Public Health Association
AUSTRALIA

Public Health Association of Australia submission to the Senate Standing Committee on Finance and Public Administration Legislation Committee:

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

Senate Finance and Public Administration Committees
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Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

Public Health

Public health includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association's role.

The Public Health Association of Australia

PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups concerned with the promotion of health at a population level.

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the Australian Government and for the Preventative Health Taskforce and National Health and Medical Research Council (NHMRC) in their efforts to develop and strengthen research and actions in this area across Australia.

PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

Advocacy and capacity building

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

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Senate Standing Committee on Finance and Public Administration Legislation Committee: Inquiry into the Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013

In undertaking the current inquiry the Senate Standing Committee has been requested to consider:

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

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;

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

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

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

1. Overview

PHAA welcomes the opportunity to respond to this inquiry. The PHAA does not support sex selective abortion, as it reflects deeply entrenched gender inequality. Nevertheless the PHAA believes 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 and could also discriminate against certain groups of women if implemented in Australia. There is no comprehensive or reliable evidence to suggest that sex selective abortion is occurring in Australia, 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.

PHAA notes that prior to safe and legal abortion services becoming accessible in the late 1960s and early 1970s illegal abortion was a major cause of maternal mortality in Australia. Since then, abortion deaths have been very rare, and have usually occurred in women with multiple pre-existing health problems. While there are diverse views on many aspects of abortion, the Australian community is increasingly supportive of women's access to safe, legal abortion Australian women undergoing termination of pregnancy have higher rates of socioeconomic disadvantage and partner violence than the general population.

Abortion should be regulated, as are all other medical services, under existing health care legislation. There is no case for singling out the abortion procedure in any area of legislation, including Medicare rebates. Abortion services should be included in service planning for all state and territory health authorities.

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PHAA has some concern that the Terms of Reference appear to make the assumption 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. Research indicates that the best outcome is achieved when women are in control of their own decisions about pregnancy termination. A woman's ability to control her own fertility is crucial to maintenance of her health.

2. Responses to Specific Terms of Reference:

a) 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. There is also no comprehensive or reliable evidence to suggest 'the unacceptability to Australians of the use of Medicare funding for the purpose of gender selection abortions' as studies asking this question do not exist in Australia. The PHAA is therefore unable to accept this proposition at face value.

On the contrary, the attitudes of Australians towards abortion more generally are known. Australian survey data indicate strong community support for women to have the right to choose to have an abortion.[1] 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.[2]

b) 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

Australian studies have found a broad number of reasons for women to consider terminating[3] or to terminate a pregnancy.[4] There is no comprehensive or reliable evidence suggesting foetal sex is among the reasons for this decision.

[1] Women's Health Victoria. 2010. Women and Abortion (Women's Health Issues Paper No. 6), available at: http://whv.org.au/static/files/assets/8caa639d/Women_and_abortion_issues_paper.pdf

[2] Australian Consortium for Social and Political Research. 2003. Australian Survey of Social Attitudes. Canberra: Australian National University.

[3] Rowe HJ, Kirkman, M, Hardiman, EA, Mallett, S, Rosenthal, DA. 2009. Considering abortion: a 12-month audit of records of women contacting a Pregnancy Advisory Service. *Medical Journal Australia*. 190 (2): 69-72.

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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. Australia has a normal ratio of male to female births, which would suggest that sex selective abortion is rare, if not non-existent. Australian birth sex ratios are consistently balanced, with the most recent Australian Institute of Health and Welfare reports (data from 2009 and 2010) showing typical[5] annual sex ratios of 51% males to 49% female babies born.[6]

Further, the National Health and Medical Research Council's Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research advises against sex selection for non-medical purposes (section 11).[7] Sex selection is not possible through the use of assisted reproductive treatment in states with legislation on this matter.

c) The use of Medicare funded gender-selection abortions for the purpose of 'family-balancing'

PHAA is not aware of any data indicating that the practice of gender-selective abortion for the purpose of family-balancing is common in Australia, with or without Medicare funding. PHAA notes that the current Medical Benefits Schedule Item number covering pregnancy termination does not provide any information on the purposes for which the procedure was carried out.

Further, PHAA notes that in Australia, most abortions occur early on in pregnancy,[8] before the sex of the foetus is known or can be determined with accuracy. Sexual differentiation of a foetus begins at seven to eight weeks gestation and development of external genitalia is not complete until 12 weeks[9] and is difficult to identify accurately by ultrasound until at least 14 weeks gestation[10].

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[4] Lee W, Mazza, D. 2009. Reasons for termination of pregnancy in women aged 35 and over. *Medical Journal Australia.* 191 (3): 188-189.

[5] ABS. 2010. Births, Australia, cat. no. 3201.0. ABS, Canberra.

[6] Li Z, Zeki R, Hilder L & Sullivan EA 2012. Australia's mothers and babies 2010. Perinatal statistics series no. 27. Cat. no. PER 57. Canberra: AIHW National Perinatal Epidemiology and Statistics Unit; Li Z, McNally L, Hilder L & Sullivan EA 2011. Australia's mothers and babies 2009. Perinatal statistics series no. 25. Cat. no. PER 52. Sydney: AIHW National Perinatal Epidemiology and Statistics Unit.

[7] NHMRC. 2007. Ethical guidelines on the use of Assisted Reproductive Technology in clinical practice and research 2007. Accessed on 07-04-2013. http://www.nhmrc.gov.au/guidelines/publications/e78.

[8] Rosenthal D, Rowe H, Mallett S, Hardiman A, Kirkman M. 2009. Understanding women's experiences of unplanned pregnancy and abortion. Melbourne: Key Centre for Women's Health in Society, University of Melbourne. http://www.kcwhs.unimelb.edu.au/__data/assets/pdf_file/0006/135834/UPAP_Final_Report.pdf.

[9] Hutson, JM. 2012. Embryology of the Human Genital Tract. in Garry L. Warne and Sonia R. Grover (eds) *Disorders of Sex Development: An Integrated Approach to Management*. Springer-Verlag. Berlin. pp 11-21

[10] Lubusky M, Studnickova M, Skrivanek A. 2012.Ultrasound evaluation of fetal gender at 12-14 weeks. *Biomedical Papers.* 156(4): 324-329

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

PHAA is strongly supportive of the role of the United Nations and its agencies in promoting changes in social values, and of the role of the Australian Overseas Aid Agency in promoting and financing sexual and reproductive health programs in developing nations. Access to safe abortion services is a necessary part of any comprehensive system of reproductive health services. To deny these services is to breach a woman's right to health.

We note that at the recent (March 2013) meeting in New York of the United Nations Commission on the Status of Women the following resolution was agreed:

> 14. The Commission urges States to strongly condemn all forms of violence against women and girls and to refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to its elimination as set out in the Declaration on the Elimination of Violence against Women.

Further, Article 12 of CEDAW states 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'[11].

PHAA considers that to increase the status of women and for girl children, public policies such as improved access to education, abolition of discriminatory practices and prevention of domestic violence are the most appropriate measures, both domestically and in Overseas Aid programs[12].

Sex selective abortion, with a preference for a male child, is known to take place in some countries.[13] 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:

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[11]CEDAW. Accessed 07-04-2013. http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12

[12] Sen G, Östlin P, George A. 2007. Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it exists and how we can change it. Final Report to the WHO Commission on Social Determinants of Health September 2007. Women and Gender Equity Knowledge Network. Accessed 03-04-13. http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf

[13]Barot, S. 2012. A Problem-and-Solution Mismatch: Son Preference and Sex-Selective Abortion Bans. *Guttmacher Policy Review*. 15(2). Accessed 07-04-2013. http://www.guttmacher.org/pubs/gpr/15/2/gpr150218.html.

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- 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.[12] Moreover, restrictions on sex selective abortions, 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.

e) 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. [14] 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. PHAA 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.

Conclusion

PHAA welcomes the opportunity to respond to this inquiry. PHAA does not support sex selective abortion, as it reflects deeply entrenched gender inequality. Nevertheless the PHAA believes 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 and there is no comprehensive or reliable evidence to suggest that sex selective abortion is occurring in Australia, or that Medicare is being used to fund such procedures. PHAA is also concerned that 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.

[14] RANZCOG. 2005. College Statement C-Gyn 17 Termination of Pregnancy. 1st Endorsed March 2005. Accessed 07-04-2013. http://www.ranzcog.edu.au/component/docman/doc_details/926-c-gyn-17-termination-of-pregnancy.html?Itemid=341

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PHAA believes that abortion should be regulated, as are all other medical services, under existing health care legislation. There is no case for singling out the abortion procedure in any area of legislation, including Medicare rebates.

Please do not hesitate to contact PHAA should you require additional information or have any queries in relation to this submission.

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