ABORTION LEGISLATION REFORM BILL 2023

Second Reading

Resumed from an earlier stage of the sitting.

MS M.J. DAVIES (Central Wheatbelt) [11.10 am]: I rise to offer my views on the government's Abortion Legislation Reform Bill 2023, as so many members in this house have before me.

As the opposition's shadow Minister for Health has advised, the opposition—the Nationals WA and the Liberal Party—is afforded a conscience vote on matters like this. As the member for Central Wheatbelt, I am offering my support for the changes that this bill will effect. From the outset, I note that we are not here to debate the legality of abortion in Western Australia. Although I have no doubt that these are very difficult and confronting decisions for those who believe that abortion should be illegal, it is not and has not been since 1998. However, modern management and expectations of health care has moved on since 1998, so we come together to work on making a very sensitive medical and health decision less fraught for the women who are in a position to make that decision.

The decision is a deeply personal one. The reasons that women require this healthcare service are many and varied, and only a woman who is pregnant and the people whom she trusts intimately are entitled to make that decision. Whether the decision be due to health comorbidities, genetic reasons, congenital abnormalities or a case of sexual abuse, or that the mother is not prepared for an unplanned pregnancy or simply does not wish to be pregnant, they are reasons for her and those whom she trusts alone to navigate. Our role as legislators is to ensure that we are not adding layers to the burden of that decision, or then inhibiting the abortion from happening in a timely and appropriate care setting.

Abortion has been legal in WA since 1998, so we must make the process of accessing these services as safe and appropriate as possible. Our decisions in this place should always be informed by clinicians and health practitioners, women with lived experience, and those who work and support them in their healthcare decisions, as we take advice on every other issue that comes before us. I note that the government undertook consultation, which began with a discussion paper, and promoted that discussion to test the views of the public on the matters that we now see in the bill. I understand that issues also came through the Department of Justice, and other issues came about as a result of those conversations. In essence, there are changes proposed to address the following matters. I will go through them and make some comments on each of the major reforms.

Removing any intersection of this healthcare decision from the Criminal Code is obviously central to this legislation. The Criminal Code currently provides that it is unlawful to perform an abortion unless the abortion is performed by a medical practitioner and the performance of the abortion is justified under section 334 of the Health (Miscellaneous Provisions) Act. Although it will remain an offence for an unqualified person to perform or assist with an abortion, as is the case elsewhere in Australia, this amendment will complete the decriminalisation of abortion and align us with other jurisdictions. That has my full support.

I refer to the areas of the legislation that relate to informed consent and mandatory counselling requirements. I support the removal of the requirement for a practitioner to provide mandatory counselling in order to obtain informed consent from a woman under their care. Medical practitioners will, obviously, continue to be required to obtain informed consent; that is in line with what they do on a daily basis when they are dealing with their patients' health care issues, and this should be no different. They do it in the case of other medical and health care matters, they have a scope of practice, standards of care and professional obligations, and we need to trust that they will apply those when they are making this decision, as opposed to imposing a separate decision-making mechanism. As I understand it, of course, there is no discussion that counselling would not be available—that is information that some may seek, and it should be free and non-directive—but we should not make counselling mandatory for women who are seeking access to an abortion.

This legislation also deals with the requirement that two medical practitioners be involved before a woman can have an abortion. It is currently the case that informed consent has to be obtained from two medical professionals or practitioners—one other than the one involved in performing the actual abortion. That means that once a woman going through this process has gathered herself to go in and have this conversation, which I would imagine is a fairly challenging moment for anyone, they then need to go through that process with a second professional. The person that the woman goes through that with in the first instance in most cases—I am not saying all; it may not be—is likely to be their doctor or medical practitioner with whom they have a familiarity. I think that if the woman has to then go and deal with a second person, it adds unnecessary challenges. In some cases, it is impractical, particularly for our regional communities. We struggle to have one doctor in close proximity, let alone two. Although there have been advances in telehealth and access through various different digital forms of medical provision, it still requires the patient to have to tell that story more than once and go through that informed consent process again. I absolutely support the fact that we need to leave this with the medical professional to whom the patient goes; the woman does not need more than one person making that decision for her.

I understand that there are those among our medical practitioners, as there are in the community, who object to being involved in these decisions, and there will be health practitioners who do not wish to provide advice on or practically effect an abortion. I have read through the documentation that has been provided as part of the discussion paper and some of the submissions, listened to other members, and taken note of what the Australian Medical Association in particular has provided. The AMA has a code of ethics. It points to the fact that in situations in which there are going to be conflicts in a medical practitioner's provision of health care, if a practitioner is going to refuse to provide or participate in a diagnosis or treatment, they need to make sure that they are informing the patient that they are going to do that and that the patient can seek care elsewhere. That includes in an emergency situation. I understand that this bill will create an obligation for medical practitioners who are conscientious objectors to pass on alternative options for health care. The AMA has offered an alternative option, and I understand that the shadow Minister for Health offered a solution on this matter, as well. I am interested in the minister's thoughts, whether the government considered what has been proposed by the AMA, and why it did not land on that suggestion going forward and that was not the avenue that the government chose to pursue. The shadow Minister for Health offered a solution that there could potentially be a centralised register of practitioners who provide abortions and that that information would be made available.

Ms A. Sanderson: That is in the bill.

Ms M.J. DAVIES: That is in the bill, but rather than an obligation for the practitioner to mandatorily pass that information on, my understanding of where the AMA is sitting is that someone who is a conscientious objector will not want to participate in any part of that conversation. I am seeking advice on whether they will have to provide that information. I understand that there will be different views on that. I would like the minister to touch on more detail on how the government came to the view that it has when drafting this legislation.

The gestational limit of 20 weeks was something that was canvassed quite widely. Under the current WA legislation, abortions after 20 weeks' gestation require the approval of two members of an appointed ministerial panel. Again, we seem to have a situation in which multiple people outside the scope of the doctor or medical practitioner have a view on what a woman can do with her own body. After 20 weeks, they have to agree that the pregnant woman, or the fetus, has a severe medical condition that would justify the procedure, which can then only be performed at an approved facility. I agree with the rationale for raising the gestation or time limit that was presented in the discussion paper; I note that the discussion was around 24 weeks, but the government has landed upon 23 weeks on the advice provided by very highly regarded and qualified clinicians, including Professor Jan Dickinson, AM, who made a submission and whom the member for Vasse referenced. Raising that limit takes into consideration some practicalities: if people have to go through this process upon finding that there is something very significant after the 20-week scan, they then have very limited time in which to go down that pathway. This will afford an extra three weeks to women who are in a very difficult circumstance and who are under significant pressure to try to make a decision. I think that is a sensible solution to ensure that they receive the appropriate advice. Instead of relying upon the ministerial panel, we go to a clause that allows the primary health practitioner to seek advice from other health practitioners.

I understand that the Australian Medical Association and other clinicians in Western Australia have contended this proposition. I have no doubt that we have some amazing and highly qualified clinicians in Western Australia; there is no question about that. I will be interested to hear the discussion around limiting this to Western Australia and how the government arrived at the decision to allow it to go Australia-wide. In the briefing we were provided, the reasoning was that in very rare instances—one in 100 000, or thereabouts—the fetus or the mum might have a disease for which advice will need to be sought from a specialist in Sydney or Brisbane or wherever. I understand that the questions some practitioners are asking are: If we do that, will they have the same clinical framework for making decisions as we have in WA, according to the legislation we are bringing in today? Will doctors outside our jurisdiction have the same requirements, decision-making processes and frameworks, and will they align so that we do not disrupt that process? That is a matter I will be very interested in when we get to that point during consideration in detail. I certainly do not question that we have expertise in Western Australia; I think we are incredibly lucky in respect of the research we have available into women and babies and access to medical professionals. Without having listened to the full debate, I am mindful that if there are conditions that can only be treated by someone from outside our state borders, we need to have a mechanism to allow for that. I will listen to that conversation in the chamber and see where we land.

I turn now to informed consent for mature minors. This issue hit the front page of the newspaper in a very dramatic way. I understand that it is confronting for many people to conceive of the idea that there are very young people seeking abortions or advice on abortions. Under the current laws, a young person under the age of 16 years has to get consent from their parent or guardian, and if they cannot access that, they have to go through a court process. A court process is pretty confronting at the best of times, and for someone in this situation as a minor it would most certainly not be their best time. To me, that is an unnecessary extra burden for that young person. I have to say it is not something that I actually contemplated before dealing with the detail of this legislation, but I understand the

rationale behind it and that it is a very necessary reform. Having read submissions and talked to people who have had to deal with these situations, we need to put ourselves in the shoes of such young people. They might have a dysfunctional relationship with their parents or guardians, or they may not have parents or guardians. They might be pregnant as the result of an assault from within their own family or by close friends. They may have a family that holds strong religious or cultural views on abortion, or, as a young person, they may simply not wish to discuss their sexual life or health choices. As I understand it, doctors are well-trained in making judgements on whether a minor is mature enough to make a decision of such significance, and we currently trust them to do so within the four walls of their consulting rooms. I cannot see how this would be any different. We need to continue to place that trust in doctors and medical practitioners.

We have had discussions in our party room and with interested people about allowing that decision to be conferred on a midwife or nurse practitioner. I think that proposition will be discussed in the Legislative Council. It is really a matter of scope of practice, and whether they have sufficient training to be in a position to make that objective decision. I have no doubt that will be canvassed in the Legislative Council, but I do understand the potential benefits of having access to midwives and nurse practitioners, particularly in regional settings. I wish we had more midwives and nurse practitioners in regional settings; it would certainly make it easier for people to go down that pathway for all their natal needs.

The legislation will eliminate the requirement of mandatory reporting to the coroner. As I understand it, this was not canvassed in the discussion paper; I could be wrong, and I am happy to be corrected, but it is something that was brought to the legislation separately. The requirement of mandatory reporting to the coroner will be eliminated for live births after an abortion, and I wholly endorse that position. It is mostly based on advice from Professor Dickinson.

[Member's time extended.]

Ms M.J. DAVIES: It is worth repeating what the member for Vasse, the shadow Minister for Health, said in her contribution to this debate in quoting Professor Dickinson on this matter. She stated —

> The current involvement of the WA state coroner in all live born babies after termination should cease. There are fetuses with known lethal congenital anomalies in whom the mother does not wish for her baby to be stillborn, but feels strongly she wishes to spend the short amount of time after birth that she has with her baby whilst it dies under a comfort care model. I accept these cases will need to be individualised, but this option should be available for selective cases without the threat of a coronial investigation (which currently is in place).

Again, a coronial investigation is a process that is unfamiliar to most. They are already traumatised and they have to go through a process that, in the view of this clinician and, I suspect, many others, is unnecessary. As I reflect on these changes, I think it is worth providing some context in numerical terms about what we are currently seeing in Western Australia. The discussion paper contained data that was collected by the government. In 2021, a total of 8 184 induced abortions were notified to the department. In the 20 years between 2002 and 2021, an average of 8 229 abortions a year were notified to the department. The abortion rate per 1 000 women of reproductive age—that is, between 15 and 44 years—has declined from 19.5 per 1 000 in 2002 to 14.9 per 1 000 in 2021. In 2021, 83 per cent of abortions occurred at a gestational age of less than 10 weeks. Approximately 16 per cent occurred between 10 and 19 completed weeks and 0.9 per cent occurred beyond 20 weeks, and this distribution was similar in early years. A very small number of complex abortions occur after 20 or 23 weeks. Somebody made the point to me that for someone who goes down that path after 23 weeks, it is often, but not always, a baby who is wanted and something catastrophic has happened. Obviously, there are different decision-making processes, but I think that what has been reflected in this house is that we should craft legislation to ensure that, at any stage and for any reason, a woman gets to make that choice, not someone external to the woman and the person they are relying on for their health care.

I circle back to where I started. Our role as legislators is to ensure that we do not add layers to the burden of decision-making or inhibit the decision and the actual physical act of it happening in a timely manner or in an appropriate care setting. We should always look to provide a health-first approach that is led by medical practitioners and experts, but with the woman at the centre of the decision. It is without doubt a difficult subject for many to contemplate, and I understand and acknowledge this. I thank the people who made submissions and provided their time and expertise and their lived experience, and those who have spoken about it and shared their experiences, so that this legislation can be brought to the house for us to make a decision on. I also appreciate the advice that was provided to help shape the reforms. Ultimately, it is about providing autonomy of decision-making for women over their own bodies, and that is something that I wholeheartedly support. The minister has my support for this legislation.

DR J. KRISHNAN (Riverton — Parliamentary Secretary) [11.31 am]: I rise today to support the Abortion Legislation Reform Bill 2023. I agree with the member for Central Wheatbelt that it is not about whether or not it is legal; it is about making it easy and convenient for people who need to access abortion clinics. A small number of people in early pregnancy unfortunately do not continue with the pregnancy and end up terminating naturally.

This is not about that; this is about deciding to intervene and terminate the pregnancy. Only two people initiate the process to get an abortion: it is either the woman who is pregnant or the clinician who is treating the woman who is making the decision. It is in the best interests to leave things to be dealt with by those two people rather than anybody else external to them.

Sometimes, but not always, an unplanned pregnancy is known; for the majority of the time, it is unknown. A classic example of a known unplanned pregnancy is when there has been a failure of contraception. A patient who takes regular medication for depression may not be aware that it will impact the efficiency of the contraceptive pill and will end up falling pregnant. Her intention was not to get pregnant in the first place, but it happens. Taking antibiotics for an illness reduces the efficacy of the contraceptive pill. The woman who got pregnant did not intend to get pregnant. There are known reasons. Sometimes people think that it is normal for their period to be delayed but then they realise they are pregnant. There are also other reasons. A patient might have been unconscious when the entire thing happened; an assault might have happened. A patient may not be mentally well enough to understand what is going on and may become pregnant. These are situations in which a termination of pregnancy would be initiated by either the woman or the clinician.

When I talk about "early pregnancy", I mean up to 63 days or nine weeks. This involves either a medical termination or a surgical termination. A medical termination occurs when a tablet is given by a medical practitioner—this will now be extended to health practitioners, which I will talk about a bit later—followed by a second tablet to be taken by the patient in the convenience of their home. Someone who provides this service definitely deals with a lot of pain and emotions. It is not easy to provide such service. It has a huge emotional impact. The woman who has to go through the process does not have an abortion to have an experience; she does so because she is forced to make the decision for various reasons, be they her personal or family circumstances, economic circumstances or social circumstances. It could be anything. The woman is forced to make that decision. While making that decision and going through the process, the woman would feel a sense of guilt, frustration, anxiety, fear and insecurity, and would be very conscious of walking into the doctor's consultation room. They would be careful about who is watching them, with the fear of people being judgemental about them accessing an essential service for an extreme essential need.

Even with all these emotions, the doctor is not there just to write a prescription and say, "There you go." Medical practitioners go through a lot. They assess the situation and the reason. It is not easy like some other things, because other issues could arise from this. Sometimes it is called a retained prolapse. The patient needs to be educated. The patient needs to followed up with and supported. The clinician in the room should be given complete responsibility to decide what the woman needs and not be forced to say that every patient who walks into their room for this particular service has to be referred for counselling. If the clinician finds that it is relevant and comes to the conclusion that it is important for the patient to have counselling, the clinician will do it, but it does not make sense to force it on them.

Surgical abortion involves the vacuum suction of the conceived products. It is not an easy procedure unless someone is trained well in it. It is not the talent and the physical actions that they take that matter. It is extremely difficult for the mother and the clinician to mentally and emotionally deal with the actions that are taken. Why make things more complicated? It is our duty to make things comfortable and accessible, and allow the woman and the clinician the right to make the decision, and to leave it up to those two only.

That is even more devastating for planned pregnancies. Pregnancies nowadays do not happen just like that. People plan for it. They go through a lot. They plan their finances, a career, their support system, and they plan their holidays and travel. They go to a GP to get a health check to make sure that they are not deficient in iron or vitamins or have any diseases that could affect the baby. Sometimes it is hard for women to understand when the GP tells them that they will have to come off some medication so it will not have an effect on the baby. It could be an antidepressant, for example. A woman may be fighting mental health challenges and hoping to have a baby. She might go through a lot of pain in the hope of having a baby. Some women take medications like folic acid, as advised by a GP, to prevent complications with the pregnancy or congenital malformations; there is enough evidence for that. After all that preparation, a small number of very unfortunate women are not able to succeed in becoming pregnant. They keep trying and spending money, and some do succeed after a few years. When they do, there is happiness not only for the couple, but also among the family, the community and their friends in anticipation of the new arrival. When they are told after 20 weeks that unfortunately the baby will not survive, we can only imagine the heartbreaking moment that the couple and their family go through in dealing with that issue. They need to access care in a timely fashion and they need to take action to put an end to that misery as soon as possible.

Unfortunately, in 1996, my wife and I went through that together, along with our family, with our first child. At the twentieth week of pregnancy, we were told that the child had hydrocephalus spina bifida and would not survive. What were we supposed to do? We decided to put an end to the whole process. Imagine if we were asked to apply to a ministerial panel to approve what we wanted to do. Imagine if we were asked or forced to attend a counselling session to decide whether we wanted to make our decision. We were fortunate that we did not have to go through that. We need to understand that there is a huge emotional impact when making such a decision, whether it is early

or late in the pregnancy. It is our responsibility to make that easy and convenient, without any barriers at all. Again, I insist that the decision must be left to the woman and the clinician. Stay away from getting involved in their decision-making process. That is my position.

What will this law bring? The period for the so-called termination limit will be moved from 20 weeks to 23 weeks. What is the logic behind that? We do not get enough details when we scan a pregnant woman before 20 weeks. That is when we are able to make a clear assessment and a clear judgement about how good the fetus is and how good the baby's future will be. When that is done, there is not enough time to make a decision about whether to terminate or continue with the pregnancy. That is the sole reason this limit is being pushed from 20 weeks to 23 weeks. There is no evidence that any babies born before 24 weeks have survived. The chance of a baby surviving birth before 24 weeks is zero, although there could be an error. We could even push the limit to 26 weeks. Most babies born after 26 weeks will survive. Many make it, although not all of them. At 23 weeks, there is absolutely zero chance of a baby surviving. When we are 100 per cent sure about a baby's survival, that is a safe limit, and this is the safe limit. Again, clinicians use guidelines. They do not count the number of weeks depending on the last menstrual period; it depends on the date the woman was scanned. There can be some variability in the scans because the variability increases as the length of the pregnancy increases, but 20 weeks is almost as close as we can get. That is the sole reason that the termination limit will be moved to 23 weeks, and that is the sole reason we need to accept abortion before 23 weeks.

The abortion procedure will be extended to health practitioners, which means nurse practitioners and midwives. I can tell members that not all GPs, obstetricians or gynaecologists provide this service. When someone chooses to do that, they undertake special training. The same applies to nurse practitioners and midwives. I have a lot of respect for midwives. I sometimes boast by saying that I have delivered over 400 babies. If people talk to a midwife who has worked for 20 years, the number that I have delivered would be minuscule. That is the experience that they have. They have dealt with the emotions and they are fully aware of what to look for and what they are dealing with, so it should be rightfully left in their capable hands. They will be provided the training to be able to provide that service. We have regulatory bodies to look after the training and to maintain standards. We should stay away from it and leave the decision-making process to the woman and the clinician, be it the GP, the nurse practitioner or the midwife, to go ahead and do what they have to do.

I will speak about people who refuse to participate in the termination process. I am a religious person. I was born a Hindu and brought up in a Catholic school. I have also visited mosques. As is very frequently said in the Indian language, vasudhaiva kutumbakam—the world is one family. No religion would advocate killing any life, but, at the same time, no religion would advocate causing trouble to someone who is already struggling. In my interpretation, that is not religion. It is about making things better for anybody and everybody. That is the best religion in the world.

[Member's time extended.]

Dr J. KRISHNAN: I can totally understand if someone refuses to participate in the termination procedure due to religious beliefs, but coming back to the person who is seeking help and advice, they put trust in the medical practitioner. They have walked into the consulting room seeking help with a very, very difficult situation. It is absolutely okay to say, "I do not believe in providing this service", but it is not okay to say, "I am not going to be involved in any of this process." How difficult is it to find a GP, a nurse practitioner, a midwife or an organisation who provides it, like Marie Stopes International?

Time is very critical. A couple of days back, my son had an ankle injury. I was down with the flu. I requested that my wife take a day off to look after us. She said, "No; I have two women on my list today booked in for medical terminations. The worst thing I can do is make them wait one more day. Whatever happens, I need to go." I am trying to say that time is critical. It is cruel for a doctor to send a patient out of their room, saying, "I don't want to be involved with this." It is so easy to put them on the right track to access care at the right time. I totally support this legislation and the proposed amendments in this bill.

I have spoken about mandatory counselling. Let me share a story. While I was a GP, a 14-year-old girl came in with abdominal pain. Obviously, after a routine test, I found that she was pregnant. I had to deal with the situation. Was she a mature minor? Yes, she was, but the circumstance was that she had been homeless in the past six months. Someone exploited her. What was I supposed to do? Should I have sent her off for mandatory counselling? Should I have sent her away, saying she needed to come back with her parents for me to provide her with care? It was a complex situation. It is not easy to deal with these complex situations, but it is important to take responsibility, stand there and take whatever action we can.

As clinicians, we follow the Gillick principle. We have the capability to decide whether a minor is mature enough to understand what is going on and what can be provided. Trust the clinicians. Leave the decision-making process to the woman in the room and the clinician and stay away from everybody else. For adults without decision-making abilities, I support the process of the State Administrative Tribunal being involved and making a decision. I think that is the right way to go about it. The collection of information for abortions is extremely important to plan for the future and make sure the systems and processes are working properly.

Before I finish, I want to clarify a few things. There have been reports in the media relating to "failed abortions". As a clinician, I do not understand what a failed abortion means. Some groups are advocating for care of a baby who was born alive. Let me make it very simple. When a pregnancy is terminated through a surgical process at, say, 23 weeks, the clinician will offer the woman the option of injecting her baby, under ultrasound guidance, so that the baby is stillborn. The mother will not have to go through the process of seeing the movements of the baby or life being there. The choice is given to that woman. If that woman decides she cannot do that, due to religious belief or for whatever reason, the clinician accepts that and continues with the termination. A termination is basically an induction of labour, with contractions, and the baby comes out. If an injection is given, the baby is stillborn. If an injection is not given, the baby still has life, but zero per cent chance of survival. The clinician knows that; the entire world knows that. What are the people talking about, advocating and asking us to do—to care for the baby? What do we intend to do? In the few minutes of whatever time is left, the mother will be able to hug her baby and spend time with it. If we listened to these people who are asking us to care for the baby, we would be plucking the baby away from the mother and treating the baby, absolutely sure that there is a zero per cent chance of survival. How cruel is that? Please do not spread false information. The reality is that either the baby is stillborn or the baby is born after an abortion, in which case that baby's survival chance is zero, so do not force care and do not cause further emotional trauma to the mother who is already struggling by taking the baby away from her.

Some people are also talking about sex-selective abortion. There is no real evidence of this. I do not deny that it happens in various parts of the world, but there is no real evidence that it happens in Australia and there is no real reason we should do that.

A few other things are being debated, including whether a practitioner from interstate should be allowed to be involved in the process. Why not? We do so with every other type of medical care. How is this different? When I am registered with the Australian Health Practitioner Regulatory Authority, I am registered nationally, not for WA. The clinical standards remain the same throughout the world. It is about opinion from another clinician. It is disrespectful to think that a clinician outside of Western Australia is not good enough to contribute to this decision-making process.

I offer my sincere thanks to the Minister for Health, Hon Amber-Jade Sanderson. I personally witnessed her putting in the effort through consultation, across parties, with multiple stakeholders. She was willing to listen, engage and do the right thing for the women and the people of Western Australia. I sincerely thank her for bringing this bill to this place. I have made my best effort to simplify things and to put the facts together. I urge members to carefully consider the facts and support the bill. Thank you for the opportunity, Mr Deputy Speaker.

MS J.L. HANNS (Collie–Preston — Parliamentary Secretary) [11.58 am]: I rise to also contribute to the debate on the Abortion Legislation Reform Bill 2023. From the outset, I wish to say that I will obviously be supporting this bill. In beginning my speech, I would like to thank the Minister for Health, her staff and everyone who was involved in the drafting of this very important legislation. I would also like to acknowledge, very importantly, the over 17 000 people who participated in the community consultation phase, which really guided the development of the legislation in its current form. I want to begin by acknowledging the fact that parenthood and pregnancy is a challenge for many women and many families. Although for me, personally, abortion is not a decision that I have had to face, it is certainly not a decision that should be restricted in any way for any other woman who may be in a position to make that choice themselves. I spent my late teens and 20s avoiding pregnancy like the plague, and my 30s trying to start a family. I had not foreseen that, nonetheless, it would be an incredibly challenging time for me and my husband. I am a very proud mum of two gorgeous children, but I have also experienced three very significant miscarriages as part of my family journey, one of which ended quite badly in that a doctor and nurse saved my life at Collie Hospital, and, to them, I will always be grateful.

I absolutely support the Abortion Legislation Reform Bill. We need to recognise that this legislation will provide women with the choice over their bodies and their decisions about their reproductive rights. I would also like to acknowledge the many women—the member for Nedlands mentioned one yesterday—over the past decades and, in fact, centuries who lost their lives through unsafe backyard abortions. This legislation will allow women who make the difficult decision to access abortion to do so in a safe environment.

On Tuesday, the member for Burns Beach alluded to the fact that this is a very emotional topic and people have very strong opinions about this issue. When I listened to the contribution from the member for Burns Beach, I unashamedly had some tears when he recounted his story as a police officer attending the suicide of a young person who had found themselves pregnant and unwilling to tell their family. The line from his contribution that really stuck with me, as reported in *The West Australian* online, was —

> "During my inquiries, it became clear the behaviour of the males in the home had terrified her to such an extent that she decided it was safer to be with her God than it was to be with her family.

That was the bit that did me in, because I cannot understand how a woman making a decision, even a young woman, about whether to continue with a pregnancy ends up in suicide. As a teacher and mother, I feel that is a tragic outcome for that young person.

Part of the debate around the reasons for objecting to abortion come back to the values that people hold as individuals. I acknowledge that the issue is challenging for some members of the community. It challenges their values and belief systems. I have had many people take the time to contact my electorate office to express their personal views about this issue, and I acknowledge the concerns that they have, but I will always maintain that their values and beliefs influence the choices that they make about themselves. This legislation will ensure that other women have the opportunity to exercise their own values and appreciate their own personal circumstances to make a healthcare choice relevant to them.

Female reproductive health care around the world varies from country to country and looking at the history of that in the context of Australia is incredibly important. My family on my grandfather's side was very, very large, and women at that time were not in a position to make choices around reproductive health. My great-great-great-grandmother—I do not know how many greats—was a woman by the name of Mary Dooley, who was born in county Galway, Ireland, in 1826. She went on to have eight children, one of whom was stillborn, which is a story that resonates across so many people in our society. My husband's side of the family also has a history of having very large families—10 or 12 children were commonplace. The reason for that was there was no opportunity for women in that period of history in Australia to exercise their rights over family planning and reproduction.

I will give members a picture of my great-great-great-grandmother's life. Mary Dooley entered the Mountbellew Workhouse in 1852. She was orphaned as a result of the potato famine in Ireland. A lot of women in those workhouses were identified as being suitable for transportation to Australia and were destined to provide labour for, and possible marriages to, the settlers in Australia, and particularly for Mary in Western Australia. Girls between the ages of 15 and 22 years were selected. It is difficult to know whether they were happy with the prospect of this new life in their new homeland. Historical accounts refer to desperate times in Ireland, surrounded by hunger, death and disease, so I think that passage to Australia and the promise of a new life may not have been as frightening as the circumstances that Mary found herself in.

Mary came across on the *Palestine* and arrived in Fremantle on 28 April 1853 with a number of other girls. During this time, Irish and Catholic settlers to Western Australia experienced strong prejudice from the Western Australian colony, so life was definitely not easy for young women like Mary. Care of the workhouse orphan girls once they arrived in Western Australia was transferred to the orphan committees, and the girls stayed in depots until they were hired by settlers. Mary found employment with a servant at a local hotel proprietary, the Ship Tavern, in Busselton—then known as Vasse. I think it is now called the Ship Inn.

In 1854, Mary married John Dawson, who was a free settler and 26 years her senior. One can only imagine the horrors that Mary managed to survive during the famine years, and I am not sure how much easier her life was after her arrival in Australia. As I said, Mary and her husband, John, went on to have eight children, one of whom was stillborn. After her family journey, she became one of the first midwives in the south west, and joined another three Irish girls—two Marys and a Johanna—who saw into the world an entire generation of Western Australians born in the south west region from Wallcliffe to Wonnerup. It is said that Mary had a very fulfilling life, and the story goes, through the family, that she was offered the opportunity to go to America but chose Australia instead. She said that one day she would return with her apron full of gold. After her family was born, she was often known to say that she had her apron full of gold in her many children. It highlights that those large families were commonplace in the early era of families being established in Western Australia.

One of the significant changes in family planning for Western Australian families, and Australian families more broadly, was the introduction of the contraceptive pill, and I have done some research around this innovation. According to the National Museum of Australia, it is listed as one of the defining moments in Australia. I thought I would provide some background to that because I was interested and surprised at some of the facts surrounding the introduction of the pill in Australia. The National Museum of Australia's website provides this information —

> The release of the oral contraceptive pill 'Anovlar' in Australia on 1 February 1961 ushered in a momentous change in women's lives. Initially available only to married women, and burdened with a 27.5 per cent luxury tax, the pill gave women —

Some women —

> the freedom to avoid unwanted pregnancies and plan parenthood.
>
> This control over their reproductive future saw more women enter the workforce. Increased participation … became the basis for ongoing social change that included legislation around equal pay for equal work and freedom from discrimination.

I reflected on the fact that in 1961, the pill was introduced in Australia. Then I came across this particular fact that in 1972, 11 years after the introduction of the pill, the luxury tax on the pill was abolished, and I wanted to understand why. I went back and looked at all the Australian Prime Ministers since 1961. Here is the list: Prime Minister Menzies—do we know which political party he was in?

A member interjected.

Ms J.L. HANNS: Yes, the Liberal Party. Then we had Prime Minister Holt, who was a Liberal, Prime Minister McEwen —

The ACTING SPEAKER: The Country Party.

Ms J.L. HANNS: Yes, correct, after the disappearance of Prime Minister Holt. He was followed by Prime Minister Gorton and Prime Minister McMahon, and in 1972, Prime Minister Gough Whitlam was elected. Does anyone want to guess how many days he was in office before he abolished the luxury tax on the pill? It was 10 days.

Ms A. Sanderson: That was Margaret.

Ms J.L. HANNS: Yes, that is very true. In 1972, Prime Minister Gough Whitlam abolished the luxury tax on contraceptives and placed the pill on the pharmaceutical benefits scheme list, reducing its cost to $1 a month. All of a sudden, the pill was affordable to many more women across Australia. I did not know that fact and that particular article is incredibly interesting to read. I certainly will not read it into *Hansard*. If anyone is interested in it, please go and have a look.

I talked about my grandmother and about the pill. Now I am going to talk about the introduction of RU-486 in Australia because that was also incredibly interesting. In the early 1990s, RU-486—I cannot pronounce the drug name itself—which is sometimes referred to as the abortion pill, was available in Australia after the World Health Organization's international trials of the drug. The results of those trials determined that it was a safe and effective method of pregnancy termination for women. It was also legal and accessible in many other countries around the world. As soon as the expectation grew that the drug would be approved for use in Australia following the international trials, anti-choice activists began lobbying to ensure that medical abortion was not widely available to Australian women.

In the mid-1990s, the Howard government was in power in Australia, with conservative Tasmanian Senator Brian Harradine holding the balance of power in the Senate. As a result of a political deal, Harradine pledged his support for government bills, including the privatisation of Telstra, in return for the introduction of restrictions on women's reproductive rights. I find that appalling for so many reasons, but probably the most pertinent reason in this discussion was that the reproductive rights of women, once again, were politicised and used as a political bargaining tool by men in exchange for the Liberal Party's agenda of economic reform and the privatisation of telecommunication assets. No wonder the cry of "Get your rosaries off my ovaries" resurfaced around Australia.

When I watch things on television or I read books, the teacher in me analyses things. I want to briefly touch on an incredible book by Margaret Atwell, and the television series based on it, called *The Handmaid's Tale*. This particular book was published in 1985 and refers to the patriarchal state known as the "Republic of Gilead" that has overthrown the presiding United States government. Handmaids were forcibly assigned to produce children for commanders within the Republic of Gilead. The book and the series followed the story of June, who was the handmaid for Fred Waterford. The teacher in me, with a minor in English, tuned into the themes in the book and the TV series. It covered the systematic rape of handmaids, with the handmaids becoming a symbol of control under the commanders of Gilead—what some might say are symbols that we could potentially link to the control that the Catholic Church and the patriarchy have over women's choices in modern-day society. The handmaids of Gilead are valued only by their ability to bear children. June is known by the name of Offred, which literally means the property of her commander Fred Waterford. Other handmaids in the book are known as Ofwarren or Ofglen, again the property of the commanders to whom they were assigned. In one episode of the TV series Offred said that these women were reduced to walking wombs, which could be argued to be the world view of churches, misogynists and, dare I say, male politicians—no disrespect to the male politicians in here, of course—who have historically made laws that impact on the rights of women to access health care. May I have a short extension, please?

The ACTING SPEAKER: It is either an extension or it is not, so you can have an extension. There is no such thing as a short extension.

[Member's time extended.]

Ms J.L. HANNS: I will have a long one. That is great, thank you. I thought that *The Handmaid's Tale* was a fantastic piece of fiction and that Gilead was as far away from the modern world as anywhere could be—that was until the US Supreme Court overturned the Roe v Wade decision. *The Handmaid's Tale* in the context of that decision, and I have watched it since that decision, is uncomfortable reading or viewing at best. I will not even start by deconstructing the idea of patriarchy in relation to the *Barbie* movie; that is for another day. As a mum of a 19-year-old daughter, I want my daughter to be the only person to exercise a right over her body through the choices that she makes, and the only person to have a say in accessing health care that is right for her. I do not want anyone else making those choices for her—not me, not a doctor and certainly not the people who do not know her or her personal circumstances. It is for those reasons that I absolutely support this Abortion Legislation Reform Bill.

I reflect back on the nearly 30 years that I spent in the teaching system supporting young people through the joys and the trials of teenagehood. I have been in the position in which young people have come to me and disclosed that they are pregnant and really struggling to have that initial conversation with their parents. That support system that teachers and teaching administrators in schools around Western Australia provide young people who find themselves in that situation is outstanding. As a teacher in the education system, it has been a privilege to have the opportunity to link those young people to the support systems and structures that they need to examine a choice that they may or may not make in that circumstance.

In the context of regional health care, I will discuss the parts of the bill that really highlight for me how important this legislation is. The first is the amendment to require that only one medical practitioner, not two, will be required to perform an abortion by prescribing, supplying or administering the drug to a patient, which is identified as a significant barrier to health care for people living in regional, rural and remote Western Australia.

I find the mandatory counselling part of the current legislation the most difficult to accept because no woman makes the decision to have an abortion lightly. I do not subscribe to the idea that it is a flippant decision and that women have total disregard for their future children; that is absolutely not the case. The women I know who have had abortions have really struggled to come to that decision and have weighed up all the pros and cons of their various personal circumstances, circumstances they are best placed to assess—not doctors, certainly not the courts and certainly not neighbours or churches or any of those things in their society and community.

The increase to a 23-week gestational limit for late-term abortions is incredibly important. Many parents who have a planned pregnancy are very excited to go to that 20-week scan, but, crushingly, some find out that something is significantly wrong with their baby. It is only at that point, at 20 weeks, that some people find that there may be major fetal abnormalities that mean that the baby will not live post birth. I have not been in that situation in which I have needed to decide, and I cannot imagine what it would be like, but I support the opportunity for people who find themselves in that situation to be able to take time, have the results of the scan come back, have a really important conversation with their partner and their families and make a decision that is right for them and their circumstances. Regional people will have the opportunity to really think about that and then potentially access those services, having to think of the logistics of travel, and will have the opportunity to go to a hospital to have that medical procedure performed. Yesterday, the member for Nedlands spoke about the example of Pippa's parents, who had to travel interstate, and the member for Riverton alluded to his own personal experience of that particular issue.

I reflect on the idea that families and women make these decisions around parenting. In these circumstances, what that looks like for me is that I will make a decision that reflects on my attitudes and values and the personal circumstances I find myself in. Some women are not in a financial or emotional position to have a child. They might not have supportive family networks. There might be drug or alcohol abuse issues for themselves or within the relationship they find themselves in. They may be having health or mental health issues. Family and domestic violence might be prevalent in their home, or they may be victims of rape or incest. These are realities for women who find themselves making those decisions. I think that when women really think through their own personal circumstances and make those choices, those are things that they think really clearly about.

Once a baby is born, the burden—not the burden, the joy, although sometimes it is a burden!—of parenting still really falls, certainly in my household, to women. I wish it were different, but that is the reality of it. As a woman, I carry the emotional and mental load of my family.

What that looks like in my house is when I go off to work in Perth for a week, I think about what I have to pack, what clothes I need, and what I leave behind so that the uniforms are ready for the next week at school. I cook some meals so that there is something in the house for Monday and Tuesday night, at least, and then the boys are left to their own devices. Domino's is a regular recurrence! The lunches are ordered so that my son has lunch during the week when either he or his dad forgets to make it while I am away. I am booking doctor's appointments, following up on those doctor's appointments, booking parent–teacher nights, buying my daughter a car—all those things fall to me. That is not to say that I have a deadbeat husband. Jason, you are not a deadbeat husband! I remind my husband on a regular basis that the emotional and mental load in the household is not distributed. Although the household tasks might be—the washing, the shopping, the cooking and all those things—the emotional load still predominantly falls to women.

It is very important that women have the opportunity to reflect on all those things, not only their personal circumstances, but also whether they have the mental and emotional load to be able to look after a child at whichever point in their life and whatever their personal circumstances.

All those factors make—sorry, minister, is that okay?

Mr R.R. Whitby: I'm just observing that I'm the only male member in here, with increasing frequency, maybe!

Ms J.L. HANNS: I have not been looking at you, I promise!

Mr R.R. Whitby: No, but you are absolutely right about that mental load. I am feeling very guilty. I think blokes have a bit in their brain that does not exist for that. I'm sorry. On behalf of my —

Ms A. Sanderson: What a load of rubbish—"I don't have that bit of my brain"!

Mr R.R. Whitby: It's true, I think!

Ms J.L. HANNS: We will do a very good job of helping you, minister; it is okay. But all these factors play a very significant role in a woman's choice about whether they are going to have a child. You go home and be good to your wife, minister; that is all I am going to say.

Mr R.R. Whitby: I will!

Ms J.L. HANNS: I believe that caring for a child is a whole-of-community responsibility. It has to start with giving women the initial choice of whether they are ready or able to be a parent. Choosing to have a child does not automatically guarantee a happy ending, and I make that point really sincerely. There is no guarantee that having a child will end up with that child being cared for, having adequate housing, being safe from violence, or being raised in a family that cares for them or even a family that loves them. In my experience as a teacher, I have very sadly seen so many children come into the care of child protection under the Department of Communities. They may do so for some of the same reasons that those women seek abortion care in the first place, and that is the irony of it—the absence of supportive family networks, drug or alcohol abuse, health and mental health issues, family and domestic violence. I want to say a huge thankyou to foster carers who step in and provide care for young children when they find themselves in those circumstances. I say a very big thankyou particularly to an organisation in my electorate called Foster Families South West, which does an incredible job of looking after young people whose parents find themselves unable to care for their children.

In summarising my contribution to this debate, I absolutely thank the minister for her commitment to this legislation. I really hope that she takes the time to reflect on the fact that since 2017, she has influenced or developed other legislation as well as this bill, the Abortion Legislation Reform Bill 2023, and the Voluntary Assisted Dying Bill 2019. The minister has been a huge part of transforming the healthcare system, which provides greater health care options and choices to all Western Australians. It is an incredible legacy and a testament to her commitment to health care in Western Australia.

In saying all that, I would like to say a huge thankyou again to the minister and her staff and all the people involved in the drafting of this legislation. I commend this bill to the house.

MS S.F. McGURK (Fremantle — Minister for Training) [12.26 pm]: I have really appreciated being able to listen to the other contributions to the Abortion Legislation Reform Bill 2023. I know it is something that a number of people who have spoken, particularly the women, feel quite strongly about, because, essentially, the history of the fight for women's equality is also a history of women's reproductive rights. We see around the world that there is a better quality of life for families in places where there is population control and education of women. Central to that is that women have choices about how they control their reproductive capacity. Therefore, I join in supporting the Abortion Legislation Reform Bill, and also thank the Minister for Health for her shepherding of this legislation to the point that we are debating it here in Parliament. This is important for our state. It is an issue that is debated with increasing fervour and ferocity across the world. In my view, there should not be a debate about access to abortion in our community. Women's health care should not be up for debate. Women's bodies are not up for debate. Women's fundamental reproductive autonomy and women's safety, privacy and dignity should not be up for debate.

I have heard it said before that one cannot ban abortion; one can only ban safe abortion. With that in mind, I begin my contribution on this critical piece of legislation. As other members have observed, it has been 25 years since Western Australia's laws on abortion were changed. Now, with the support of the WA community, our government will bring our abortion laws in line with the rest of the country. This legislation will remove unnecessary barriers to care by streamlining care pathways for women and make contemporary WA's statutory framework.

After two doctors were charged under the Criminal Code for conducting an abortion in February 1998, Hon Cheryl Davenport introduced a private members' bill into the Legislative Council, the Criminal Code Amendment (Abortion) Bill 1998, which sought to repeal the sections of the Criminal Code that made it an offence to procure an abortion. That bill became the Acts Amendment (Abortion) Bill 1998, introducing amendments to the Health Act 1911 on the performance of abortions. This major reform is the basis of WA's abortion provisions currently in the Health (Miscellaneous Provisions) Act 1911.

Before I go on, I join others in acknowledging the efforts of Hon Cheryl Davenport and a former member for Perth, Diana Warnock, for their work. The bill they shepherded through the Parliament in opposition was nothing short of radical at the time. Without them, the community of women and other supporters who worked with them we would not be where we are today.

I also pay tribute to other supporters who have had a hand in bringing this bill before the Parliament. I thank the providers of abortion services in Western Australia, including Marie Stopes International Australia; Nanyara Medical Group, Rivervale; and also Sexual Health Quarters.

When I was conducting research for this speech, I looked at the Marie Stopes International website, and I was really heartened to see the straightforward way that the information is provided. I know that other providers do this as well. I want to read from its website, because I hope that women with an unwanted pregnancy, and women and girls who perhaps have not had the good fortune to receive good sex education or access to reliable information, find themselves on this website. I quote —

> Abortion, also known as termination of pregnancy, is a safe and standard medical procedure used to end a pregnancy through surgical intervention or by taking medication that causes the contents of the uterus to be expelled.
>
> We understand that women and pregnant people at all stages of their reproductive life can find themselves faced with making the difficult decision to terminate a pregnancy.
>
> Our services provide women and pregnant people with a supportive, compassionate and confidential environment to discuss and assess available options. In addition, we assist you in deciding the correct procedure for you, depending on your preferences and the stage of the pregnancy.
>
> Clients with or without Medicare card, who are undergoing a termination of pregnancy procedure at a MSI Australia clinic, are eligible for a free STI check by assessment or at your request.
>
> We can also fit long-acting contraceptive methods after your procedure. Insertion of a long-acting contraceptive method is free for all clients choosing a surgical abortion at the time of their procedure. Clients seeking medical abortion or teleabortion can access a discounted insertion of a long-acting contraceptive method following their appointment.

Interestingly, the MSI website still states —

> You do not need a referral from your doctor to make a booking, except in Western Australia, where it is a legal requirement.

I mentioned the clinic in Riverdale, but I also acknowledge the work of SHQ, Sexual Health Quarters, formerly known as Family Planning WA, located in Roe Street. SHQ provide services to women every day. Whether its staff are doctors, nurses, advocates or support staff, the dedicated team at SHQ has improved the availability and accessibility of sexual and reproductive health in WA for over 50 years. It has played a key role in educating and informing the next generation of young people, empowering young people throughout the state to prioritise their sexual health. It is very important. This is an organisation that prioritises education and information about unwanted pregnancies, reproductive health and contraception information for all clients. It is especially accessible for young people, and I thank SHQ for its work.

In 1998, Western Australia became the first Australian jurisdiction to decriminalise abortion, but 25 years ago is a long time. It is indeed a lifetime for many of the women who are now taking up the renewed fight to improve access and the legal framework surrounding abortion services. The fight to improve our legal framework in WA was in part spurred by the massive protests that took place in America following the overturning of Roe v Wade, as well as Planned Parenthood v Casey. As we watched those hard-fought gains be eroded in the United States, and women's rights set back decades, people in Australia rightly turned their focus on our own abortion laws, including in our state. It became clear that the time had come to further strengthen and enshrine access to abortion for WA women.

I am proud to be standing here alongside those members of this house who are doing just that. The government, through the health minister, has consulted widely on the bill before us today. More than 17 500 people have had their say on reform work in the four-week consultation period. Those results showed overwhelming support for change from both the public and health professionals. Over 80 per cent of those respondents were women. What this bill will change has been well covered in contributions in this chamber, especially by the health minister, so I will largely steer clear of that.

However, I note that one of those proposals is to increase the gestational age to which additional requirements will apply to 23 weeks to better align with the situation in other Australian jurisdictions. I recently heard an abortion clinician say that she saw a pregnant 14-year-old girl and her mother, who were seeking an abortion for the girl. At the time, the girl thought she was roughly six or seven weeks pregnant. She was, in fact, over 20 weeks pregnant. For the clinician, this meant telling the girl and her mother that she was unable to help them. She had to tell them that they would need to fly interstate. To me, it is simply unacceptable that girls and women cannot access the services they need here in Western Australia.

On Tuesday, the member for Kimberley reflected on the experiences of Aboriginal women in her electorate who face challenges accessing abortion health care in rural and remote areas, particularly where access to doctors can be limited. For regional women, and especially Aboriginal women in remote communities, the time it takes to get an appointment can mean the difference between being treated close to home or having to travel to Perth—or, worse, interstate.

As many in this chamber know, my electorate of Fremantle is a place of progressive people. It is hard to imagine now, but Fremantle, like many places in WA, was home to some harrowing historical stories about women seeking abortion. This is an opportunity to acknowledge the work being done to document the social history of members of my community. The website is the Streets of Freo; some members might be familiar with it. It is a street-by-street history of the City of Fremantle, its heritage buildings, places, notable people and unique stories. It is an initiative by the member for Perth. Many members would know Reece Harley, who has been involved in documenting that history, but he is also in partnership with the University of Notre Dame Australia. Local artist Jo Darbyshire, a friend of mine, has documented some of this work.

It is worth acknowledging and thinking a bit about how things have changed. However, if we are not careful, and if we are students of what is happening in the United States, perhaps things have not changed all that much. This project goes through Fremantle street by street, so people understand what happened in their houses and various streets.

There is a story about Agnes Lee, who was born in 1875. Agnes was aged 31 years and worked as a waitress at the Victoria Coffee Palace in Packenham Street, which is a block away from my electorate office. She worked there with her sister and brother-in-law, and they lived together in Cantonment Street. Agnes fell pregnant, but was later abandoned by her boyfriend.

Debate interrupted.

[Continued on page 3689]

[Emergency evacuation alarm system activated.]

Sitting suspended from 12.40 to 12.57 pm