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Submission on the Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013

Australia is a signatory to the International Conference on Population and Development (ICPD) programme of action. This means we have agreed to take all necessary measures to achieve the ICPD's objectives, including action 4.23 which states:

> Governments are urged to take the necessary measures to prevent infanticide, prenatal sex selection, trafficking in girl children and use of girls in prostitution and pornography.

While acknowledging the difficulties of identifying couples who may be seeking termination on the grounds of sex-selection, and while acknowledging there are no solid figures on the possible practice of prenatal sex selection in Australia, the *Health Insurance (Medicare Funding for Certain Types of Abortion) Amendment Bill 2013* would at minimum signal that appropriating Medicare payments for such terminations would be a serious misuse of public funds in a country that has pledged to end discrimination on the basis of sex.

The Medicare system provides healthcare to all Australians. Abortions on the basis of the sex of the unborn child are not related to health.

Evidence globally points to significant distortions in sex ratios at birth in a number of countries. This distortion is most prevalent in relation to the number of boys born compared to the number of girls. A culturally ingrained preference for boys has resulted in millions of 'missing' baby girls. According to the UN, about 200 million girls in the world today are 'missing'. India and China are believed to eliminate more baby girls than the number of girls born in the US each year.

There is evidence that, unfortunately, some of these cultural biases are being practiced by particular ethnic groups who have migrated to countries such as the US, Canada and UK. Research by Douglas Almond (National Bureau of Economic Research, October 2009) shows concerning sex ratios for Indian, East Asian, Chinese, Korean and Vietnamese immigrant groups. While there is no corresponding

research in Australia, there is no reason to suspect we are immune from such practices being duplicated here.

Australia needs to signal strong opposition to prenatal sex selection as part of its broader goals to eliminate gender inequality and bias which contributes to women's second class status. Allowing these practices to possibly go unchecked - and permitting their payment out of the public purse - undermines our efforts to have women and girls treated equally. Discrimination against girls especially, begins at the earliest of ages - in utero - thus efforts to eliminate the practice must begin then if we are going to increase the value of the girl child. Women are often placed under inordinate pressure not to give birth to a child of the 'wrong' sex, which is a form of violence against them. This legislation is one small way of signalling our opposition to coercion on the basis of harmful cultural practices.

Australia already has a ban on using Prenatal Genetic Diagnoses and Assisted Reproductive Technology for sex selection purposes. We also do not permit the use of our aid money for sex-selection abortion. Making it an offence to use the public health system to fund sex selection termination would be consistent with the values expressed in these other prohibitions.

Of course this legislation should not just apply to ethnic groups and women who are members of these groups should not be singled out. No form of sex bias should be publicly funded including sex bias for so called 'family balancing' purposes.

The bill makes an abortion performed solely because of the sex of the child not eligible for a Medicare payment. A doctor who cited a Medicare item number for a sex-selection abortion would be judged under the legislation as "inappropriately billing". The legislation thus means practitioners would need to take steps to make sure they are not inappropriately billing. While, again, cases may not be easy to detect, a clearly stated legislative action could act as a deterrent to some medical practitioners who may know the real reason for the abortion. It could, also hopefully, encourage doctors who have sensitive conversations with patients to ascertain if sex-selection is a factor, and explain why this is not appropriate and not supported in Australia. Exploring possible coercion of the patient with her is something that should also be encouraged.

Melinda Tankard Reist

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