ABORTION LEGISLATION REFORM BILL 2023

Second Reading

Resumed from an earlier stage of the sitting.

MS S.F. McGURK (Fremantle — Minister for Training) [3.09 pm]: I was rudely interrupted by the emergency siren, which meant that we all spent a bit of time getting some fresh air out in the rain. I was talking about the example of someone in my electorate from 115 years ago, Agnes Lee, who experienced an abortion in Fremantle. For the chronicling of her life, we are grateful to the Streets of Freo, a not-for-profit and community contributed social history program that includes stories from around my electorate. I was saying that Agnes was 31 years old at the time, although I think she claimed to be younger. She was working at tearooms on Packenham Street. She had a relationship with a man who was already married and she was, sadly, admitted to Fremantle Hospital and died in September 1907 of septic peritonitis due to an abortion having been performed. It is just one small story, but reading some of the details about her life, who she lived with and her relationship with this man she expected to marry brings home just how much we hope to have a modern system in the twenty-first century that gives women choice and enables them to come forward and seek help.

As I was saying before the adjournment, although we hope that this is something that is very much of the past, we can see in other countries that are not that different from ours—that is, the United States—that in fact things have not changed as much as we would have liked. As a result of decisions in senior courts in the United States, we are starting to see an outlawing of abortion in a number of states, and women have to undergo some very dangerous procedures when they find themselves with unwanted pregnancies. In fact, just to finish off Agnes's story, although there was some media coverage and people were critical of the person she was in a relationship with, Charles William Dunn, because he was already in a marriage, two months later he received a billiard table licence at Wellington Mill and was able to continue with business.

The Streets of Freo has other stories of what happened to women who had unwanted pregnancies and underwent dangerous terminations. There were criminal convictions of those who performed the abortions and some of them are chronicled through that website. That is what we do not want. We want women to have choices, to have good reproductive and sexual health services available and to be educated about their choices. We want them to have accessible contraception, as the member for Collie–Preston talked about, but if they find themselves with unwanted pregnancies, we want them to have a genuine choice and professional, affordable and accessible services. This legislation will give us the framework to provide that in Western Australia and that is why I am supporting it.

I spoke earlier about the history of bringing this bill to the house, the awareness of the United States and people understanding that we cannot take the rights that we have in the modern world for granted, that we have to defend them, continue to update them and make sure they are fit for purpose.

We have done other work as a government to support women exercising their reproductive rights. In August 2021, this government strengthened protections for women seeking abortion by legislating safe access zones around premises that provide those services. I am pleased to say that legislating those safe access zones has worked. No longer are women confronted with protesters when they seek an abortion, an act that had a profound impact on not just those women, but also the staff working at the clinics.

[Member's time extended.]

Ms S.F. McGURK: The changes enshrined a 150-metre exclusion zone around the services, and harassing, intimidating and threatening a person accessing those premises was outlawed. The laws also prohibit a person from publishing and distributing recordings of a person accessing those premises, which also extends and protects women's right to privacy. Just as workers have a right to a safe workplace, people who work at abortion clinics have a right to attend their workplace free from obstruction and harassment. This bill today is another piece in this important body of work.

There is also a will across Australia on this important issue. On 1 August this year, the Therapeutic Goods Administration moved to lessen the amount of red tape for people accessing medical abortions. Prescribers and chemists will now be able to dispense MS-2 Step medication, known as RU486, without special registration or extra certification. The drug can now be prescribed by any healthcare practitioner with appropriate qualifications and training, including, importantly, nurse practitioners. Restrictions on pharmacists have also been lifted. RU486 is only available for the first nine weeks of gestation, meaning that early access is critical. All of this means that bit by bit we are making access to abortion easier for Australian women. The federal Assistant Minister for Health and Aged Care, Ged Kearney, said of the TGA's decision —

> "The [federal government's] Women's Health Advisory Council has heard many, many stories from women about deserts of care when it comes to reproductive health care, whether that's maternity care, quality care, or indeed access to terminations."

Our own government's bill will help improve access and equity to abortion services in WA.

I take the opportunity to speak about an issue that the member for Vasse raised on this bill, and that is proposed section 202ME(4)(a). The member for Vasse wants to amend this clause and it is my understanding that she seeks to limit the opportunity for people to get advice from medical practitioners residing outside this state. The current situation is that abortions from 20 weeks can only be performed if a medical practitioner has sought agreement from two members of a ministerial panel. As we know, Western Australia is the only jurisdiction with a panel approval process. In all other jurisdictions, an abortion after the gestational limit may be performed if two medical practitioners agree. Both patients and clinicians are in agreement that this process can be traumatising for families who are faced with an incredibly difficult decision about what is often a wanted pregnancy.

What does the bill propose? Proposed section 202ME will abolish the ministerial panel to bring WA into line with other states. From 23 weeks' gestation, a medical practitioner, the primary practitioner, must instead consult with another medical practitioner and both must agree that the abortion is appropriate, considering all relevant medical circumstances and/or current and future medical, physical and social circumstances. Proposed section 202ME(4)(a) states that the consulting medical practitioner need not reside in WA. The question I put to the house is why would a primary practitioner need or want to consult interstate? It is acknowledged that in a vast majority of cases, the primary practitioner would choose to consult another medical practitioner based in WA, as almost all abortions after 23 weeks are performed at King Edward Memorial Hospital for Women. It follows that medical practitioners would consult with their colleagues.

Notwithstanding that, there may be circumstances in which it would be appropriate for the primary practitioner to consult with an interstate medical practitioner—for example, for a patient who has been under the long-term care of an interstate specialist and has recently relocated to this state; or a patient in the East Kimberley who may have an existing relationship with a specialist based at Royal Darwin Hospital; in circumstances in which there is a rare fetal abnormality and it may be useful to consult with a geneticist from another state; or for futureproofing, noting that many regional medical practitioners already work across jurisdictions.

Medical practitioners can exercise their clinical judgement, as they do every day. Medical practitioners in all Australian jurisdictions are bound by their professional standards and guidelines. Concerns about a medical practitioner's practice or conduct can be appropriately investigated by the Australian Health Practitioner Regulation Agency, the Health and Disability Services Complaints Office, or their employer.

I think that addresses some of the questions that have been raised by the member for Vasse. She has sought to say that people are, effectively, doctor-shopping. Her amendment would require the second practitioner to reside in this state. The Minister for Health will have an opportunity to address that in her reply to the second reading debate, but it is my understanding that there are no other medical procedures or provisions for which that sort of restriction is applied to medical practitioners. Professional guidelines and professional complaints procedures are available if there are concerns that practitioners are abusing the process; however, we reside in a state in which people often work across jurisdictions and seek professional advice across jurisdictions; that is not limited only to people in regional Western Australia who might access health services from another state or territory. We need to question why the member for Vasse decided to flag this amendment, because it would be another restriction on women seeking an abortion that we do not seek to put on any other medical procedures.

I want to briefly talk about some issues facing young people in respect of the modernisation of our health legislation on abortion. As Minister for Youth I am privileged to have the opportunity to speak with and interact with many young people aged between 10 and 25 years, amongst other people. Along with those who have fought for decades, there is a fierce cohort of young people who have been marching on the streets of the USA, demanding reproductive rights. I am really struck by how literate young people in our state are about these issues and more broadly, but we cannot take that for granted. We need to make sure that we are proactive in public education and in listening to those young people. I am struck by their sensitivity, cleverness and insight and, critically, their ability to make decisions for themselves.

An element of this bill that has attracted attention is the removal of statutory provisions in the Health (Miscellaneous Provisions) Act and the Children's Court of Western Australia Act that require parental involvement when a dependent minor seeks an abortion. Under the existing legislation, a dependent minor is a person under 16 years of age who is supported by a parent or guardian. Currently, Western Australia is the only jurisdiction in which minors, regardless of their maturity, are required to meet a higher standard of informed consent for abortions compared with other medical care. The act currently prohibits dependent minors from giving informed consent unless their parent or guardian has been informed of their intent to access abortion and has been given the opportunity to participate in counselling and decision-making processes. At present, the only pathway to accessing care for a dependent minor who is unable or unwilling to inform their parent or guardian is by making an application to the Children's Court. This bill will remedy that by recognising the concept of the mature minor, in circumstances in which a young person has sufficient understanding and intelligence to consent to their own

medical treatment. This principle is already recognised in other pieces of legislation in Western Australia and in other jurisdictions.

Medical practitioners are well versed in processes for determining decision-making capacity; it is something they quite literally do every day. Removing this limitation will bring WA into line with other states. It also recognises that for many young people it may be unsafe, inappropriate or impractical to notify their parents or guardians. Should there be doubt about a child's competence to make a decision regarding abortion, the child will be able to choose to include their parents or guardians in the process. The registered health practitioner or hospital involved will be able to obtain consent from the child's parent or guardian pursuant to proposed section 202MM. Currently, parents can provide consent for a child for most medical procedures; however, this ability is confirmed in the bill to avoid any doubt that may arise due to an unsettled position in the common law with regard to abortion. In situations in which the child does not want parental involvement, or the practitioner is of the view that the parent or guardian is not acting in the best interests of the child, the registered health practitioner can make an application to the Supreme Court or Family Court to determine the course of action. This is consistent with other jurisdictions. Put simply, abortion is a legal medical procedure for which informed consent can, and should, be obtained in line with other existing standards of care. This legislation is about remedying an inequity of access. Women's reproductive rights are for women, and women alone, to determine. Our government will continue to defend women's rights, and so will I.

I want to again acknowledge everyone who has had a role in working on the bill, including the women of Western Australia, the staff, and especially the clinicians who do such important work providing healthcare to women when they need it most. My hope is that all the Western Australian women who have been calling for these changes feel heard and seen. When Hon Cheryl Davenport and former member for Perth Diana Warnock worked so hard to get the previous bill over the line in 1998, they knew there was more work to be done. I am proud that, led by Minister for Health Amber-Jade Sanderson, the Cook Labor government will finish that work.

Finally, I would like to pay tribute to former Labor MP Judyth Watson, who passed away last month. Judyth was a tireless campaigner for equality for women and for their reproductive rights. When she was elected in 1989 she was critical about the lack of discussion on abortion in this place. In 1995 she stated in this chamber —

> Reproductive issues and rights must be recognised as a critical part of overall general health and a key element of health care …
>
> …
>
> Abortion should be decriminalised …

Unfortunately, Judyth did not make it to see this bill become law; I am told she was pleased to see us introduce it in her final months. This is a historic bill, and I commend it to the house.

MS M.M. QUIRK (Landsdale) [3.27 pm]: I am taking a slightly different approach from the majority of the other speakers we have heard, but I have to emphasise that I am not so naive as to imagine that anything I might say today will influence the passage or ultimate fate of the Abortion Legislation Reform Bill. I can count.

Few, if any, members have opposed this bill in its entirety or expressed reservations about specific clauses. I am also acutely aware of the history and the determined Labor women who drove that reform. As we have heard on many occasions during the second reading debate, Western Australia was the first Australian jurisdiction to decriminalise abortion in 1998 under the Acts Amendment (Abortion) Act. Although I was not a member at the time, I witnessed some of the gruelling debate from the public gallery; it was emotional and fierce on both sides. There were many disrespectful and intemperate jibes across the chamber. Happily, the passage of this bill has proceeded more amicably and respectfully. Of course, this bill will modify the existing arrangements for abortion rather than establishing its practice without criminal sanctions.

There is no doubt that community standards, demographics and even medical practices have changed since 1998. We live in a pluralistic and increasingly secular society. That said, I also know that there are significant numbers of people in the community who have fundamental concerns. They might be about this bill or more broadly about abortion itself. They hold firm convictions about the sanctity of life. In fact, I received a letter today from a woman whose name I will not give because I do not have her permission. I suspect she is elderly because she has written it on notepaper herself, not typed it on a computer. I am making some assumptions here, but she writes —

> Many years ago I gave birth to a 9 week prem baby. He was so small his grandmother knitted him a layette using a doll's pattern!

"Layette" is not a word that is heard often these days —

> My tiny baby is now 193cm tall: a kind, loving responsible adult—and a taxpayer.
>
> Abortion is an unconscionable waste of human potential.
>
> I am so grateful my mother did not abort me.

Yours faithfully

As I said, this is the view of a number of people in the community and I think it is my duty to at least have those views expressed. They consider, as I do, that life begins soon after conception. Some actually believe it begins at conception. Others, although supportive in general of the notion of abortion, may have reservations about extending the gestational age, the oversight mechanisms, the de facto removal of parental consent or the rollout of some health practitioners being able to perform the procedure, some of whom are yet to be specified in regulations, as those practitioners are not doctors. As I said, their views on such an important issue merit being aired in this house. Those who sincerely hold those convictions deserve respect.

By way of preliminary observations, I value the opportunity that the Labor Party gives me to exercise a conscience vote. In this context, I should note that the bill we are debating is a government bill, not one introduced as a private member's bill. As a former government Whip, I know that distinction is more than a technicality.

The use of a conscience vote has been the subject of discourse in the ALP for many years and acknowledges the broad base of our party. I am indebted to an article by Dr Michael Easson, AM, in 2001. Dr Easson has had a distinguished business, union and party career, having been the secretary of the Labor Council of New South Wales, vice-president of the Australian Council of Trade Unions and senior vice-president of the New South Wales branch of the ALP. His article entitled "Conscience, Religious Tolerance, and Why It Matters to the ALP" sets out the background. In it, he refers to the 2002 federal ALP executive review of party policy on the conscience vote that looked at the history, custom and practice, and future of voting by conscience. He notes that the reviewers followed the Labor orthodoxy in proposing that binding ALP caucuses is a good thing, but that some exceptions are merited. Mr Easson says —

> In Labor's early years in the Australian parliament, "free votes" were allowed on some contentious economic policy, including tariff measures. Over the years, the Federal ALP Caucus allowed free votes on certain Bills and Motions of the Parliament, including divorce laws, the Matrimonial Bill … Matrimonial Causes Bill … Marriage Bill … fluoridation … abortion in the ACT … decriminalising homosexual acts … family law reform … medical benefits for the termination of pregnancies … euthanasia laws in the Territories … research involving embryos and prohibition of human cloning … the Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Bill …

Through the years, those are situations in which conscience votes were permitted, although I suspect that it is much narrower now. He continues —

> In the early 1970s, with all-party Committees in the Senate and the House of Representatives, ALP Leader Gough Whitlam argued that ALP members had a free vote on all committee matters.
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> …
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> Overall, the position of the Labor Party is that where there is Federal or State policy, then that position is binding on MPs. Where there is no policy, the majority position of the relevant parliamentary caucus is binding. One exception is abortion. In 1984, the ALP National Conference decided: "Conference resolves that the matter of abortion can be freely debated at any State or federal forum of the Australian Labor Party, but any decision reached is not binding on any member of the Party."
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> The conclusion of the National Executive review of conscience voting in 2002 was pragmatic: resolving to consider the conscience vote on a case-by-case basis, considering deeply held moral, social, and religious views as key.

Finally, by way of general observation, although trite, it needs to be reiterated that not all opposition to abortion is religious based.

I will now go on to talk about some background on the current state of play in Western Australia and Australia. The discussion paper that preceded this bill, "Abortion Legislation—Proposal for reform in Western Australia", was released in November 2022 and it summarises the latest data. It says that 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; the abortion rate per 1 000 women of reproductive age—that is, 15 to 44 years—declined from 19.5 per 1 000 in 2002 to 14.9 per 1 000 in 2021; and 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 weeks and 0.9 per cent occurred beyond 20 weeks, which of course this bill will extend.

In an earlier report, *Induced abortions in Western Australia: 2016–2018: Sixth report of the Western Australian abortion notification system: November 2019*, significantly we learnt, however, that the abortion rate per 1 000 Aboriginal women in WA was 10.1 per cent in 2016, 12.9 per cent in 2017 and 14.1 per cent in 2018. That is an increase from the previous triennium. For all other demographics, there has been a decline, but for Aboriginal women, there has been an increase of four per 1 000. I would have thought that that was quite a significant fact and maybe should have been included in the discussion paper that was released last year.

We further know from Australian research that with the wider availability of the so-called abortion pill, mifepristone and misoprostol, surgical terminations are declining. A study led by the University of Melbourne's Centre for Health Equity and published in the *Medical Journal of Australia* in 2021 found that the number of surgical terminations had decreased by 5.1 per cent since 2013, while at the same time prescriptions for these two drugs had increased more than sixfold. In an earlier study, "Factors associated with induced abortion over time: secondary data analysis of five waves of the Australian Longitudinal Study on Women's Health", which is in the *Australian and New Zealand Journal of Public Health*, researchers looked at five longitudinal studies of women's health and found that abortion is a common experience for Australian women and that one in six have had an abortion by their 30s. They further found that women from all walks of life may have had an abortion—married, single, child-free and mothers. In fact, women who have already had children are more likely to have a termination than those who have not. That research also investigated factors associated with abortion as women move from their late teens into their mid-30s. It found that women with lower levels of control over their reproductive health, whether through family violence, drug use or ineffective contraception, are more likely than their peers to terminate a pregnancy. It concluded that if we want to reduce the rate of unintended pregnancies and abortion in Australia, we need to empower women to have control over their fertility and support them with appropriate health services. After examining the factors associated with induced abortions, excluding those undertaken because of fetal abnormality, the researchers concluded that women whose alcohol use had recently become riskier and women who reported using illicit drugs in the last 12 months were more likely to have an abortion.

Violence is also a big factor. The researchers found that women who had recently experienced partner violence were more likely to terminate a pregnancy than women who reported no violence. Even women who reported childhood sexual abuse had a significantly increased likelihood of abortion in their 20s, although that decreased in their 30s. In fact, women who reported violence of any kind and at any time had a significantly increased likelihood of having an abortion.

It was concluded that we need to improve training and resources for health providers to identify and help women who may be at risk of unintended pregnancy, and particularly those who are using illicit drugs or experiencing partner violence. We need better ways of reaching all vulnerable women, but especially young women who are experiencing reproductive coercion.

I do not think it is contested that surveys undertaken both here and internationally show that support for surgical abortion is highest at the earlier stages of pregnancy—for example, six weeks—and that it declines significantly as gestational age nears 24 weeks. Even something like the method of calculating gestational age creates controversy, although I think that is probably diminishing with the refinement of ultrasound. In the 1998 act, the words "20 weeks of pregnancy" were used. The 2022 proposals for reform discussion paper had a more precise definition of gestational age—the duration of a pregnancy in the number of completed weeks. Methods used to assess gestational age include the known date of ovulation, the date of the woman's last menstrual period and diagnostic ultrasound. The average term of a pregnancy is between 37 and 42 completed weeks of gestation. Others argue that gestational age should be calculated from the moment of conception, but that of course depends on the mother's memory of an event that occurred several weeks before she realised she was pregnant. I have no medical expertise to assess the appropriate gestational age to be applied to these laws. It varies across the states and territories, from 24 weeks in Victoria and the Northern Territory to 22 weeks in New South Wales and 16 weeks in Tasmania. This bill proposes 23 weeks.

The Child and Adolescent Health Service very helpfully lists the likelihood of survival at various stages of gestation. It notes on its website that not all babies born between 23 and 25 weeks are able to survive the birth process and resuscitation. That in itself implies that reasonably sophisticated resuscitation methods are available. The survival rate of babies admitted to a neonatal intensive care unit is 60 per cent at 23 weeks and 80 per cent at 24 to 25 weeks. However, at 23 weeks, there is a 55 per cent chance of disability and a 15 per cent chance of severe disability. Similarly, at 24 weeks, there is a 39 per cent likelihood of any disability and an eight per cent chance of severe disability. By 25 weeks, there is a 35 per cent chance of any disability and a two per cent chance of severe disability.

My view is that the differences between jurisdictions on gestational age may be more about the tolerance level of different communities, which to some extent may be a political assessment rather than a medical certainty. I note, however, that Australian Medical Association (WA) president, Dr Michael Page, in an article on AusDoc on 19 June 2023, said that he believed the consensus among his obstetric and gynaecological members was that 22 weeks was more appropriate. He said —

> "If you're doing a late term abortion, say 24 weeks, there are not too many medical specialists who can, or are willing to do, late-term abortions on what might be a viable fetus if it's delivered live."

[Member's time extended.]

Ms M.M. QUIRK: I did not ask for a short extension, but I suspect it will be short, member for Churchlands.

Dr Page observed that changing the rules required an investigation of the capacity of the health system. He said —

> "The government needs to investigate what capacity there is and what the model would look like.

> "For example, you're not going to be able to deliver it in most regional parts of WA.
>
> "While the services can be delivered in Perth, they'd be very unlikely to be delivered anywhere else after 21-22 weeks."

Any legislative provision to improve access to termination services needs to be viewed in the broader context that access to all reproductive health services is seriously lacking for women in regional and remote WA. I commend to members the May 2023 Senate Community Affairs References Committee report *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia*. Amongst the findings in the report, paragraph 3.40 states —

> Access to maternity and birthing services for women who live outside Australian cities has been decreasing for decades. Evidence received from the National Rural Health Commissioner during the inquiry indicated that there was a 41 per cent reduction in the total number of maternity units in Australia between 1992 and 2011—from 623 to 368—with many of these closures impacting small maternity services located in rural areas. The Royal Australian College of General Practitioners … also submitted that some hospitals no longer support birthing deliveries at all.

Paragraph 3.43 states —

> When there are inadequate local birthing services, women are often advised to relocate and give birth away from home. This removes them from their existing support networks, disrupts continuity of care, and impacts on their ability to care for family members and undertake paid work. It can also result in relocation to a culturally unsafe environment for First Nations women.

Paragraph 3.134 states —

> The committee is concerned by the evidence illustrating the lack of maternity and birthing services for women who live in regional, rural, and remote areas of Australia. In particular, it is concerned to hear that women without access to adequate local birthing services must relocate and give birth away from home. The committee highlights evidence showing that this leads to poor outcomes for women and their babies, given that relocation comes with a financial cost, removes them from their support networks and families, and disrupts their continuity of care.

It continues at paragraph 3.135 —

> The committee considers it extremely important that women, regardless of where they live in Australia, have easy access to high quality, culturally safe maternity care. Women and their families should not be disadvantaged for living outside of a metropolitan area.

In terms of abortion, the report states —

> 3.139 Throughout the inquiry, the committee heard from stakeholders that Australia lacks adequate clinical services for termination care, resulting in women facing long waiting lists and lengthy travel times, often across state and territory borders and under acute time pressures, to access the appropriate care.
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> 3.140 The committee heard that this can cause delays and increase the cost, complexity and risk of trauma. The committee is mindful that these issues were raised as particularly acute for women and girls living in rural, regional and remote Australia, where access to any hospital can be challenging.

These findings lead me to conclude that the provision of broader access to abortion services that this bill will facilitate is only part of the picture. We should be just as committed to other aspects of women's health, including maternity services, and provide more opportunities for birth on country.

Finally, some food for thought. For those opposed to abortion, they contest that the underlying premise of this bill is that unborn children do not merit any consideration nor get any protection at law. Although we denounce instances of family violence where a partner kills their pregnant spouse, at law the unborn child is seen as extraneous or invisible.

In the public discourse, we consider it a circumstance of aggravation that the partner was pregnant. At law, however, that child does not exist. In March 2022, the NSW Crimes Act was amended to create two offences. One is an offence of causing loss of a fetus. This offence applies to a wide range of criminal acts, such as dangerous driving causing grievous bodily harm or grievous bodily harm with intent to injure the pregnant woman. The offence carries a maximum penalty of five to 28 years' imprisonment. The second offence is of causing loss of a fetus; that is where the pregnant mother dies as well. This offence will apply to a person's act or omission, which constitutes a homicide offence, such as murder, manslaughter or dangerous driving occasioning death where the fetus is lost

and the expectant mother is also killed. That carries three years' imprisonment in addition to the maximum penalty for the homicide offence itself.

What is significant and why I think the laws have been eschewed in Western Australia is that it may diminish the standing of the abortion laws or in some way interfere with the policy objectives of those laws. In the New South Wales legislation, it is expressly stated that they are not to affect the reforms introduced in its Abortion Law Reform Act 2019. It expressly excludes any act or omission of the pregnant woman. With the consent of my caucus colleagues, I would be prepared to draft and introduce a private member's bill to that effect, creating these criminal offences. Maybe the bill could be limited to gestational age greater than 23 weeks in order to ensure that there was no remote possibility of an overlap or conflict of laws. That is food for thought. Maybe, as we have now reached a level of maturity in abortion laws, we can look at what are horrific instances of domestic violence in which pregnant women are killed or injured and the fetus is also killed.

To conclude, I fully understand the notion of women's autonomy over their bodies, which has been expressed by most members. I also appreciate the desire to treat abortion simply as a health issue divorced from political or religious perspectives or interference. However, for some in our society, motherhood is seen as an impediment to full participation in the workplace or an education. While that attitude prevails, there will continue to be pressure, albeit subtle, and expectations that advancement and the path to equality is in the absence of children. As I said, it is subtler and there are certainly laws against discrimination these days, but the easier access to abortion may lead to some expectation by some third parties about it being the first rather than the last resort.

The way forward is to continue to collect data to ensure that birthing as well as termination resources are more readily made available in all parts, especially in remote and regional Western Australia. We need to address the broader social issues for women highlighted in the research I quoted. We need to address the correlation between exposure to family violence and abortion and illicit drug use and risky alcohol consumption and abortion. We also need to identify vulnerable and those at risk at an early age and those at risk of reproductive coercion and how we train health practitioners to recognise it. Finally, as I have said, although unlikely, I would like the limited protection of the criminal law to be considered where a fetus is killed in the course of the commission of a crime, including assault or homicide by a partner.

MS C.M. TONKIN (Churchlands) [3.55 pm]: I rise to make a relatively brief contribution to the second reading of the Abortion Legislation Reform Bill 2023. This is a bill on which we will each exercise a conscience vote, and I will be voting in support of this bill. We are not debating the rights or wrongs of abortion. Abortion has been lawful in Western Australia since 1998 and will remain so. We are now seeking to address very outdated, unnecessary and traumatising provisions in the current legislation. That said, I acknowledge the strength of leadership and character of those great woman who, from opposition, steered the 1998 abortion law reform through this Parliament—Hon Cheryl Davenport and Diana Warnock. This 1998 reform, which was groundbreaking at the time, provides the basis for this state's abortion provisions in the Health (Miscellaneous Provisions) Act 1911. I also acknowledge the leadership and sensitivity of the Minister for Health in shaping this bill through extensive stakeholder consultation. It takes another great woman to ensure that this legislation respects and eases the deeply personal experiences of women faced with unenviable choices.

Like my good colleague the member for Bassendean, I had a Roman Catholic upbringing. As such, I would have been personally deeply conflicted if I had ever needed to seek an abortion. That said, I understand the deep trauma of dealing with an unviable pregnancy. Over 40 years ago, I was looking forward to a second child and went to King Edward Memorial Hospital for Women for a scan at 14 weeks' gestation. I thought it was all good and I was really looking forward to the arrival of this new baby. I remember every detail of that scan because it revealed that the fetus had died. I saw a tiny lifeless being on the monitor and I will never forget that image. I then had to return to the hospital for a surgical abortion because I did not miscarry naturally. I still grieve that loss.

In listening to the stories of women recounted by my good colleagues the members for Nedlands and Hillarys, I understand something of the grief with which they have lived, but I was horrified that their grief was compounded by the traumatising aspects of the current legislation. We owe it to all women facing the need for a later term abortion to ensure that their choices are respected and that they are provided with the best and most supportive medical care here in this state. That is why I am exercising my conscience vote in wholeheartedly supporting this legislation. I am supporting this legislation because it enshrines measures that remove unnecessary barriers to later term abortions, provides the option of abortion to those without decision-making capacity, and eases access for mature minors. I am supporting this legislation because it includes these measures in a way that demonstrates compassion and respect for the agency and circumstances of the women who find themselves in need of abortion care.

Key changes provided to abortion access under this bill include reducing the number of health practitioners required to be involved in providing abortion care from two to one. One medical or health practitioner is more than sufficient to advise a woman and provide her with information about her options and the implications of an abortion. Having to tell your story to many people is very confronting and very difficult and traumatising. The other key aspect is abolishing the ministerial panel requirement for approval of later term abortions. This would not be acceptable in

any aspect of male health care, and it is an affront to women that this provision exists. We now have the opportunity to remove it.

Allowing health practitioners to conscientiously object to support a woman through an abortion but requiring them to refer patients to a clinician willing and able to provide that care is another important provision. It is not good professional conduct for a medical practitioner to, effectively, run down the clock by ordering more tests, more scans or more delay for a person seeking an abortion. If a medical or health practitioner does not wish to support a woman through that process, they should immediately refer her to someone who will, and that is why this provision in this bill is very important.

Another really important aspect of this bill is the removal of mandatory counselling provisions. Medical and health practitioners are required as a matter of practice to provide women with information about the options and implications of an abortion for their health and wellbeing. That is standard professional practice and good conduct.

Removing the requirement for ministerial approval for a health service to perform late abortions is also essential and an important aspect of the bill, as is increasing the gestational age for which additional requirements apply to abortion care from 20 weeks to 23 weeks to better align with the situation in other jurisdictions.

I will focus in my contribution on only three aspects of the bill—later term abortion, easing access to abortions for mature minors and addressing restrictions on access to abortion for people without decision-making capacity. The vast majority of abortions in this state are undertaken at nine weeks or fewer of duration, and they are medical abortions. The member for Landsdale quoted that 83 per cent of abortions are at nine weeks or fewer duration. The extent to which abortions are carried out after that date reduces dramatically. There are currently considerable restrictions in this state on abortions beyond 20 weeks of fetal gestational age.

Because fetal abnormalities often only become apparent through a scan at 20 weeks' gestation, there is then little or no opportunity for a woman to come to terms with her situation and consider her options within such a very short time frame. This is a deeply difficult decision for many women, particularly at that later stage of gestation, and to be forced in literally days to make what is a critical decision is unfair and impractical, and it shows a distinct lack of compassion. Giving women more time to come to terms with the information they have received and to deal with it and consider their options is crucial. Raising the gestational age for which there are additional requirements to obtain abortion care to 23 weeks relieves some of the pressure on women who may be faced with what is often a very traumatic decision. That said, in this state later term abortions after 20 weeks are very rare, representing less than one per cent of abortions.

This bill will remove the requirement for an abortion to be considered by two medical practitioners, the practitioner performing the abortion and another—rather, it will authorise one practitioner to perform an abortion on a patient who is not more than 23 weeks pregnant. This is a crucial aspect of this bill because it allows better access for women, particularly in regional, rural and remote communities, and it also means that women are put through the trauma of having to visit multiple providers and explain themselves in order to seek the assistance they require.

The bill will also introduce a provision to the Public Health Act to allow other registered health practitioners to perform a medical abortion on a fetus of no more than 23 weeks by prescribing, supplying or administering an abortion drug to the patient. This is consistent with the recent changes at the commonwealth level that allow nurse practitioners and endorsed midwives to prescribe medication. Of course, the prescribing practitioner will be limited to the class of practitioner set out in the regulations and authorised under the Medicine and Poisonous Act 2014 to prescribe the drug. The prescribing practitioner will be bound by regular restrictions associated with the administration of abortion medication. For example, the medication may be taken at home for pregnancies of not more than nine weeks, and a hospital or clinical setting is required for pregnancies of more than nine weeks. That makes a lot of sense because the risks for the mother increase over gestational time and a clinical setting is really important in that context.

Looking at the performance of an abortion by a medical practitioner at more than 23 weeks, we must acknowledge that seeking a later term abortion is extremely rare and is most often due to the discovery of a serious fetal anomaly or because of a serious risk to the person's health. Often, women seeking these late-term abortions are heavily conflicted because the pregnancy is very much wanted, and having to consider an abortion at that stage is deeply traumatic. It is almost always a difficult decision to make and a challenging process for women to endure.

The bill removes the constraint that currently exists under the Health (Miscellaneous Provisions) Act on patients seeking late-term abortions. Currently, a patient must seek approval from both their original medical practitioner and then obtain joint authorisation from another two medical practitioners who are members of a statutory panel appointed by the Minister for Health. My good colleagues the members for Hillarys and Nedlands outlined the deeply traumatising impact on women who have had to go through that process of explaining their circumstances to a ministerial panel. Under this legislation, proposed section 202ME will enable a patient to access an abortion when the primary medical practitioner has consulted with another medical practitioner and they both agree that

performing an abortion is appropriate in all the circumstances, including the person's relevant medical circumstances and their current and future physical, psychological and social circumstances. Importantly, women will be able to receive abortion care in this state after 23 weeks' gestation.

I now consider the matter of mature minors. It is very uncommon for young people to need access to an abortion. For those who do, most are able to bring their parents or guardians in on the decision-making and have their support, but often that is just not possible or safe. The member for Riverton gave a very eloquent example of a young homeless person without parental support who found herself in need of an abortion. Currently, girls under 16 years of age can access an abortion by involving their parent; if that is not possible, they can make an application to the Children's Court, so there are currently circumstances in which girls can obtain abortions without parental involvement. But consider the circumstances of a young person under 16 years of age who is faced with a need for abortion care and who has to seek the assistance of the Children's Court to have a decision made. Of course, these cases are very rare, but they are very much the reality for some girls.

This bill will provide two avenues for young people. If a young person is deemed to have decision-making capacity so they understand fully the proposed medical care that can be provided and is assessed as a mature minor on what is a very objective test by a medical practitioner, their decision-making can be supported. Health practitioners are well versed in assessing patients' decision-making capacity. When appropriate, they can make referrals to additional services to support a young person, such as counselling or a social work team. If a young person cannot make a decision for themselves, they can opt to have their parent involved, who may consent on their behalf. If that is not possible or safe, there remains an option to get the decision through the courts. Mature minors—yes, their decision-making capacity can be assessed and respected, but for those who do not have that decision-making capacity, there are other options, albeit not easy ones.

[Member's time extended.]

Ms C.M. TONKIN: Another aspect of this bill is access for adults who cannot give informed consent for an abortion. I was amazed to learn that under the current Health (Miscellaneous Provisions) Act an adult who is unable to give informed consent for an abortion is unable to access an abortion except in emergency situations. That is horrific. This bill will enable relevant parties to apply to the State Administrative Tribunal to make a decision on behalf of a patient who is unable to make reasonable judgement of an abortion proposed to be performed on them. In situations in which the patient has a guardian an application to the SAT will still be required. This model is consistent with other jurisdictions in which the consent of a guardian is replaced with that of a tribunal for certain medical procedures.

The provisions of this bill will ease access to abortion care for women in the most vulnerable of circumstances. The bill will provide better access to compassionate and professional care. I commend this bill to the house.

MS M. BEARD (North West Central) [4.15 pm]: I rise to make a very short contribution to the debate on the Abortion Legislation Reform Bill 2023. I am a little overwhelmed. Firstly, I acknowledge the many personal contributions that have been made in this place during the week and thank those who have bravely told their stories, sharing personal and heartfelt experiences that are very difficult to recount. It has been an emotional week in Parliament that has provided me with much greater insight. I have felt overwhelmed by the strength of many in here who have shared their stories willingly—thank you.

The provision of abortion services is a deeply personal and complex matter with no one clear answer and with many conflicted opinions, but we need to ensure that women are afforded the opportunity to make the right decisions for themselves. We need to operate in balance with all aspects of health for women, and we need to allow women to make the right choices and decisions on their own health care and wellbeing. Furthermore, women's circumstances are all unique, and they are best placed to make decisions about their own health and circumstances. We should be able to help them make those informed decisions without judgement and afford them the compassion that they deserve.

I believe that women faced with these difficult decisions do not take those decisions lightly. It is often a necessary option due to health risks or very challenging circumstances that many of us would not understand or ever have to endure. We need to ensure that women are adequately supported throughout their journey and well beyond and able to seek the help that they need to navigate this pathway, no matter what choice they make. It is imperative that if these changes pass the Parliament, the government makes sure that it addresses the concerns that have been raised by some in the community around some elements, some of which we have heard today, particularly that the provision of support and wraparound services for mothers who go through this process are adequate, accessible and easily available.

We know that there are complex legal issues and social, ethical and deeply personal questions and views relating to abortion. Under these proposed reforms, the Criminal Code offence is set to be repealed, with abortion to be decriminalised. This should assist women to make clearer and better informed decisions without additional pressure, and more easily access safe and timely care to seek the advice and assistance they need in this personal journey

and decision-making process. It should reduce the level of trauma often experienced and help them to make the right decision for themselves in their personal circumstances. Reducing the need for unsafe and illegal abortion should allow women to make more informed choices about decisions relating to their health and personal circumstances and ensure better access to medical services.

We need to be guided by the strength of our medical experts and clinicians and have comfort that their experience and knowledge over time will allow the stigma attached to abortion to be diluted so that every woman can take comfort in being able to freely and easily access professional advice and support. Some people have not been able to do this in the past.

I refer to regional areas that cover vast distances. I agree with the view of the member for Kimberley, as confirmed by the member for Bateman, that women who live in remote and smaller communities and are from diverse backgrounds and cultures, some living in very challenging circumstances, are in need of support and access to services, ongoing wraparound services, and help if and when needed. People who live in smaller close-knit communities can have increased challenges in personal health issues, such as a lack of health services, a lack of doctors and nurse practitioners, and limited anonymity. Everyone knows who everyone is in a very small community and can probably tell more about each other than one would think!

I also concur with the member for Kimberley's view that it is important for these services to be available on country. It is a positive thing for women if they can stay and access services and have options to help them through what might be a difficult time. I concur with the comments from the member for Landsdale this afternoon around the need for holistic women's medical services. I think we should find a way to bundle these in a holistic fashion in a one-stop shop. There is more than just the abortion side of it. It flows onto a whole raft of other issues within the women's health space. This is really important.

In relation to the cohort of young people impacted, I firmly believe we need to strengthen our education programs in schools around women's health in general. There is not enough sex education. I speak to my children who have been through school and one who is still going through school. I think there would be people in this house who probably remember the two books that I received—I am showing my age: *Where did I come from* and *What's happening to me?* My family lovingly gave them to me, and I was on my way. After that, it was left to high school and, if I think back, it could have been a whole lot better with a lot less mystery around all this. This is my point around women's health services in general and what needs to happen from a young age.

It is my understanding that the bill brings WA closer into line with the rest of Australia, removing the need for women to travel interstate and away from home to seek the care they need. In the minister's third reading, I would appreciate a summary on how the WA laws compare with other jurisdictions if it is available. I would appreciate some information to better understand—this may be in the regulations—if a woman makes a decision to seek an abortion, what support information is then provided, how it is conveyed and by whom. Is there an opportunity to extend that ongoing support? Listening to contributions in the house, this does not go away. Decades later, people still deal with the outcomes. Will there be free counselling services in regional WA that will encourage people to come forward and seek information? I am unsure whether there is a mandatory point in the process at which counselling is required, particularly for that younger cohort. I wonder what wraparound services are currently provided and how they will change under this reform if it comes to fruition, which for many people will be life changing.

In closing, I thank members for listening and I thank everyone who has made a contribution and provided submissions. It is an important debate for our state. It is an important debate for women. With many personal and individual views and values, it is a debate that is difficult for some people, and I recognise that from the feedback we have had here this week that has been incredibly enlightening for me. I look forward to the consideration in detail, and I thank everyone for their contribution in what has been a journey for me this week.

MR G. BAKER (South Perth) [4.23 pm]: I want to make a small contribution to the Abortion Legislation Reform Bill 2023. Firstly, I thank the Minister for Health for the briefing she provided last Monday on this topic, and for bringing medical experts in to inform our deliberations. I was struck by the many complications and variations in women's circumstances when they face these decisions, many of which I had not considered.

It got me thinking about a situation a few years ago when I got a phone call from a friend. She was about two months pregnant, and had just received a cancer diagnosis. She was reaching out to a small group of friends to help her with her decisions. Over a few short days, she had to work through options for both treatment of the cancer and the future of the pregnancy. The cancer was advanced, and chemotherapy was probably the best treatment option, but, as we know, chemotherapy and pregnancy are not compatible, so she also had to briefly consider where this process sat with WA's abortion laws. She was well supported by her partner, her extended family and friends and did not have difficulty accessing medical expertise and legal advice. None of these advantages made those days easy, nor her decisions easy.

When I sat in the briefing last Monday listening to the medical experts discuss the practical shortcomings of the current legislation, I reflected on my friend's experience and the many variations that could have occurred. It would have only taken a slightly different diagnosis, a slightly different treatment method or a more advanced pregnancy and my friend might have found herself in a completely different legal situation for her decision. As I listened to the medical practitioners last Monday, I heard of the many different circumstances that can come to play in these decisions—medical complications; economic complications; social and family complications; and intersection of faith and deeply held beliefs and the realities of medical care in regional and remote Western Australia. I found myself wondering what choice I might make under that medical circumstance or that family circumstance or in different combinations of complications. But the truth is that it would not even be my choice. It would never be my body on the line. It would never be my life on the line. I could never fully understand the position of the women who face these decisions. This bill makes the woman's decision central to the process and removes artificial barriers this Parliament has created.

This bill will increase the time lines for decision-making; ease the legal barriers and hurdles to abortion; reflect the reality of medical care in regional and remote WA; and, most importantly, remove abortion from the Criminal Code. As legislators, we are not sent here to make the easy decisions; we are sent here to make hard ones. I congratulate the Minister for Health for bringing forward these essential reforms, and I commend the bill to the house.

Debate adjourned, on motion by **Ms C.M. Rowe**.

House adjourned at 4.27 pm