THE UNIVERSITY OF WESTERN AUSTRALIA

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Universal Access to Reproductive Healthcare Inquiry
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

To the Senate Community Affairs References Committee,

RE: UNIVERSAL ACCESS TO REPRODUCTIVE HEALTHCARE

Thank you for the opportunity to make a submission in relation to the inquiry into universal access to reproductive healthcare. I write on the basis of my experience and expertise as a legal academic who researches and teaches about health and medical law, including reproductive care, abortion, capacity, and LGBTQIA+ people. I am also a legal member on the Human Research Ethics Committee at the South Metropolitan Area Health Service (Fiona Stanley Hospital, Perth). I am very happy for this submission to be quoted or cited in any future report or publication.

My submission discusses the following matters which I hope will be of assistance to the Committee:

- The Commonwealth's power to legislate with respect to abortion and reproductive care;
- Substitute decision-making in relation to abortion (relating to term **'f'** of the Terms of Reference); &
- The use of gendered language in any legislation relating to reproductive care and abortion (relating to term **'g'** of the Terms of Reference).

My submission aims to provide some information about the legislative barriers which might impact on the accessibility of care for people with disability and LGBTQIA+ people.

1 The Commonwealth's power to legislate with respect to abortion and reproductive care

Health is generally regarded as a residual area of power, left to state regulation. Of course, there are many ways the Commonwealth can effect change in relation to reproductive and sexual healthcare – not all change is legislative in nature. However, the Commonwealth does have certain powers which would enable it to make legislative changes in the area if it so desires. These powers include:

a. The Corporations Power in s 51(xx) of the *Constitution*:

The majority in *Work Choices* confirmed that the Commonwealth's ability to legislate with respect to foreign, trading and financial corporations under s 51(xx) does include: 'regulation of the activities, functions, relationships and business of a [constitutional corporation] ... and, in respect of those matters, to the regulation of the conduct of those through whom it acts, its employees...'[1] More recently, *Williams (No 2)* has indicated that for a law to be supported by s 51(xx), it needs to regulate or permit acts done by or on behalf of constitutional corporations.[2]

[1] *New South Wales v Commonwealth* (2006) 229 CLR 1, 178 citing and approving *Re Pacific Coal Pty Ltd; Ex parte Construction, Forestry, Mining and Energy Union* (2000) 203 CLR 346, 375 (Gaudron J).
[2] *Williams v Commonwealth* (2014) 252 CLR 416, 461.

Consequently, a Commonwealth law which relates to reproductive and sexual healthcare might be supported by s 51(xx), provided that it is sufficiently focussed on the conduct of health professionals who provide that healthcare in the course of their employment for a constitutional corporation. Such legislation could then trigger s 109 of the *Constitution*, rendering inoperative any inconsistent state legislation.

The major limitation of this power is that it only extends to care provided by a constitutional corporation (most relevantly in this context, trading corporations).[3] Indeed, some hospitals, clinics, and medical practices are incorporated.[4] Further, Kirby J's dissent in *Work Choices* does indicate that the majority judgment to lead to Commonwealth regulation of medical providers' activities.[5] However, such corporations would need to have substantial trading activities to be regarded as trading corporations. Though some doubt exists, Appleby, Olijnyk and Williams conclude that 'many (though not all) corporations that provide medical services will qualify' as constitutional corporations.[6]

b. The social services powers in s 51(xxiiiA) of the *Constitution:*

The Commonwealth can provide Pharmaceutical Benefits and Medicare Benefits for certain services pursuant to s 51(xxiiiA) of the *Constitution*. This section also enables the Commonwealth to directly provide medical services of its own. Notably though, s 51(xxiiiA) is not a power to regulate medical services and the relevant benefits generally. It is only a power to make laws with respect to their *provision*.[7] This caveat has three general consequences:

First, the power could not support legislation that simply deems a certain service legal or illegal. It can only support legislation that provides medical services or benefits through some legislative scheme.

Second, the High Court has construed 'provision of' to refer only to provision by the Commonwealth.[8] This means that the Commonwealth is unable to legislate with respect to the provision of healthcare services provided wholly by the states or private sector, except to the extent that those services are 'brought under' the Commonwealth system (eg, because a Commonwealth benefit is claimed in relation to the service).

Third, there are consequences for the principle of inconsistency which result from the 'provision of' caveat. It is likely that a Commonwealth law made under s 51(xxiiiA) could not provide for the complete control of healthcare benefits and services to be rendered within Australia.[9] That is, states must be able to run their own concurrent reproductive and sexual health schemes providing for such benefits and services if they so wish. Therefore any Commonwealth scheme probably cannot 'cover the field' and invoke s 109's inconsistency mechanism in that manner.[10]

2 Substitute decision-making in relation to abortion (relates to term 'f')

There are many inconsistencies relating to abortion law across Australia. This is because abortion is regulated by states and territories, as noted above. One matter which may affect the accessibility of abortion and reproductive care for some people with intellectual disability and those with mental or

[3] Sharon Scully, 'Does The Commonwealth Have the Constitutional Power to Take Over the Administration of Public Hospitals?' (Research Paper No 36, Parliamentary Library, Parliament of Australia, 2009) 11-15.
[4] Ibid 12.
[5] *New South Wales v Commonwealth* (2006) 229 CLR 1, 224.
[6] The Public Law and Policy Research Unit at the University of Adelaide, Submission No 47 to the Senate Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *Inquiry into the Exposure Draft of the Medical Services (Dying With Dignity) Bill 2014*, 2014, 8.
[7] *British Medical Association v Commonwealth* (1949) 79 CLR 201, 243.
[8] *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987) 162 CLR 271, 279.
[9] *British Medical Association v Commonwealth* (1949) 79 CLR 201, 244 (Williams J), 260 (Dixon J).
[10] See, eg, *Commercial Radio Coffs Harbour Ltd v Fuller* (1986) 161 CLR 47.

cognitive impairment is the significant state-based variation as to whether a substitute decisionmaker (eg, a guardian) can consent to an abortion on behalf of a person who does not have capacity. For example, in New South Wales, the *Abortion Law Reform Act 2019* (NSW) s 5(2) clearly sets out that an authorised substitute decisionmaker can provide consent for a person to obtain an abortion:

> *The medical practitioner may perform the termination on the person only if the medical practitioner has obtained informed consent to the termination from—*
>
> *(a) the person, or*
>
> *(b) if the person lacks the capacity to give informed consent to the termination, a person lawfully authorised to give consent on the person's behalf.*

By way of comparison, in Queensland a termination of pregnancy for a person who is unable to provide consent must be approved by the Queensland Civil and Administrative Tribunal.[11]

Other states have regulation which is not clear on this point. For example, in Western Australia, s 334 of the *Health (Miscellaneous Provisions) Act 1911* (WA) sets out that consent for an abortion must be personal consent (ie, it sets out that consent means consent 'freely given **by the woman**'). Whilst s 50 of the *Guardianship and Administration Act 1990* (WA) might operate to enable a guardian's consent to act in place of the pregnant person's consent (where the pregnant person lacks capacity). However, this is not sufficiently clear in the *Health (Miscellaneous Provisions) Act 1911* (WA) itself and might be misunderstood, especially given the significant variations in laws on this point across Australia.

Indeed, this is a difficult and complex issue upon which reasonable minds might differ. On one view, substitute decisionmakers are obliged to act in the best interests of the person concerned, and thus preventing substitute decisionmakers from being able to consent to an abortion arguably unduly restricts and complicates access to vital healthcare for people who do not have capacity to consent.

On another view, abortion might constitute an extreme violation of bodily and reproductive autonomy for a person who does not have decisional capacity, and oversight by a court or tribunal may be desirable (as exists in Queensland).

Whilst my submission does not recommend any particular regulation in this regard, I believe it is important to bring this significant variation to the Committee's attention so it can be considered properly. Any consideration of this matter must also look to ways to improve the support provided to people with intellectual disability, cognitive impairment, and mental impairment, so as to assist those who need support to self-determine and make their own decisions.

3 The use of gendered language in any legislation relating to reproductive care and abortion (relates to term 'g')

A recent Discussion Paper released by the Western Australian Department of Health notes that *'abortion care is accessed by a variety of people, including adult women, girls and people who identify as any gender.'*[12] Similarly, the Australian Government's Pregnancy Care Guidelines webpage notes that *'individuals have diverse gender identities. Terms such as pregnant person, childbearing people and parent can be used to avoid gendering birth, and those who give birth, as feminine.'*[13]

It is important for governments to acknowledge this, and for this to be reflected in the terminology used in healthcare settings. However, this recognition must extend further into the terminology used in legislation relating to pregnancy and abortion. Using the term 'pregnant person' in place of 'woman' in abortion legislation and other legislation relating to pregnancy would not make such legislation less accurate – it would make it more accurate. Legislation which uses the term 'woman' in place of 'pregnant person' fails

[11] *Guardianship and Administration Act 2000* (Qld) s 71.
[12] Western Australian Department of Health, 'Abortion Legislation – Proposal for Reform in Western Australia' (Discussion Paper, 18 November 2022) 6.
[13] See generally, <https://www.health.gov.au/resources/pregnancy-care-guidelines/introduction>.

to recognise the medical, social, and psychological realities that there is a diversity of sex and gender,[14] and that people who might legally be classed as any gender can become pregnant and should be able to seek an abortion. This may occur for many reasons – for example, many trans people obtain social and/or legal recognition for their affirmed gender whilst retaining their reproductive characteristics. People with non-binary gender identities may also become pregnant. Some intersex people who were assigned male at birth might also become pregnant (depending on the variations of sex characteristics they have).[15] However, the reasons *why* pregnancy occurs across a range of gender identities are not of present importance – what is presently important is that governments accept this reality and ensure that legislation relating to pregnancy and abortion reflects this.

Indeed, this terminology is widely accepted by clinicians and professionals who work in the relevant fields. It has been noted by researchers that the use of non-inclusive language around pregnancy significantly worsens patient outcomes.[16] Further – as noted in a recent article co-authored by an interdisciplinary group of medical doctors, mental health and psychiatric professionals, paediatricians, and social workers – using the more accurate term 'pregnant people' does not devalue, other, or disrespect cisgender women:

> *'Some might object that this nomenclature favours inclusivity over the experiences of the majority of pregnant people who are cisgender women, and that we should instead be centring the experiences of these women. However,* ***the term 'pregnant person' does not discredit cisgender women; rather it opens the umbrella to cover everyone seeking obstetrical care****. Language evolves, and words matter. Providing comprehensive and accessible healthcare to all includes broadening gender-neutral and affirming language...'*[17]

For these reasons, I strongly encourage the Committee to consider how use of the term 'pregnant person' (in place of 'pregnant woman') can be expanded in legislation, policy, and healthcare settings across Australia.

Thank you for considering my submissions.

I would be very happy to further discuss any of these matters, and I consent to this submission being quoted or cited in any future report or publication by the Committee.

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[14] Goran Strkalj, 'Beyond the Sex Binary: Toward the Inclusive Anatomical Sciences Education' (2020) 14(4) *Anatomical Sciences* 513; Janet Hyde et al, 'The Future of Sex and Gender in Psychology: Five Challenges to the Gender Binary' (2019) 74(2) *American Psychologist* 171; Sarah Hunt, 'Embodying Self-Determination: Beyond the Gender Binary' in *Determinants of Indigenous Peoples' Health, Second Edition: Beyond the Social* (2nd ed, 2018); Emmie Matsuho and Stephanie L Budge, 'Non-binary/Genderqueer Identities: a Critical Review of the Literature' (2017) 9(1) *Current Sexual Health Reports* 116; Ada S Chung et al, 'Non-Binary and Binary Gender Identity in Australian Trans and Gender Diverse Individuals' (2020) 49(1) *Archives of Sexual Behaviour* 2673.

[15] It should also be noted that an intersex person – like any person – may have any gender identity.

[16] K MacKinnon et al, 'Recognizing and Renaming in Obstetrics' (2021) 14(4) *Obstetric Medicine* 201.

[17] Ibid.