Submission on the Religious Discrimination Bill 2021 and Related Bills

About LGBTIQ+ Health Australia

LGBTIQ+ Health Australia (LHA) is the national peak organisation working to promote the health and wellbeing of LGBTIQ+ people and communities. LHA is uniquely placed with a diverse membership that spans across states and territories, and includes LGBTIQ+ community-controlled health organisations, LGBTIQ+ community groups and state and territory peak bodies, service providers, researchers, and individuals. LHA is strategically positioned to provide a national focus to improving the health and wellbeing of LGBTIQ+ people through policy, advocacy, representation, research evidence, and capacity building across all health portfolios of significance to our communities. We recognise that people’s genders, bodies, relationships, and sexualities affect their health and wellbeing in every domain of their life.

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Executive Summary

LGBTIQ+ Health Australia (LHA) welcomes the opportunity to make a submission on the Religious Discrimination Bill 2021, Religious Discrimination (Consequential Amendments) Bill 2021, and Human Rights Legislation Amendment Bill 2021.

LHA has long advocated for reducing discrimination to achieve equitable health outcomes for all Australians. As such, comprehensive protection from discrimination for people of faith, and those who hold no religious belief is important. However, this should not and cannot be achieved by undermining existing rights and protections for LGBTIQ+ people.

We endorse the submissions and recommendations of our sector partners Equality Australia, and member organisations. We ask that consideration is given to the potential health and wellbeing impacts on LGBTIQ+ people and their families as a result of prolonged national dialogue on this issue.

LHA acknowledges the improvements that have been made to the Religious Discrimination Bill since its second exposure draft, and in particular welcomes removal of the conscientious objection in healthcare clauses. However, given existing health disparities for LGBTIQ+ people and communities, we ask that consideration be given to the potential health and wellbeing impacts on LGBTIQ+ people and their families as a result of prolonged national dialogue on this issue.

LHA acknowledges the improvements that have been made to the Religious Discrimination Bill since its second exposure draft, and in particular welcomes removal of the conscientious objection in healthcare clauses. However, given existing health disparities for LGBTIQ+ people and communities, LHA does not support the passage of these bills. In this submission we detail research relating to LGBTIQ+ health and wellbeing, identify potential negative impacts of health and wellbeing for LGBTIQ+ people and communities, and outline our key concerns, including that:

- Section 12 ‘Statements of Belief’ will legitimise discriminatory comments against LGBTIQ+ people when they are accessing services, which will have a negative impact on health and wellbeing
- Section 15 undermines the ability of professional bodies, including those for health practitioners, to promote inclusive and safe workplace cultures, and provides for religious expression to take precedence over consumers’ needs and right to safe and affirming care
- Section 47C of the Human Rights Legislation Amendment Bill 2021 prioritises religious privilege over the wellbeing of LGBTIQ+ people.

LGBTIQ+ Health & Wellbeing

Although many lesbian, gay, bisexual, transgender, intersex, queer people and other sexuality and gender diverse (LGBTIQ+) people live healthy and happy lives, a disproportionate number experience poorer health outcomes compared with the broader population. These adverse health outcomes are directly related to stigma, prejudice, discrimination, and abuse experienced due to being part of diverse LGBTIQ+ communities. Intersections with other identities and experiences also impact on wellbeing and access to health care, including but not limited to, being Aboriginal and/or Torres Strait Islander; racial and cultural background; age; having a disability; socioeconomic status; and geographic location.
In *Private Lives 3*, Australia’s largest national survey of LGBTIQ+ people to date, more than half (57.2%) of participants reported high or very high levels of psychological distress. This is four times higher than the proportion of people reporting high or very high levels of psychological distress among the general population (13.0%). When analysed by sexual orientation, 75.9% of participants who identified as pansexual, 66.7% as bisexual, 71.7% as asexual and 67.8% as queer reported experiencing high or very high levels of psychological distress. When analysed by gender, almost 75.8% of trans men, 65.6% of trans women and 74.9% of non-binary participants reported experiencing high or very high levels of psychological distress. This is compared to 59.4% of cisgender women and 43.7% of cisgender men.

In *Writing Themselves in 4*, an online survey of LGBTIQA+ people aged between 14 and 21 years living in Australia, a greater proportion of trans and gender diverse participants reported very high levels of psychological distress than cisgender men or cisgender women. Nine-tenths (90.4%) of non-binary participants and trans men (89.9%) reported experiencing high or very high levels of psychological distress, followed by 88.0% of trans women, 82.0% of cisgender women, and 66.9% of cisgender men.

*Private Lives 3* shows an estimated 29 per cent of sexuality and gender diverse people live in regional and remote areas, comparable to the broader Australian population. More than one-third of participants residing in rural/remote locations rated their health as ‘poor’ or ‘fair’ and approximately half of participants who live outside of inner cities had experienced suicidal ideation in the past 12 months. This figure is even higher for young LGBTQ+ people. *Writing Themselves In 4* found that almost two out of three participants in rural/remote areas reported experiencing suicidal ideation in the last 12 months.

*Private Lives 3* also found that six in ten (57.0%) participants reported that they had been treated unfairly to some degree (either a little, somewhat, a lot or always) because of their sexual orientation in the past 12 months. Over three quarters (77.5%) of trans and gender diverse participants reported that they had been treated unfairly to some degree because of their gender identity in the past 12 months, with 19.8% reporting a lot or always.

*Private Lives 3* participants also reported high levels of heterosexist violence or harassment, with more than one third reporting verbal abuse, one quarter harassment and one in ten reporting sexual assault in the past 12 months due to their sexual orientation or gender identity. In addition to the many social impacts on the lives who are victimised, experiences of discrimination and violence are

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4 Hill et al. (2020)
commonly associated with poorer health. These experiences have a significant impact on overall health and wellbeing. For example, verbal abuse and physical assault have been associated with higher levels of feeling suicidal among gay and bisexual men and experiences of victimisation have been shown to be associated with poorer self-rated physical health and other health-related indicators and the health and wellbeing of trans and gender diverse people was found to be associated with how they are treated.6,7,8,9

Aboriginal and Torres Strait Islander people who are also LGBTIQ+, Sistergirls or Brotherboys experience significant and intersecting points of discrimination and marginalisation. This includes structural, institutional, and interpersonal forms of discrimination based on race, gender, colonialism, and sexuality, gender, and/or intersex status. As a result, Indigenous LGBTIQ+ people face further challenges in relation to their overall mental health and social and emotional wellbeing. Research has shown that Aboriginal LGBTQA+ adults face specific health burdens including increased isolation, rejection from community, and increased risk for suicide, homelessness, and mental health problems.10

Many national strategies, including the National Mental Health and Suicide Prevention Plan, recognise LGBTIQ+ people as a priority population. These acknowledge disproportionately high rates of illness, the limited impact of existing approaches and the need for targeted responses. LHA’s National LGBTIQ+ Mental Health and Suicide Prevention Strategy highlights that the fundamental driver for most of these worse health outcomes is stigma and discrimination.11

LHA is concerned that this religious discrimination legislation may entrench conditions that limit opportunities, resources and well-being, including of public debate that stigmatises gender, sexuality and bodily diversity. Particularly to reduce unacceptable levels of poor mental health and suicidality for LGBTIQ+ communities, the Strategy seeks a more supportive societal environment that is a protective factor for mental health and wellbeing.

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5 Ibid
LGBTIQ+ and Healthcare Services

Australian and international research has shown that LGBTIQ+ people under-utilise health services and delay seeking treatment due to actual or anticipated experiences of stigma and discrimination from service providers.\textsuperscript{12, 13} This can lead to reduced screening for physical and mental health conditions and poorer health outcomes. It can also mean that LGBTIQ+ people do not fully disclose relevant information about themselves and their health or support needs. Negative experiences in accessing services can include:

- homophobia, biphobia and/or transphobia
- discrimination on the basis of sex characteristics
- abuse or discrimination from staff or other clients
- incorrect assumptions being made by staff about sex, gender, sexuality, or variations in sex characteristics
- incorrect usage of language, terminology and misgendering of clients
- lack of community-specific knowledge

Importantly, in some cases, anticipation of experiencing stigma or discrimination has been found to have a greater negative impact on people than actual experiences.\textsuperscript{14}

People with intersex variations also face unique barriers, with many having experienced medical interventions at an early age. Some studies have found that many report trauma and anxiety related to medical settings as a result.\textsuperscript{15}

While mainstream health and mental health services were the services most frequently accessed by LGBTIQ people, these services were also reported to be least likely to respect their gender. In \textit{Private Lives 3}, only one third of trans and gender diverse people reported feeling that their gender identity was very or extremely respected at a mainstream medical clinic or hospital.\textsuperscript{16} Potential outcomes of heteronormative attitudes held by health professionals include delaying care, lack of disclosure and a lack of targeted health promotion and care.

For LGBTIQ+ people in rural and remote communities, there are often additional barriers to health due to discrimination and lack of expertise. GPs can and do refuse treatment due to moral and religious beliefs. In rural and regional areas there may be no alternative provider. This can be particularly acute for trans and gender diverse people as providers generally have limited knowledge about specific needs and refer to city-based providers even for routine care, such as hormonal treatments. Most healthcare providers do not have expertise with intersex variations and adults,


\textsuperscript{13} Waling, A., Lim, G., Dhalla, S., Lyons, A., Bourne, A., (2019). Understanding LGBTI+ Lives in Crisis. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, and Lifeline Australia

\textsuperscript{14} Waling et al. (2019).


\textsuperscript{16} Ibid
including parents, may be directed to a small number of teams in capital cities, including those responsible for harmful practices on children with intersex variations.

Meaningful consideration of the significant health disparities experienced by LGBTIQ+ people, and the multiple barriers that currently discourage them from accessing the healthcare they need is crucial to adequately responding to policy proposals that risk having an adverse impact on the health and wellbeing of LGBTIQ+ people and their families.

Impact of religious prejudice on poor health outcomes and accessing services

Australian research has examined whether religious-based anti-gay, or homonegative, prejudice had a detrimental impact on the health and wellbeing among lesbian, gay, and bisexual (LGB) individuals as well as their heterosexual counterparts. The results of this study demonstrated that exposure to religious anti-gay prejudice (the disapproval of homosexuality on religious grounds) predicted higher levels of anxiety, depression, stress, and shame; more harmful alcohol use; and more instances of both physical and verbal victimisation. These harmful outcomes were observed among both LGB individuals as well as heterosexual individuals, regardless of whether these individuals were religious themselves.

These key findings have significant implications for policy and legislation relating to religious freedoms, specifically the Religious Discrimination Bill, for the following reasons:

- The disapproval of homosexuality on religious grounds amounts to more than just a harmless expression of one’s religious beliefs. Rather, significant harm ensures when religious bodies, organisations, and people of faith espouse, or expose others to, anti-gay messages in the public sphere.
- Provisions that facilitate and legitimise the expression of anti-gay prejudice on the grounds of religious belief will pose broad and significant threats to overall health and wellbeing of sexual minority populations.

Overall, these findings highlight the extensive and pervasive nature of the adverse health and wellbeing implications associated with anti-gay religious exposure, given the variety of harmful outcomes this kind of prejudice predicted, and insofar that it extends to non-religious LGB individuals and heterosexuals more broadly.

The dominance of faith-based service providers in aged care is a barrier to LGBTI elders accessing services. During LHA’s consultations to prepare submissions for Royal Commission into Aged Care Quality and Safety, many people reported experience of discrimination and exclusion where workers express and act on faith-based convictions that being LGBTI is sinful. Participants reported being actively told to suppress their identity and experienced loss of connection with their LGBTI community. The problems are compounded in remote, rural and regional Australia where there are fewer choices for care and, in some circumstances, faith-based service providers are the only provider in the area.

18 LGBTI Health Alliance (2020-2021), Submissions to Royal Commission into Aged Care Quality and Safety, https://www.lgbtiqhealth.org.au/submissions_aged_care_rc
Participants in LHA’s consultations also highlighted the issues of faith-based providers being able to fire staff on the grounds of sexual orientation, gender identity and intersex status, or not hire them in the first place, resulting in a lack of staff with lived experience capable of understanding the needs of LGBTI elders.

The Religious Discrimination Bill provides the possibility that older LGBTI people will be forced to use aged care services provided by faith-based organisations where discrimination against them will be lawful.

In 2021, a national online survey by LGBTIQ+ Health Australia and the Australian College of Applied Psychology focused on the needs of LGBTIQ+ people in palliative care found that 84.7% of LGBTIQ+ people and 75.2% of health professionals strongly agreed with concern about faith-based institutional settings that expressed negative views about LGBTIQ+ people. Participants reported concern about religious providers, for example indicating that the treatment they received at a religious affiliated hospital was not equal.¹⁹

Section 12 ‘Statements of Belief’

The proposed Religious Discrimination Bill removes existing discrimination protections for LGBTIQ+ people, women, people with disabilities and others when people make discriminatory statements based in or about religion.

Despite Australia’s universal health care system, fundamental structural shortcomings remain, preventing the health system from providing high quality, inclusive, accessible, and equitable services and support to LGBTIQ+ people and communities. As discussed above, these barriers are further compounded by intersectionalities with overlapping communities including Aboriginal and Torres Strait Islander People, culturally and linguistically diverse people, people with disabilities, people living in rural, regional and remote locations, children and young people, and older people. Misconceptions about variations in sex characteristics intersex are pervasive, and contribute to ongoing discrimination against intersex people.

LHA is concerned that Section 12 of the Religious Discrimination Bill overrides existing anti-discrimination protections in federal, state and territory laws to privilege certain ‘statements of belief’ based in or about religion that may be expressed in workplaces, schools, and service settings across Australia.

Section 12 legitimises discriminatory comments against LGBTIQ+ people, negatively impacting on their overall health and wellbeing. The result of this is that section 12 protects a wide range of prejudiced, harmful or derogatory statements that could be made by healthcare providers. For example, a trans woman who seeks a referral from her GP to a specialist to discuss affirming her gender identity may be told by her doctor that “God made humanity male and female, and, in his creative purposes, biological (bodily) sex determines gender”. This significantly impacts her ability to access safe and affirming healthcare. Under the proposed Bill, the patient could lose her discrimination protections.

¹⁹ LGBTIQ+ Health Australia, Australian College of Applied Psychology, (2021) National Palliative Care Survey.
Changes to the proposed legislation have been made since the second exposure draft, including that there is now a narrower test of conditions that do not apply to a statement of belief in subsection 12(2)(b). For example, the phrase ‘likely to’ has been removed, and a ‘reasonable person’ has been inserted as its replacement. As explored in Equality Australia’s submission, this opens the door on statements that may offend, insult, and humiliate others wherever they work, study or access goods, services or accommodation. LHA is concerned about the impact this can have on accessing safe health care services. This change could protect a broader range of statements that a person or group would be likely to find harassing, threatening, intimidating, or vilifying.

Section 15 ‘Qualifying body conduct rules’

The Section 15 of the proposed Religious Discrimination Bill stipulates that qualifying bodies cannot act or impose conditions against an individual where a statement of belief has been made in a personal capacity. In practice, this means that the Bill will allow people to express prejudiced or harmful views based in or about religion without facing consequences for their conduct, even if it impacts on clients and consumers. This undermines the ability of professional bodies, including those for health practitioners, to promote inclusive and safe workplace culture.

LHA is concerned that this could discourage regulation of discriminatory behaviour and that for patients this could mean the right of religious expression will take precedence over their needs and right to safe and affirming care.

Section 47C of Human Rights Legislation Amendment Bill 2021

The proposed Human Rights Legislation Amendment Bill amends the Marriage Act 1961 (Cth) to allow religious educational institutions to refuse to make facilities available, or provide goods or services, for the purposes of the solemnisation of a marriage, or for purposes reasonably incidental to the solemnisation of the marriage, provided the refusal conforms with their religion or is necessary to avoid injury to the religious susceptibilities of adherents of that religion. Currently, wide exemptions already exist for religious bodies under the Marriage Act 1961 (Cth). This provision shines a light on the prioritisation of religious privilege over the wellbeing of LGBTIQ+ people.

Conclusion

Enshrining discrimination and further cementing access barriers to healthcare in legislation will have the unintentional and undesirable consequence of deterring government efforts related to achieving equitable healthcare outcomes for all Australians. Fear of discrimination such as withdrawal of care, may lead LGBTIQ+ people to have difficulty disclosing, even where they believe these issues are directly relevant, to the detriment of their care.