

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About the Health Services Union

The Health Services Union (**HSU**) is a growing member-based union with approximately 95,000 members working across the health and social assistance sectors in every state and territory. Our members work in aged care, disability services, community health, mental health, first response, alcohol and other drugs, allied health, administration, medical research, public hospitals and private practices. HSU members work in public, private and not-for-profit organisations, in a range of demographic, socio-economic and geographic settings.

HSU National is the trading name for the Health Services Union, a trade union registered under the *Fair Work (Registered Organisations) Act 2009*. This submission has been prepared by the HSU National Office, on behalf of our branches Australia-wide.[1]

Introduction

The experiences of HSU members inform us of the inextricable link between safe, accessible, timely and inclusive health care, and optimal health, social and economic outcomes for individuals and communities. A system that delivers care and outcomes of this nature is one supported by a strong and principled anti-discrimination framework. The HSU is deeply committed to ensuring the values of equality, freedom and social justice are enshrined in the legislative and policy structures governing our health system.

The proposed religious discrimination legislative package, namely the *Religious Discrimination Bill 2021* (**the Bill**), which is the focus of this submission, will undermine the existing anti-discrimination framework. It will introduce complex and untested legal concepts, override existing state and territory laws proven to protect individuals, undermine the legitimacy of courts and regulating bodies, preference one set of rights over many others, and codify discrimination which already occurs in workplaces and healthcare settings. This is too big a risk to take for a country supposedly driven by a 'fair go' ethos. The Bill will adversely and disproportionately affect already vulnerable and marginalised community members. Gaps in existing frameworks that allow discrimination to occur will be pronounced, placing community wellbeing under greater threat.

For healthcare workers, the Bill will confuse the operation of professional codes and standards, in turn diverting attention away from care delivery. It will encourage workplace and social disharmony, having the perverse effect of increasing rates of discrimination. Additionally, the Bill will restrict employers from managing their workplaces in accordance with existing laws, thereby threatening inclusive and safe workplaces. This will place increased stress on individuals, leading to higher rates of absenteeism, lost professional development, and reduced economic and social participation.

The HSU supports the submission of the Australian Council of Trade Unions (**the ACTU**).

The case studies contained within this submission are from HSU members. Names have been changed to protect the individual's privacy, including that of any client or patient.

[1] The HSU has registered branches with coverage of aged care workers in New South Wales, Victoria, Tasmania, Western Australia, South Australia/Northern Territory. The HSU also has coverage of aged care workers in the Australian Capital Territory and Queensland.

Discrimination is a health care issue

When discrimination occurs, it places the physical and mental wellbeing of the individual(s) at risk. In healthcare settings, discrimination can exacerbate the condition for which the patient has sought help and cause new conditions to develop. The COVID-19 pandemic has placed already strained health and social assistance systems under immense pressure. From workforce issues, funding, growing burden of disease, and declining social and economic participation,[2] the health and wellbeing of Australians, including those working in health and related fields, has never been more compromised. The introduction of legislation that will add additional stress and legitimise harmful practices, particularly at a time we continue to struggle to meet COVID-19 driven demands, is irresponsible.

Healthcare is a human right

The HSU notes the Bill will have implications for various human rights. The HSU believes that the right to healthcare is primarily engaged in addition to those specified in the explanatory memorandum.[3] Under the International Covenant on Economic, Social and Cultural Rights, Article 12 stipulates the right 'of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[4] The Bill will have a substantially adverse impact on the right to access health care by allowing practitioners to restrict, deny or delay health care on the basis of religious belief; deter or prevent individuals from seeking health care for fear of experiencing discrimination; and/or place health practitioners under duress where compliance with the Bill, a religious belief or associated policy requires them to restrict, deny or delay providing health care.

Case Study One

Marie* lives in central Melbourne. She is tertiary educated and financially independent. She unexpectedly falls pregnant with her partner. She is unsure as to whether she wants to continue with the pregnancy or access a termination. Her partner and family provide emotional support while she begins the process of seeking medical advice. She visits her GP to request information on abortion and/or a referral to pregnancy counselling.

The GP advises Marie she would be 'stupid to have an abortion', that abortion is 'very risky for future fertility' and that 'abortion is immoral'. The GP insists that Marie will 'be happy if she has the baby' and comments that it appears Marie has the 'economic means to continue with the pregnancy and raise a child.' The GP refuses to provide further information on abortion. When Marie presses the GP for a referral to another practitioner or service that can assist, she is told, 'I do not know of any doctors who do that (abortions or pregnancy counselling)'.

Marie, through her own research and resourcefulness, identifies and accesses 1800MyOptions – a sexual and reproductive health service that provides general information and connects people with the appropriate service and/or practitioner for their needs. Marie is referred to a registered social worker specialising in abortion and pregnancy. During their first 1-hour counselling session, the social worker makes a note that the first 40 minutes is spent discussing the impact of the psychological and emotional shaming Marie experienced from the first GP; the fear and terror she felt as a result of the false information she was given about abortion, including that it increases the risk of future infertility and breast cancer; and the difficulty she faced in finding a non-faith based organisation that could provide non-judgmental and accurate health care and counselling.

The social worker discusses with Marie the obligations, under various professional guidelines and codes, of registered health practitioners who conscientiously object to abortion.[5] It is evident that the GP Marie first attended had breached their professional and legal obligations. The social worker explains to Marie that she may

[2] See as examples, Royal Commission into Aged Care Quality and Safety, Final Report, March 2021 and Productivity Commission Inquiry into the social and economic benefits of improving mental health, inquiry report, June 2020.
[3] *Religious Discrimination Bill 2021*, Explanatory Memorandum, p. 9.
[4] United Nations Human Rights Office of the High Commissioner, https://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
[5] Abortion Law Reform Act 2008 (Vic) s. 8 (1).

make a complaint. Marie, despite being traumatised by the experience, makes a successful complaint against the practitioner under the relevant state legislation and professional codes.

Statement of belief and erosion of existing protections

The introduction of the 'statement of belief' concept in the Bill is particularly problematic and will exacerbate adverse outcomes for vulnerable people, such as that set out in *Case Study One*. The medical professional in this scenario has expressed their religious belief that abortion is immoral and unsafe. This statement has a significant adverse impact on the patient's psychological wellbeing by inducing feelings of shame, humiliation and intimidation. Under existing laws, such conduct is prohibited, and Marie has legal recourse to pursue the practitioner for engaging in discriminatory practice.

Under the proposed Bill, a 'statement of belief' would not be found to be discriminatory provided the person made it in good faith, genuinely considers it to be in accordance with the doctrines, tenets, beliefs or teachings of [their] religion, and did not have malicious intent.[6] In previous iterations of the Bill, while still problematic, a person of the same religion had to reasonably consider the statement to be in accordance with the shared religion.[7] By removing any external test for reasonableness, there will be no scope to objectively assess the appropriateness or intent of a statement of belief. Additionally, the Bill specifically stipulates that a statement of belief cannot be considered discrimination under existing anti-discrimination laws.[8]

The inclusion of such provisions means existing legal precedents will be overridden and new precedents will have to be established by way of litigation and court decision. This undermines the legitimacy of well-established court decisions and the existing discrimination framework. Not only will this require judges to interpret religious texts and practices, but it will also require victims of discrimination to pursue their matter at the time the trauma of their experience is being realised, placing a heavy and avoidable personal and social burden on them. In work and healthcare settings, this provides an opportunity for not only harmful discriminatory statements to be made, but for them to negatively impact upon the type, consistency or availability of care.

Case Study Two

Brandon* is a psychologist who works in private practice. He previously also worked part-time teaching psychology at a large religious university. He worked across these two roles for nearly 8 years. Brandon is also a member of the LGBTQI+ community and is Catholic. After productive negotiations with his employer a few years into his working at the university, he was allowed to put a small rainbow flag sticker on his office door. He felt it was very important to indicate to students that they had support and allyship within the faculty, should any issues ever arise for them during the impactful years of tertiary education. Brandon himself had already spent many years working through the tension that can exist between being a member of a religious community and the LGBTQI+ community. He wanted his students to be as engaged with their studies as possible and he knew that for this to happen, they would also need to feel supported and have a trusted space to express themselves. His employer agreed with this outcome for students.

In 2017, when the marriage equality postal survey was happening, Brandon also put up a "Vote Yes" poster in his office. He sought permission to do so from his supervisor and although they agreed, he was told he had to keep it as much out of sight from the hallway as possible. He had abided by this rule although he remembers feeling

[6] Section 5
[7] Religious Discrimination Bill 2020, Second Exposure Draft, Section 42.
[8] Section 12(1)(a-c)

very 'small' at the time. He felt as though there was an unspoken pressure and preference for him not to display the poster at all. Brandon had a number of students come to him and express their distress during this period of intense public debate. He also noted that in private practice, his clients who were also a part of the LGBTQI+ community were experiencing increased levels of anxiety, stress and depression relating to real and perceived discrimination arising from the debate. It was a very difficult time for him personally and professionally.

On multiple occasions during this time, Brandon would arrive to his office on campus to find that the poster was torn down. This meant that someone would have had to step right into his office. The rainbow flag sticker on his door was also rubbed out with black marker. After multiple times, he recalls at least six, Brandon stopped replacing the sticker and poster. He reported it to his supervisor, but he was told that it was not really an issue they wanted to 'take up' and that Brandon should just 'let it go'. He was told he was accepted by the university for who he was but that he had choices to make about what parts of himself he expressed. Brandon said that he was left feeling very confused by this mixed messaging and it triggered a lot of the confusion he had felt in his earlier years coming out to his loved ones and church. He started locking his office door. He recalls feeling unsafe in his workplace and worried for his students.

After the postal survey and even after the Yes vote was confirmed, Brandon said things never felt the same working at the university. He felt like an outsider and that he should hide himself. He never replaced the sticker on his door. About 12 months later, he decided to resign and focus on private practice. In this space, he has been able to specialise in working with people who are members of both religious groups and the LGBTQI+ community, to help them understand and accept who they are and be confident no matter what community group or workplace they are in.

Intersection with industrial rights

The HSU, as a worker representative organisation, is concerned by how the Bill will impede upon the operation of the *Fair Work Act 2009 (Cth)* (FWA). Under s 351 of the FWA, workers who have experienced discrimination in the workplace can pursue claims for adverse action. The worker must demonstrate that, due to their race, colour, sex, sexual preference, age, physical or mental disability, marital status, family or carer's responsibilities, pregnancy, religion, political opinion, national extraction or social origin,[9] they suffered injury or disadvantage in the workplace. A statement of belief made in a work environment may cause an individual to feel distressed, intimidated, bullied, vilified or disadvantaged. This will in turn affect their own wellbeing and for HSU members, this could impact negatively on the care they feel able to provide. The Bill would take legal precedence over the FWA and there would be no recourse for the worker.

Case Study Three

Sita* is a personal care worker in aged care. She is employed on a 'zero-hours' part-time contract but has regularly worked the same 4 shifts per week, of 6 hours each. Her employer is a large, Anglican not-for-profit organisation. Sita is Nepalese and a member of the Buddhist faith. Sita came to Australia on a temporary work visa, seeking work in residential aged care. She was interviewed by two facility managers and a long-term member of the personal care staff. They outlined the organisation's values, centred on love, empowerment and community. They mentioned the Christian background briefly but did not ask Sita about her own faith. Sita believes very much in the values that were set out to her. The interview focused on questions about her skills and how these align with the inherent requirements of personal care work. Sita was also complimented on her diligence in obtaining her Certificate III since arriving in Australia only 6 months earlier. Sita got the job.

Sita flourished in her role as a personal care worker. She took time wherever she could to go the extra mile for the residents. She was by all accounts an exemplary employee who often received compliments from the loved ones of those she cared for.

[9] http://www5.austlii.edu.au/au/legis/cth/num_act/fwa2009114/s351

Nearly a year into the role, Sita was speaking with a family member of a resident whose health was declining. The family member was asking Sita for information about what the facility's processes were for palliative care. The family member was satisfied with the responses Sita gave and the conversation moved on. At some point, the family member had asked Sita if she was religious and Sita had advised she was a Buddhist. This was not dwelled on and the family member in no way seemed upset or concerned by this information.

Shortly after this conversation took place, Sita started receiving less shifts. She also noticed that any time she went to assist residents with more complex needs or those requiring end of life support, she was directed away from them by her manager and asked to carry out tasks such as cleaning or running meals. Sita was very confused. She approached her manager to ask if she had done something wrong. The manager informed Sita that she had heard her tell the resident's family member she was a Buddhist and was worried Sita would 'fill the minds of the old folk with that reincarnation crap'. Sita was taken aback. At no point had she ever discussed reincarnation with any resident, their loved ones or colleagues. She had barely ever told anyone she was Buddhist.

Sita was sure that the changes to her rostering and tasks were because this manager disagreed with Sita's faith and had made assumptions. The work environment became so difficult for Sita that she had to accept work elsewhere. She was too frightened to raise the issue with the manager again.

Professional codes and restricting qualifying bodies

Many health practitioners are bound by professional codes of conduct. Various professional bodies, such as the Australian Health Practitioner Regulation Agency (AHPRA), are charged with developing, overseeing and enforcing these codes. The intent of such codes is to ensure patient and public trust in health professionals, based on the community expectation that practitioners, while free to hold their own personal beliefs, will always act in the best interests of the person in their care. Regulatory bodies such as AHPRA will investigate and where appropriate, act against individuals reported to be in breach of professional standards.

Health professionals understand that adherence to such codes and standards form an essential component of their registration and therefore licence to work in their profession. For example, a physiotherapist registered under the relevant board of AHPRA must comply with the Code of Conduct, including 'the clear separation that should exist between professional conduct aimed at meeting the health needs of patients or clients and a practitioner's own personal views, feelings and relationships which are not relevant to the therapeutic relationship'.[10] The HSU is aware of founded complaints resulting in restriction or loss of registration against AHPRA-registered health professionals for conduct carried out in a personal capacity, because it adversely affected the care provided to a patient.

The proposed Bill applies the term 'qualifying body'[11] to regulatory agencies such as AHPRA and at section 15, stipulates that qualifying bodies cannot act or impose conditions against an individual where a statement of belief has been made in a personal capacity.[12] The Bill is essentially redefining the purpose and scope of action able to be taken when investigating and prosecuting breaches of

[10] Physiotherapy board of Australia, Code of Conduct, Clause 8, March 2014, https://www.physiotherapyboard.gov.au/
[11] Section 5
[12] Explanatory Memorandum, p. 63.

professional codes. The Bill goes so far as to make any action taken in response to statements of belief made in a personal capacity as an act of discrimination by the qualifying body.[13]

The effect will be confusion for health practitioners as to what professional code or legislation they should adhere to. These clauses of the Bill will discourage regulation of discriminatory behaviour and its impediments on healthcare. It will set health professionals of faith against non-religious counterparts. The right to religious expression will take precedence over the obligations to preference the therapeutic relationship and needs of patients over the practitioner's personal views. For patients accessing healthcare, it will present inconsistencies, discrimination and confusion in health service delivery. Lack of consistent, clear and enforceable professional standards will lead to compromised health outcomes.

Case Study Four

Cody* is a graduate physiotherapist from South Australia. He grew up in a small town outside of the city and is eager to get experience working in a rural or remote area. Growing up, he saw first-hand how limited healthcare could be and he and his family often had to travel to the city for care. Cody is thrilled when he gets a job servicing regional, rural and remote communities in the Northern Territory, through a public health provider.

Cody is 'buddied up' with another physiotherapist, John*, for visits to the communities they are working with. Cody and John also live in the same small town. They begin socialising outside of work and Cody learns that John is involved with the local church. Cody is learning a lot from John at work and also appreciates the growing friendship as the town he is required to live in is small and he is missing home.

At a barbecue one weekend, Cody overhears John discussing his faith with another colleague. Cody hears John make derogatory remarks about LGBTQI+ people. He is alarmed by the comments but decides he is best not mentioning anything to John, given they have to work together and share a social circle.

A few weeks later, Cody is working with John and a young client. The client is a lesbian. When the client leaves, John makes a comment about feeling 'uncomfortable' around the client. Cody makes a mental note of the comment, believing John is referring to the person's sexual orientation. At the next appointment, John is outwardly rude to the client and unexpectedly advises them that he and Cody are unable to book them in for any more appointments. The client seems surprised by this and explains they do not believe the injury for which they are receiving physiotherapy is healed. John does not really respond to the concerns. Cody agrees with the client that treatment should continue.
When Cody speaks with John about the situation afterwards and asks some questions about the clinical status of the client, John is dismissive. He tells Cody 'that person has problems we cannot help with' and that the person's 'spirit is broken.'

Cody feels that his own, and John's, professional ethics are being compromised by denying further care to the client. Cody makes a complaint with the physiotherapy board and shortly after, he becomes aware that disciplinary action was taken against John. When he bumps into John in town a short time after making the complaint, John ignores him.

Workplace policy

Health care and social assistance, including aged care, disability and mental health, is the largest employing industry in Australia. Throughout the COVID-19 pandemic, it has proven to be most essential to the wellbeing and functioning of our communities. The workforces that provide these services are growing. However, demand for care is outpacing supply, particularly in the face of the unprecedented pandemic pressures. It is vitally important that legislative and policy decisions support

[13] Section 15(1)(a-b)

the growth and stability of these workforces. Currently, as an example, the Government is looking to migration as one policy mechanism to bolster workforce numbers in aged care.[14]

In aged care, migrant workers are commonly employed on temporary visas. They are on average younger, female, speak English as a second language and come from a range of culturally diverse, non-Anglo backgrounds. These workers are often more vulnerable to exploitative wages and conditions at work. The Royal Commission into Aged Care Quality and Safety heard evidence that migrant workers in care sectors experience high rates of workplace discrimination.[15]

Concerningly, under section 9 of the Bill, religious aged care providers (and religious providers in other health and social assistance sectors) will be able to discriminate against prospective and existing employees on religious grounds provided they are acting in good faith, a person of the same religion could reasonably consider the conduct to be in accordance with the religion, and the conduct is in accordance with a policy made publicly available by the organisation.[16] Behaviour that would be considered discriminatory under other legislation would be exempted under this clause. The HSU is concerned about the positing of one piece of discrimination legislation over others. This provision will codify discrimination in workplaces, undermine existing industrial obligations and precedents, and allow for open interpretation of faith in practice.

The focus of Government should be on attracting and retaining health and social assistance workers. The Bill will have the opposite effect – it will deter and arbitrarily exclude workers from these sectors. Low wages, poor conditions and supply and demand pressures already act as impediments to workforce attraction and retention. These provisions will only exacerbate the issues and in turn compromise care outcomes for vulnerable Australians reliant on these services.

Case Study Five

Julie* lives in a rural town in Western Australia. There is only one general practitioner (GP) working in the town. Julie unexpectedly falls pregnant. She is unsure as to whether she wants to continue with the pregnancy or access a termination, although she thinks a termination is the right choice and decides to seek information. She has no existing knowledge or experience of pregnancy or termination and requires medical expertise prior to deciding. She makes an appointment with the local GP.

The GP is hesitant to provide information about termination. The focus of the appointment is on keeping the pregnancy and referring Julie on for an ultrasound and blood tests. As there are limited services in the town, Julie must wait some time for the ultrasound to be carried out, and then wait again for a follow up appointment with the GP.

By the time Julie undergoes the ultrasound and blood tests, and all results become available as well as an appointment with the GP, she is past the first 12-weeks of the pregnancy. The GP tells her that as she is now over 12-weeks, an abortion cannot be carried out by them, and she will have to find a practitioner who is willing to assist. The GP tells Julie this will be difficult as there is only one clinic in the state that carries out termination of pregnancy after 12-weeks and there is limited appointment availability as they only have a few surgeons. The

[14] For example, the Pacific Australia Labour Mobility Scheme
[15] Federation of Ethnic Communities Councils of Australian, Submission to the Royal Commission into Aged Care Quality and Safety, AWF.650.00096, February 2019.
[16] Section 9(3)(b-d)

impact of the delays (unnecessary tests, awaiting results and a follow-up appointment) on Julie's ability to access a termination was at no time explained to her.

It is only at this point the GP informs Julie they object to termination on religious grounds. The GP refuses to provide Julie with a referral to an appropriate practitioner and/or the one Western Australian clinic offering termination of pregnancy after 12-weeks. Julie is now left to find all information about termination on her own, as well as locating and travelling to a new GP who will provide the appropriate healthcare to her. By the time she finds a new GP/clinic that will assist, and an appointment becomes available, she is now over 16-weeks pregnant. During this period, Julie has decided to terminate the pregnancy. She informs the new GP of this decision and is advised that unfortunately, she will need to seek advice and treatment from a third GP/clinic as she is over 16-weeks. Julie must take further time off work to travel, at her own additional and considerable expense, to an interstate abortion clinic.[17]

It is at this time that Julie is connected with a registered social worker specialising in abortion and pregnancy, who works for the interstate clinic. The social worker counsels Julie on the pregnancy, decision to terminate and actions of the GP. Julie is informed that there was no requirement for the ultrasound or blood tests to be carried out and that these were a common 'delay tactic' used to push women over the 12- and 16-week periods in pregnancy, with the intention to deter them from choosing termination and/or make access to a termination considerably harder.

A large proportion of the counselling sessions between Julie and the social worker are spent working through the trauma of the interactions with the initial GP and delays in accessing accurate and sufficient advice, free from judgment. The social worker recommends that Julie be referred for ongoing psychological therapy to address the trauma arising from the situation, namely the feelings of shame, judgement and fears of social isolation arising from the discrimination by the initial GP. The social worker advises Julie of her right to make a complaint under the Health Commissioner system. Julie declines to lodge a complaint, citing that she is too fearful of repercussions from the GP in the close-knit, small town they both live in. The social worker is not able to make a complaint on Julie's behalf.

Prevention of access to timely and affordable care

The social worker who handled Julie's case reported that during her time employed at the clinic that carried out Julie's late-term abortion, an average of 1 out of 10 women per week attending for a termination of pregnancy matter were there due to treatment by a practitioner who conscientiously objected, but contravened their ethical or legal requirements to refer on;[18] and/or did not minimise disruption to the patient's care, for example by causing unnecessary delays. Even where state and territory laws are strong and clear as to the protections and level of service a patient should receive, the dissemination of misinformation as a fear and delay tactic is prevalent. A Bill codifying this kind of practice is irresponsible and unethical on behalf of the Government.

Access to timely, affordable and appropriate healthcare is not always possible due to geographic, economic and service availability factors. The harmful effects of discrimination in health are especially pronounced at these intersections of socio-economic and geographic standing. LGBTQI+ identifying persons, persons living with disability, women, CALD groups, and first nations persons, particularly where members of these communities live in regional, rural and remote locations, already face

[17] There is one private practice clinic in Australia that will carry out termination of pregnancy when the term is over 16 weeks.
[18] Dependent on the jurisdiction from which the patient was travelling. Western Australia does not have conscientious objection provisions under the relevant state legislation, making referral on an ethical and professional obligation whereas, Victoria has a conscientious objection provision under the relevant state legislation, making referral on also a legislative obligation.

greater challenges in accessing the health care they need, when they need it. Codifying discrimination under the guise of freedom will only further exacerbate the uneven playing field.

Inadequacies in complaint mechanisms and data collection

HSU members report that the impact of discrimination, on the basis of religious belief or otherwise, is a major driving factor in preventing patients from pursuing complaints against health professionals in breach of their ethical or legal obligations. Our members also tell us that fear of repercussion is one of the most common reasons they do not pursue complaints in the workplace when experiencing or witnessing discrimination. Existing complaint mechanisms rely on individuals - assuming they are able and willing to advocate for themselves - to lodge and pursue a complaint, often at the time they are experiencing the loss and trauma arising from discrimination. Where complaints are lodged, they are often settled informally, meaning there is a dearth of accurate data as to the rates of causally linked discrimination on religious grounds and prevention of timely, safe, consistent and accurate health service provision.

Conclusion

The HSU and its members do not oppose the right to religious freedom. We celebrate the diversity of Australian society. We are concerned that the passage of this Bill without striking out the areas of concern as outlined above, will have the opposite effect to enshrining freedom. It will place one set of rights over others, driving social and economic inequities.

We reiterate our concerns that the Bill:

- Introduces new, complex, untested and unnecessary legal concepts.
- Is unclear in its intersection with and impact on state and territory anti-discrimination laws, the *Fair Work Act 2009* and other Commonwealth laws.
- Allows for open and inadequately tested integration of religious doctrines, tenets, beliefs or teachings.
- Overrides well-established professional codes, standards and policies, and diminishes the ability of regulatory bodies to enforce these.
- Gives rise to, or will exacerbate, social conflict and disharmony.
- Adversely and disproportionately impacts already marginalised and vulnerable groups.

The HSU supports the ACTU's recommendation that the appropriate remedy be to include 'religion' as a protected attribute under federal anti-discrimination law; either in the *Race Discrimination Act* or in a new act which follows the usual structure of other discrimination laws.