Chapter 3

Evidence not supportive of the Bill

Introduction

3.1 This chapter canvasses evidence from submitters who did not support the Bill. The committee notes that most submitters who opposed the Bill made it clear that they were also opposed to gender selective abortion.[1]

The ineffectiveness of the Bill

3.2 Many submitters questioned whether the Bill would be effective in removing Medicare funding for gender selective abortion. It was also argued that there may be undesirable consequences if the Bill were to be passed. Issues that were identified included that:

- the arrangements to implement the Bill would be easily circumvented as Medicare items cover more than one service;
- the approach taken by the Bill has been shown to be ineffective in other countries;
- if heavily enforced, the Bill would risk causing discrimination; and
- the Bill does not address the root causes of gender selective abortion.

Medicare items cover multiple services

3.3 Submitters argued that a restriction on Medicare funding of gender selective abortion would not be effective as the Medicare item numbers for abortion do not distinguish between the reasons for that procedure being undertaken.[2] There are many reasons why these item numbers are used including fetal death, miscarriage and unintended pregnancy endings.[3] In addition, it was noted that the Bill does not provide for a mechanism to separate gender selective abortion from other types of abortion. The Women's Abortion Action Campaign commented:

> [The Medicare] rebate is payable for a group of services, including induced termination of pregnancy. There is no mechanism within the Medicare system to determine the reasons for induced terminations of pregnancy. Therefore, any 'estimate' of the prevalence of gender selective abortions (or other reasons for termination of pregnancy) can only be based on anecdotal data.

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1 Children by Choice, *Submission 160,* p. 2; Women's Health Victoria, *Submission 2,* p. 1; Women's Centre for Health Matters, *Submission 157,* p. 2; Professor Diane Bell, *Submission 175,* p. 1; Australian Women Against Violence Alliance, *Submission 191,* p. 1; Women's Legal; Services NSW, *Submission 192,* p. 1.

2 Women's Centre for Health Matters, *Submission 157,* p. 3.

3 Women's Centre for Health Matters, *Submission 157,* p. 3; Children by Choice, *Submission 160,* p. 3.

> Neither the proposed Bill nor the Explanatory Memorandum make clear the mechanism by which sex selective abortions would be separated from other types of termination of pregnancy, or indeed other medical procedures covered by Medicare Benefits Schedule items 16525 and 35643.[4]

3.4 Women's Health Victoria indicated that there would be substantial practical difficulties in implementing the Bill, submitting that:

> 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?[5]

Ineffectiveness of similar restrictions in other countries

3.5 The type of approach set out in the Bill to address gender selective abortion has been tried in other countries but submitters commented that it has not been effective.[6] Women's Health Victoria, for example, pointed to a study of practices in China and India and found that restrictions were not successful as:

> …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.[7]

3.6 The Young Women's Christian Association (YWCA) Australia also noted that the UN agencies and WHO interagency statement indicated that such restrictions had been ineffective:

> Governments in affected countries have undertaken a number of measures in an attempt to halt increasing sex-ratio imbalances. Some 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

4 Women's Abortion Action Campaign, *Submission 182*, pp 1–2.

5 Women's Health Victoria, *Submission 2,* p. 3; see also Public Health Association of Australia, *Submission 72,* pp 7–8;

6 Women's Health Victoria, *Submission 2,* p. 1; Women's Health West, *Submission 71,* p. 2; Public Health Association of Australia, *Submission 72,* p. 4; Women's Centre for Health Matters, *Submission 157,* p. 5; Professor Diane Bell, *Submission 175,* p. 3; Australian Women Against Violence Alliance, *Submission 191,* p. 4.

7 Women's Health Victoria, *Submission 2,* p. 3; see also Women's Health West, *Submission 71,* p. 2; Australian Women Against Violence Alliance, *Submission 191,* p. 3.

isolation from broader measures to address underlying social and gender inequalities.[8]

3.7 Liberty Victoria stated that legislation to restrict abortions based on sex selection had been unsuccessful in the United States and Canada. In the United Kingdom some members of parliament had suggested that legislation was needed to monitor abortions by gender to protect girls. Liberty Victoria went on to note that the Health Minister, Lord Howe, in rejecting government monitoring of abortions stated that 'introducing testing to determine the sex of the foetus would require new laboratory tests, which would have a cost implication and require consent' and would cause women distress 'during what is already a difficult time'.[9]

Failure to address root causes

3.8 A further reason that restrictions on gender selective abortions were not viewed as being effective in other countries is because they do not address the reasons why they are being sought, such as poverty, social attitudes, entrenched gender inequality and discrimination.[10] Professor Diane Bell pointed to the UN interagency which states:

> The rise in sex ratio imbalances and normalization of the use of sex selection is caused by deeply embedded discrimination against women within institutions such as marriage systems, family formation and property inheritance laws…
>
> Although the relatively recent availability of technologies that can be used for sex selection has compounded the problem, it has not caused it.[11]

Undesirable consequences of the Bill

3.9 Submitters argued that there is potential for discrimination, stereotyping and stigmatisation of certain groups of women if the Bill is passed.[12] YWCA Australia suggested that the Bill may encourage discrimination against women from some South Asian, East Asian and Central Asian communities when they are seeking access to reproductive health services.[13]

3.10 In addition, Children by Choice submitted that the aims of the Bill:

> …would contravene Australia's domestic and international obligations to uphold women's human rights.

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8 YWCA Australia, *Submission 167,* pp 1–2; see also Women's Health Victoria, *Submission 2,* p. 4; Women's Health West, *Submission 71,* p. 2.

9 Liberty Victoria, *Submission 164,* pp 5–6.

10 Women's Health Victoria, *Submission 2,* p. 3; Women's Health West, *Submission 71,* pp 3–4; Liberty Victoria, *Submission 164,*pp 3–4; Australian Women Against Violence Alliance, *Submission 191,* p. 4.

11 Professor Diane Bell, *Submission 175,* p. 5.

12 Women's Health Victoria, *Submission 2,* pp 1, 3; Women's Health West, *Submission 71,* pp 2, 4; Public Health Association of Australia, *Submission 72,* p. 4.

13 YWCA Australia, *Submission 167,* p. 2.

> Such scrutiny by government and health authorities of women's decision making as may be required by the Bill would constitute unnecessary intrusion and surveillance into a woman's personal life and health care decision-making. Surveys of Australian community attitudes have shown that a large majority support legal abortion and believe that it should be private matter between a woman and her doctor.[14]

3.11 Professor Bell argued that, if the Bill was passed, it may limit the information sought and provided in the doctor/patient relationship and therefore may be a restriction of women's rights. Such a restriction would not align with the empowerment envisioned by the interagency statement and the Convention on the Elimination of All Forms of Discrimination Against Women.[15] Women's Legal Services NSW had similar concerns, submitting that:

> The Bill purports to limit gender selective discrimination and enhance human rights. However, the Bill fails to identify and address the potential for erosion of human rights, for example, the risk of such legislation obstructing access to safe, affordable, legal reproductive health options, including abortion.[16]

3.12 Submitters also noted that restrictions on Medicare funding for gender selective abortion would potentially compromise access to abortion more generally, thereby limiting a vital health service for women in Australia and an important reproductive health right.[17]

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

3.13 As noted earlier, most submitters who opposed the Bill, made it very clear that they were also opposed to gender selective abortion.[18] However, submitters noted that there was no comprehensive or reliable evidence to suggest that gender selective abortion was unacceptable to Australians. Thus, submitters stated that they were unable to accept the proposition concerning the unacceptability to Australians of the use of Medicare funding for gender selective abortions at face value.[19] For example, the National Foundation for Australia Women (NFAW) stated that:

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14 Children by Choice, *Submission 160,* p. 3.

15 Professor Diane Bell, *Submission 175,* p. 7.

16 Women's Legal Services NSW, *Submission 192,* pp 1–2.

17 Woman's Health Victoria, *Submission 2,* p. 1; see also Women's Health West, *Submission 71,* p. 2.

18 Children by Choice, *Submission 160,* p. 2; Women's Health Victoria, *Submission 2,* p. 1; Women’s Centre for Health Matters, *Submission 157,* p. 2; Professor Diane Bell, *Submission 175,* p. 1; Australian Women Against Violence Alliance, *Submission 191,* p. 1; Women's Legal; Services NSW, *Submission 192,* p. 1.

19 Women's Health Victoria, *Submission 2,* p. 2; Women's Health West*, Submission 71,* p. 2; Public Health Association of Australia, *Submission 72,* p. 5; Women's Centre for Health Matters, *Submission 157,* p. 3.

> NFAW is unable to accept at face value or agree entirely with the proposition inherent in the first Term of Reference, while deploring terminations of pregnancies solely for cultural reasons.[20]

3.14 Several submitters provided information from the Australian Survey of Social Attitudes which provides evidence on attitudes of Australians towards abortion generally. Women's Health Victoria stated:

> 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.[21]

The prevalence of gender selection by abortion

3.15 It was acknowledged that gender selective abortion is prevalent in other countries.[22] The NFAW commented it 'is aware of the existence in some countries of such practices, and finds such practices abhorrent'.[23]

3.16 However, it was argued that there is no evidence that gender selective abortion is being undertaken in Australia or that the use of Medicare funding for gender selection abortion was prevalent.[24] Liberty Victoria stated:

> We believe that changing access to Medicare for abortions in Australia because of cultural biases and practices occurring in other countries is inexcusably bad public policy.[25]

3.17 Reproductive Choice stated that evidence that gender selective abortion 'cannot be disguised' and pointed to the skewed gender ratios in China and India.[26] However, it was submitted that there is no such evidence of a skewed gender ratio in

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20 National Foundation for Australia Women, *Submission 74,* p. 2.

21 Women's Health Victoria, *Submission 2,* p. 2; see also Women's Health West, *Submission 71,* p. 3; Public Health Association of Australia, *Submission 72,* p. 5; Women's Centre for Health Matters, *Submission 157,* p. 3.

22 Liberty Victoria, *Submission 164*, p. 2; National Foundation for Australian Women, *Supplementary Submission 74*, p. 2; Family Planning NSW, *Submission 171*, p. 4; Professor Diane Bell, *Submission 175*, p. 3; Australian Women Against Violence Alliance, *Submission 191,* p. 2.

23 National Foundation for Australian Women, *Supplementary Submission 74*, p. 2.

24 Women's Centre for Health Matters, *Submission 157,* p. 2; Children by Choice, *Submission 160,* p. 2; Liberty Victoria, *Submission 164,* p. 2; YWCA Australia, *Submission 167,* p. 1; Family Planning NSW, *Submission 171,* p. 4; Professor Diane Bell, *Submission 175,* p. 1; Health Consumers Alliance of SA Inc, *Submission 176,* p. 1; Women's Abortion Action Campaign, *Submission 182,* p. 1; Women's Legal Service Australia, *Submission 190,* p. 1; Australian Women Against Violence Alliance, *Submission 191,* p. 2; Women's Legal Service NSW, *Submission 192,* p. 1.

25 Liberty Victoria, *Submission 164*, p. 4.

26 Reproductive Choice, *Submission 3*, p. 2.

Australia. Several submitters point out that Australia's sex ratio at birth is 105.7 male births per 100 female births and therefore within the normal range of 102 and 106.[27] Family Planning NSW also argued that the sex ratio in Australia has remained stable and provided data on the sex ratio for each state and territory for children aged zero to six which showed that all states were in the range 1.04 to 1.08.[28]

3.18 The Australian Women Against Violence Alliance concluded that, in its view, 'Australia continues to exhibit one of the healthiest sex ratios in the world and lowest maternal mortality rates, both strong indicators of gender health and well-being'.[29]

3.19 Submitters provided further evidence which indicated that gender selective abortion is not occurring in Australia. Family Planning NSW, for example, stated that:

> Last financial year we had around 28,000 client visits and in the 85 years we have been operating we have no evidence to suggest that pregnancy terminations occur solely on the basis of gender selection.[30]

3.20 Several submitters also pointed to a 2008 Melbourne study of 578 patients having pre-natal diagnosis, which found that none of the patients had a pregnancy termination for gender selection.[31]

3.21 In addition, submitters noted that in Australia most abortions occur before the gender is known at around 18–19 weeks gestation.[32] Children by Choice submitted information from the Australian Health and Welfare Institute indicating that almost 95 per cent of pregnancy terminations occur in early pregnancy, that is, before 14 weeks gestation, 4.7 per cent between 13 and 20 weeks, and 0.7 per cent after 20 weeks.[33]

3.22 Submitters also commented on the argument that, because gender selective abortion is occurring in some countries overseas, communities from those countries are seeking gender selective abortions in Australia.[34] Submitters argued that there are no studies or evidence-base to show that this occurs. The Australian Women Against Violence Alliance pointed a study undertaken in Australia in 2000 which 'provided evidence to show that immigrants adapt to the fertility patterns and behaviours of the Australian population'. A similar study in Canada found that the fertility of immigrant

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27 Women's Centre for Health Matters, *Submission 157*, p. 3; Women's Health Victoria, *Submission 2,* p. 2.

28 Family Planning NSW, *Submission 171*, p. 4.

29 Australian Women Against Violence Alliance, *Submission 191*, p. 2.

30 Family Planning NSW, *Submission 171,* p. 4.

31 National Foundation for Australia Women, *Submission 74,* p. 2; Children by Choice, *Submission 160,* p. 2; Reproductive Choice Australia, *Submission 3,* p. 1.

32 National Foundation for Australian Women, *Submission 74,* p. 4; Children by Choice, *Submission 160,* p. 3.

33 Children by Choice, *Submission 160,* p. 3.

34 National Foundation for Australian Women, *Submission 74*, p. 2; Women's Abortion Action Campaign, *Submission 182*, p. 3.

women tended to increasingly resemble and converge with that of Canadian-born women, the longer they resided in Canada.[35]

3.23 The NFAW stated that from its analysis of population statistics by ancestry and religious affiliation it can be concluded that 'there is no widespread practice of abortions leading to skewing of the sex ratio'.[36] In addition, Liberty Victoria noted:

> Even amongst migrant groups where the country of origin has a son-preference and sex-selection problem, the same social pressures do not exist in Australia. Indeed, all academic research as well as UN and [non-government organisations] research indicates that it is confined to only a few regions of the world, namely East and South Asia, Korea, China and parts of India.[37]

3.24 It was also noted that Australia has a very different society and approach to gender equality than some other countries. Children by Choice drew attention to existing initiatives in Australia aimed at gender discrimination and submitted that:

> …in Australia today, women and girls have more social, cultural and economic equality with their male counterparts compared to many other nations. While gender discrimination still exists in our society and must be addressed, there is robust government legislation, regulations and many other programs and education campaigns that aim to advance, monitor and promote the status of women and girls living in our community. Some examples of these include anti-discrimination legislation, a national Sex Discrimination Commissioner, initiatives to promote girls' education and participation in non-traditional areas, and campaigns to educate and discourage practices such as Female Genital Mutilation.[38]

3.25 The Women's Legal Services NSW also argued that should the Bill be passed, 'there could be disproportionate scrutiny of women and girls from particular ethnic, race, cultural and religious backgrounds when they access sexual and reproductive health services'.[39]

The use of Medicare funded gender selection abortions for the purpose of family balancing

3.26 Submitters noted that there are legal barriers to the use of gender selection technologies, anonymous egg donation, with or without payment, and commercial surrogacy and that gender selection technology is only allowed for reducing the risk of transmission of sex-linked disorders.[40] For example, in Victoria the *Assisted*

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35 Australian Women Against Violence Alliance, *Submission 191,* pp 2–3.

36 National Foundation for Australian Women, *Supplementary Submission 74*, p. 2.

37 Liberty Victoria, *Submission 164*, p. 2.

38 Children by Choice, *Submission 160*, p. 4.

39 Women's Legal Services NSW, *Submission 192*, p. 3.

40 National Foundation for Australian Women, *Submission 74*, p. 1; see also Women's Health Victoria, *Submission 2*, p. 3; Women's Health West, *Submission 71,* p. 4; Public Health Association of Australia, *Submission 72,* p. 6.

Reproduction Treatment Act 2008 bans gender selection except to avoid the transmission of a genetic abnormality or a genetic disease to the child or it is approved by the Patient Review Panel.[41]

3.27 Submitters also noted that gender selective abortion for non-medical purposes is constrained by the National Health and Medical Research Council's Ethical Guidelines on the use of Assisted Reproductive Technology in Clinical Practice.[42] The Victorian Council for Civil Liberties quoted the guidelines as follows:

> Sex selection is an ethically controversial issue. The Australian Health Ethics Committee believes that admission to life should not be conditional upon a child being a particular sex. Therefore, pending further community discussion, sex selection (by whatever means) must not be undertaken except to reduce the risk of transmission of a serious genetic condition.[43]

3.28 The NFAW argued that 'it is unlikely that an Australian medical practitioner (eligible to raise a charge on the Medical Benefits Schedule) would act in breach of this prohibition'.[44]

3.29 Where abortions are undertaken, the reasons for doing so are varied and complex but gender selection is not a reason given.[45] Submitters cited a study by the University of Melbourne's Key Centre for Women's Health in Society which reported that the reasons for an abortion usually relate to the woman herself, the potential child, existing children, the woman's partner and other significant relationships, and what it means to a woman to be a good mother.[46] Other issues relating to violence, completed family size, educational aspiration, age and medical issues were also identified.[47]

Support for United Nations campaigns

3.30 Submitters opposing the Bill were critical of the term of reference relating to UN campaigns as they did not consider that the UN agencies and WHO supported the approach envisaged in the Bill. The Bill's statement on human rights was also criticised as not accurately representing relevant human rights documents.

3.31 Liberty Victoria submitted that:

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41 Liberty Victoria, *Submission 164*, pp 4–5.

42 Women's Health Victoria, *Submission 2*, p. 3; Woman's Health West, *Submission 71*, p. 7; National Foundation for Australian Women, *Submission 74*, p. 3.

43 Victorian Council for Civil Liberties, *Submission 164*, p. 5.

44 National Foundation for Australian Women, *Submission 74,* p. 3.

45 Women's Health Victoria, *Submission 2,* pp 3–4; Women's Health West, *Submission 71,* p. 4; Public Health Association of Australia, *Submission 72,* p. 5; National Foundation for Australian Women, *Submission 74,* p. 2; Women's Abortion Action Campaign, *Submission 182,* p. 4; Australian Women Against Violence Alliance, *Submission 191,* p. 3.

46 Women's Health Victoria, *Submission 2*, pp 3–4; Women's Health West, *Submission 71*, p. 4; Children by Choice, *Submission 160*, p. 3; Women's Centre for Health Matters, *Submission 157*, p. 4.

47 Children by Choice, *Submission 160*, p. 5.

> The phrasing of this 'Term' misleadingly implies that UN agencies are advocating limiting abortion as a means of solving the problem of sex-selection. This is untrue. Indeed, although states have an obligation to address the issue of gender biased sex selection, the UN interagency statement makes clear, that it must be addressed:
>
> > without exposing women to the risk of death or serious injury by denying them access to needed services such as safe abortion … Such an outcome would represent a further violation of their rights to life and health as guaranteed in international human rights treaties, and committed to in international development.[48]

3.32 Submitters supported campaigns by UN agencies to implement disincentives for gender selection by abortion. However, they argued that the WHO was not advocating the type of restrictions proposed in the Bill, as such measures have not been found to be effective.[49] The Public Health Association of Australia submitted that it:

> …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.[50]

The Bill's statement on human rights

3.33 Concerns were raised about the human rights statement in the Bill and whether it adequately addressed the human rights of both mother and child. The Women's Abortion Action Campaign stated that the reports cited in the Bill's human rights statement:

> …have been used in a way which does not acknowledge their full context, and obscures the fact that the United Nations' World Health Organisation recognises access to safe abortion as an important marker for women's health and publishes a technical and policy guide for (national) health systems to assist in this.[51]

3.34 Submitters also stated that a number of UN human rights instruments were omitted from the Bill's statement including the Beijing Declaration, which stemmed from the Fourth UN Conference on Women.[52] The declaration unequivocally affirms that 'the right of all women to control all aspects of their health, including their own

48 Liberty Victoria, *Submission 164*, p. 3.

49 Women’s Health Victoria, *Submission 2*, p. 4; Women's Health West *Submission 71*, pp 4–5; YWCA Australia, *Submission 164*, p. 2.

50 Public Health Association of Australia, *Submission 72*, p. 7.

51 Women's Abortion Action Campaign, *Submission 182*, p. 2.

52 Women's Centre for Health Matters, *Submission 157*, p. 6; see also Women's Health Victoria, *Submission 2*, p. 5; Women's Health West, *Submission 71*, p. 5.

fertility, is basic to their empowerment'. In addition it was noted that 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.[53]

3.35 It was also noted that Australia has an obligation to implement the principles of the Convention on the Elimination of All Forms of Discrimination Against Women, which includes access to health services, including those related to family planning. In addition, sexual and reproductive health rights and freedoms are enshrined in the International Covenant on Economic, Social and Cultural Rights.[54]

3.36 Professor Bell concluded that the amendment contained in the Bill is a restriction of women's rights and not the empowerment envisaged by the interagency statement or the Convention on the Elimination of All Forms of Discrimination Against Women.[55]

3.37 The Parliamentary Joint Committee on Human Rights (Joint Committee) has examined the Bill. The Joint Committee noted that restrictions on Medicare benefits proposed in the Bill potentially restrict rights to health and rights to social security. Those rights are provided for under articles twelve and nine of the International Covenant on Economic, Social and Cultural Rights. In its concluding remarks, the Joint Committee indicated that:

> Before forming a conclusion on the human rights compatibility of the bill, the committee intends to write to Senator Madigan to seek further information about the prevalence of gender selective abortions in Australia and whether the limitations on the right to health and the right to social security seek to address a legitimate objective (being one that addresses an area of public or social concern that is pressing and substantial enough to warrant limitations on these rights).[56]

3.38 At the time of tabling of this report, no response had been published by the Joint Committee.

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53 Woman's Health Victoria, *Submission 2*, p. 5.

54 Women's Legal Services NSW, *Submission 192*, p. 3.

55 Professor Diane Bell, *Submission 175*, pp 6–7; see also Health Consumers Association of SA, *Submission 176*, p. 1; Women's Legal Services NSW, *Submission 192*, p. 1.

56 Parliamentary Joint Committee on Human Rights, *Examination of legislation in accordance with the Human Rights (Parliamentary Scrutiny) Act 2011, Bills introduced 18–21 March 2013, Legislative Instruments registered with the Federal Register of Legislative Instruments 16 February – 19 April 2013,* Sixth Report of 2013, 15 May 2013, p. 39.

Alternatives to the Bill

3.39 Reproductive Choice Australia submitted that 'if Parliament is inclined to utilise resources to better understand and positively respond to issues surrounding pregnancy terminations to best support the rights of Australian women', the following approaches could be considered:

- a national curriculum for comprehensive, evidence-based sexual and reproductive health in Australia schools;
- the inclusion of referral obligations for conscientious objection into the registration of health professionals and subsequent enforcement mechanisms;
- a requirement that university undergraduate medical training includes pregnancy termination related procedures;
- provision of the full range of reproductive health services, including abortion and emergency contraception for assault victims, in all federally funded hospitals regardless of faith-based affiliations; and
- lowered cost of contraception for low-income women via the Pharmaceutical Benefits Scheme.[57]

Concern from medical associations

3.40 Submitters opposing the Bill indicated that in their view, abortion was regarded as an important health service for women by medical associations including The Royal Australian College of Obstetricians and Gynaecologists; The Royal College of Obstetricians and Gynaecologists; and The American College of Obstetrics and Gynaecologists.[58]

3.41 Several submissions supported statements by medical associations that they support gender selective abortions for gender-linked genetic diseases, but not for personal or cultural reasons.[59] The Australia Medical Association (AMA) did not support the Bill, submitting that in its view the Medicare benefits arrangements should not be used to address social issues. The AMA went on to note that the interagency statement offers a range of recommendations for addressing the issues and does not recommend denying financial assistance for legal medical procedures.[60]

Senator Helen Polley
Chair

57 Reproductive Choice Australia, *Submission 3*, p. 3.

58 Women's Health Victoria, *Submission 2*, p. 4; Women's Health West, *Submission 71*, p. 5; Public Health Association of Australia, *Submission 72*, p. 8.

59 Public Health Association of Australia, *Submission 72*, p. 8; Women's Health West, *Submission 71*, p. 5; Women's Health Victoria, *Submission 2*, p. 4; National Federation for Australian Women, *Submission 74*, p. 5; Women's Centre for Health Matters, *Submission 157*, pp 5–6.

60 Australian Medical Association, *Submission 130*, p. 1.